



Royal College of
Obstetricians &
Gynaecologists

Maternal Mental Health – Women’s Voices

February 2017





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Registered charity no. 213280

www.rcog.org.uk

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Foreword

As many as one in five women develop a mental health problem during pregnancy or in the first year after the birth of their baby. The pain this causes women and their families, the negative impact on their health and wellbeing, and the economic costs to individuals, the NHS and the nation are considerable.

The *Saving Lives, Improving Mothers' Care** report by MBRRACE-UK in 2015, covering the period 2011–13, identified that around one-quarter of all maternal deaths between 6 weeks and 1 year after childbirth were related to mental health problems and one in seven of those women died from suicide. In approximately 40% of cases, improvements in care may have made a difference to the outcome. National policy and National Institute for Health and Care Excellence (NICE) guidance have identified the evidence-based interventions and services needed, but across almost half of the UK pregnant women and new mothers have no access to such care. As a result, an enormous number of women and their babies are at risk.

We are encouraged that maternal mental health has been made a priority by Government. The National Maternity Review, with its aspirations to offer more personalised and safer care, was explicit in its call for more investment in postnatal and perinatal mental health care. NHS England, working with the Maternity Transformation Programme and Mental Health Transformation Board, will implement this vision and are currently working with stakeholders to produce care pathways and protocols for specialist community perinatal mental health services. In August 2016, it was announced that a Perinatal Community Services Development Fund was being launched and this was followed in September with another announcement that NHS England was to fund four new inpatient mother and baby units for women with the most complex and severe needs in areas where there was no access.

In 2016, the RCOG marked International Women's Day by holding a one-day conference that examined the barriers to the provision of high-quality care in maternal mental health. With the support of the Royal College of Psychiatrists and input from a range of clinicians, including our midwifery and GP colleagues, we discussed why women do not seem to be receiving the care they need on the NHS. We also heard heart-wrenching stories from women who had mental health problems during and after pregnancy – a stark reminder to all of us that no woman should slip through the net and their mental health needs must be at the centre of our focus across the whole of their maternity and postnatal care.

Feedback from the event revealed that women's voices often went unheard or unnoticed. We believed that it was time to give women the opportunity to speak out by conducting a survey exploring women's experiences of perinatal mental health problems, their experiences with healthcare professionals and access to specialist services. Despite the pain, trauma and stigma that women describe as a result of mental health problems, over 2300 women responded in order to convey a clear and unequivocal messages to us all.

The results present a stark picture of an NHS in which women with poor maternal mental health during pregnancy and after birth experience low rates of onward referral and long waits, with many

* MBRRACE-UK. *Saving Lives, Improving Mothers' Care: Surveillance of Maternal Deaths in the UK 2011–13 and Lessons Learned to Inform Maternity Care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–13*. Oxford: National Perinatal Epidemiology Unit, University of Oxford; 2015 [www.npeu.ox.ac.uk/mbrrace-uk/reports].

seeking private treatment as a result. This is not delivery of evidence-based care on the basis of need, free at the point of access, and is neglecting some of the most vulnerable people in our society.

The NHS in England has a lot of work to do to ensure that women can access specialist community perinatal mental health services, as well as to meet waiting times requirement for perinatal mental health. Regional variation is evident across many of the results of the survey, demonstrating the geographical inequity of care in what should be a national health service. Equally striking is the variation in professional advice, behaviour and care experienced by these women. In an area of healthcare already beset by misunderstanding, ignorance, stigma and other barriers to access, it is tragic that professionals and services are so often making matters worse.

Throughout the UK, other serious gaps in services remain: maternity services need the capacity to offer continuity of care to this group of women, universal health visiting services must have the capacity to work with these most needy and high-risk parents and their babies, and child mental health services must invest in parent–infant attachment services. We also have work to do in addressing the needs of partners, 12% of whom were described by respondents as having mental health problems themselves, often neglected by healthcare professionals and services.

However, there are glimmers of hope. Among women who gave birth 4–5 years ago, 24% reported that they had not been asked by any healthcare professional about their mental health, but this was down to just 8% among those women who gave birth in the past year. Many of the responses also described excellent care provided at every level, as well as the benefits of specialised help from perinatal mental health services and mother and baby inpatient units. In England, we can expect that many more women will be able to access well-informed care at every level and specialist care when needed following recent Government funding. In Wales too, new funding is now being used to improve specialist care.

Highlighting the power and importance of lived experience, we have heard from women themselves. To the already well-documented health and economic necessity, these results now add the moral imperative to take action. This is truly everyone's business – healthcare professionals, managers, providers, commissioners, policy makers and politicians. Individually and collectively, we must all respond to this sobering report now and put an end to these unacceptable levels of avoidable suffering.



Royal College of
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Professor Lesley Regan
President, Royal College of Obstetricians and Gynaecologists



MATERNAL MENTAL
HEALTH ALLIANCE
Awareness Education Action

Dr Alain Gregoire
Chair, Maternal Mental Health Alliance

Maternal mental health

Putting into context

It's been estimated that maternal mental health problems cost the UK

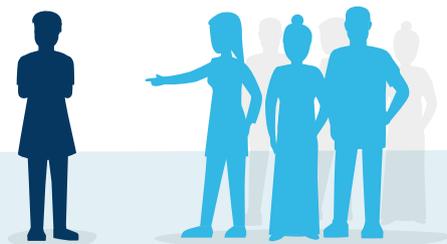
£8.1bn*
each year



Up to **1 in 5** women develop mental health problems during pregnancy or in the first year after childbirth



Around **one quarter[†]** of all maternal deaths between six weeks and a year after childbirth are related to mental health problems



Nine out of ten people with mental health problems experience stigma



Maternal mental health conditions can range from low mood to **psychosis**



In **almost half[‡]** of the UK, pregnant women and new mothers have no access to specialist community maternal mental health services

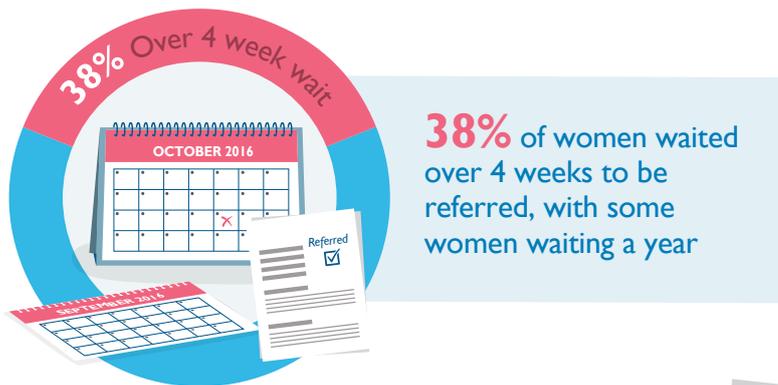
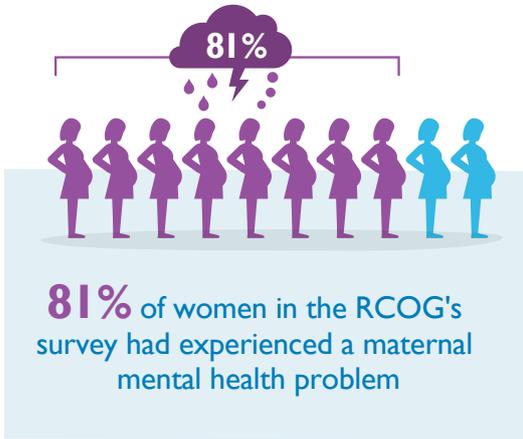
* London School of Economics and Centre for Mental Health. *The costs of perinatal mental health problems*. October 2014 [<https://www.centreformentalhealth.org.uk/maternal-mental-health>]

† MBRRACE-UK. *Saving Lives, Improving Mother's Care*. December 2015 [<https://www.npeu.ox.ac.uk/mbrance-uk/reports>]

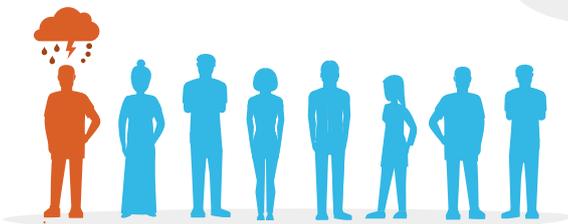
‡ Maternal Mental Health Alliance. *UK Specialist community perinatal mental health teams (current provision)* [http://everyonesbusiness.org.uk/?page_id=349]

Maternal mental health

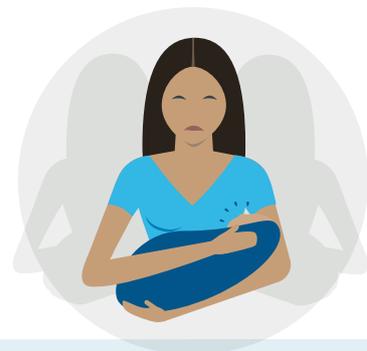
Key findings from the RCOG's survey of 2300 women



There is **poor awareness** among women and healthcare professionals of the range of mental health conditions and services available



1 in 8 **partners** experience mental health problems and most received no support



Difficulties in **breastfeeding** can have an impact on some women's mental health

Maternal mental health

Key priorities going forward



Women should feel supported by their healthcare professionals to talk openly and honestly about their feelings. NICE guidance on antenatal and postnatal mental health should be followed.



Women should have **timely and local access to maternal mental health services** and continuity of care across midwifery, obstetric and neonatal care wherever they live in the UK.



Maternal mental health conditions are wide-ranging and all conditions should receive attention. Training healthcare professionals to help them recognise symptoms and provide accurate, timely information to women is crucial.



Support should be available for partners, as part of a wider approach of treating maternal mental health and limiting the impact it can have on the whole family.

During pregnancy and after the birth of a child, women are at a higher risk of experiencing mental health problems. This period is also a time when a range of mental health conditions that a woman may have previously experienced can return or worsen. Low mood, anxiety and depression are common mental health problems that occur during pregnancy and in the year after childbirth. The pain these conditions cause women and their families and the negative impact they have on their health and wellbeing are significant.

This report is based on the findings of a survey of over 2300 women on their experiences of care in relation to their mental health during pregnancy and in the postnatal period.

Experiences of perinatal mental health

81% of women who answered our survey had experienced at least one perinatal mental health condition during or after their pregnancy. Low mood was experienced by over two-thirds of the women, anxiety by around half and depression by just over one-third.

The women who experienced perinatal mental health problems were more likely than those who did not to have experienced them in the past, but nevertheless almost three-quarters of the respondents had no previous history. Those who were previously on medication for their mental health received inconsistent and conflicting advice from healthcare professionals about whether to continue or stop.

Partners can also experience mental health problems during a woman's pregnancy and after the birth, yet they are often forgotten about. The impact of mental health problems on the whole family unit can sometimes be overwhelming, with a number of women feeling that their condition directly impacted on their partner's mental health, and in some instances led to the breakdown of the relationship. One in eight (12%) of our respondents reported that their partner had experienced mental health problems during or after their pregnancy. Women who had no mental health problems were less likely to report their partner experiencing issues during or after their pregnancies.

Experiences engaging with healthcare professionals

The majority of women (85%) had been asked about their mental wellbeing by at least one healthcare professional. Importantly, over the last 5 years there have been improvements in the number of women being asked about their mental wellbeing. Only 8% of women who had given birth in the last year were not asked about their mental wellbeing by any healthcare professional, compared with 24% of women who had given birth 4–5 years ago.

Most women said that they would be comfortable talking to at least one healthcare professional about their mental health although they emphasised that the most important aspect of this was the person themselves and not their profession. Where women were not comfortable talking to healthcare professionals about their mental wellbeing, the most common reasons were concern about it being noted on their records, not believing that healthcare professionals could or would help, and the stigma attached to mental health problems.

Referrals and services

Fewer than half of the women who reported experiencing mental health problems were referred on to services or offered any further information about where to go for support, with one in five

accessing support from services. Only 7% of the women who reported experiencing perinatal mental health problems were referred on to specialised care, such as a mother and baby unit or other specialised perinatal mental health services.

Speedy access to support and early treatment is important to improve outcomes for women and their families, yet for 38% of the women referred it took over 4 weeks after referral to be seen. Some women reported waiting over a year, with a number highlighting that their referral took so long that they had to seek private treatment as they could not wait any longer.

Regional variations

Although women throughout the UK experienced similar levels of perinatal mental health problems, their experiences of care varied greatly. In one region only 15% of women were directly referred on to services compared with 35% in another region. When women were referred, the treatment they received was also mixed, in one region only 8% saw specialised perinatal mental health services (excluding mother and baby units), compared with 50% of those referred in another. There were also disparities in the time it took women to be seen after referral, with 58% in one region having to wait over 4 weeks, compared with the lowest level of 22% in another region.

Women's voices

In the final question, an open text box, over 1100 women shared what gaps they felt there were in the mental health support given to women before, during and after pregnancy.

Women felt that when they talked to healthcare professionals about their mental wellbeing, they weren't asked in an open way and were often shut down or had to repeatedly ask for support. Appointments with healthcare professionals were often rushed, with most women feeling this was down to an overstretched service, not because the healthcare professionals did not care.

A major recurring theme throughout was that women felt that there was a lack of knowledge and understanding about the range of perinatal mental health conditions, not just from healthcare professionals, but also from the women themselves. While many had heard of postnatal depression, they felt they wouldn't be able to recognise the symptoms, let alone having even heard of the range of other conditions. Antenatal classes often failed to mention mental wellbeing, and when they did they primarily focused on baby blues and postnatal depression.

Many women who experienced anxiety conditions felt that their symptoms were ignored or not treated seriously enough because they did not fit into the category of postnatal depression. When these women were asked about their mental wellbeing, questions often focused on mood and not anxiety symptoms such as flashbacks. Women who experienced problems during the antenatal period also felt unsupported and were sometimes told they would have to wait until after the birth to receive help.

Others reported that their circumstances had had a huge impact on their mental health. For example, if a woman experienced a physical condition during her pregnancy such as hyperemesis gravidarum (severe nausea or vomiting during pregnancy) or pelvic girdle pain (pain in the pelvis during pregnancy), they were often left feeling isolated and anxious but only their physical symptoms were treated. Women also reported that following miscarriages or stillbirth there was little support for their mental health and a lack of acknowledgement of the impact these events could go on to have in subsequent pregnancies.

Overall, respondents felt that the pressures to breastfeed were sometimes overwhelming and the judgement and stigma that came with not being able to, or with not wanting to, breastfeed their babies was hard to cope with. Many felt that they were blamed when breastfeeding went wrong, and this was hard to cope with alongside their own feelings of failure. Women on the whole felt that more breastfeeding support was needed, as it impacted on their mental wellbeing, whether or not they were experiencing other perinatal mental health conditions.

For commissioners

Timely access to services is vital for the best outcomes for women, their babies and their families. Appropriate services should be available to all women who require them. Commissioners should ensure that NICE recommendations are followed. Women experiencing perinatal mental health problems should be assessed for treatment within 2 weeks of referral and psychological interventions should take place within 1 month of initial assessment.

All women, irrespective of their location, should have access to specialist community perinatal mental health services if they need them. Clinical commissioning groups should conduct a needs assessment of the available services in their area and work with NHS England to improve access to care and apply for funding.

Although NHS England's funding for perinatal mental health services is welcome, commissioners in the devolved nations should also urgently address specialist community perinatal mental health services, including wider provision of mother and baby units.

Women and their families need information on the effects that pregnancy and childbirth can have on mental wellbeing, including the signs of perinatal mental health problems to look out for. Commissioners should review and update the information currently available to women and include discussions on perinatal mental health and on where to go for help in antenatal classes.

Commissioners should consider introducing clinically supervised and trained local peer support networks and groups in partnership with the community and voluntary sector, which many women find particularly helpful in their recoveries. These should include provisions to remove barriers for women to attend, such as on-site crèches, to allow women to bring their babies with them.

Commissioners need to ensure that all healthcare professionals working with women during and after pregnancy are aware of the referral pathways for local perinatal mental health services so that women can receive support without unnecessary delays.

Bereavement support following a stillbirth should be automatically offered to a woman and her partner. Services should also take into account the impact that multiple miscarriages can have on a woman's and her partner's mental health, especially the effects that they will have on anxiety in subsequent pregnancies and births. Following a traumatic birth, recurrent miscarriages or a stillbirth, services should consider offering support for couples to attend together, such as couples therapy.

Services should explore mechanisms to diagnose and offer appropriate treatment to partners experiencing mental health problems before and after the child's birth, as part of a wider approach to treating perinatal mental health problems and limiting the impact it can have on the whole family.

Difficulties in breastfeeding can impact on a mother's mental health. Commissioners should examine opportunities for more breastfeeding support in communities. They should also consider opportunities to better link breastfeeding and perinatal mental health support services together; for instance, breastfeeding drop-ins and groups could provide opportunities to discuss and raise awareness for perinatal mental health services.

For maternity services

As recommended in the National Maternity Review report, *Better Births*,^{*} maternity services should ensure a smooth transition between midwife, obstetric and neonatal care, and ongoing postnatal care in the community provided by GPs and health visitors. Severe mental health problems in pregnancy, a previous history of mental health problems in pregnancy and a family history of poor mental health should all be 'red flagged', as should the circumstances of a difficult pregnancy or birth, so that care can be coordinated and planned with services centred around the woman. All healthcare professionals should be aware of their shared duty to protect a woman's mental health during the perinatal period.

Better data sharing of patient records between primary and secondary care will assist in ensuring that women who are at risk of mental health problems during and after pregnancy are known to maternity services and will enable timely treatment.

The National Maternity Review report, *Better Births*, recommends continuity of carer to ensure safe care. Services should also analyse the positive impact this can have on women's mental health, enabling women to develop trusting relationships with healthcare professionals where they feel more comfortable discussing mental health problems.

All labour wards should have a perinatal mental health lead who works in a team with a perinatal mental health specialist, a midwife and an obstetrician, and who can carry out quick assessments on a woman's mental health following childbirth. Any woman who has had a traumatic birth should be seen and assessed before being discharged and given information on where to seek help should perinatal mental health symptoms develop.

^{*} National Maternity Review. *Better Births: Improving Outcomes of Maternity Services in England, A Five Year Forward View for maternity care*. 2016 [www.england.nhs.uk/ourwork/futurehhs/mat-transformation/mat-review/].

For Government

As well as monitoring and publishing data on the new waiting time targets for mental health, the Government should consider setting specific targets for perinatal mental health conditions, which, owing to their unique nature, require prompt access to services.

Stretched and understaffed services not only affect the quality and safety of care but also impact on the time that healthcare professionals have to enquire about a

woman's mental health. Current shortages of doctors and midwives have left many maternity units overstretched; additional investment in maternity services would help to ensure that women have the time to discuss their mental health needs and receive personalised care.

The importance of the whole family's mental health needs during the perinatal period are currently overlooked. The Government should develop a strategy to support the mental health of partners, whether through digital platforms or community-based support.

For healthcare professionals

Healthcare professionals should acknowledge and understand the impact that pregnancy and birth can have on a woman's partner, especially if the woman herself is experiencing mental health problems.

All healthcare professionals working to support women during and after pregnancy should be better trained in the range of perinatal mental health conditions to recognise and respond to potential signs of perinatal mental health problems – from the mild to the severe. This should include an understanding of how to treat and support pregnant and breastfeeding women on medication for their mental health, in line with NICE guidelines.

How and where conversations about mental health are conducted are vitally important. Not only should mental wellbeing be enquired about at each appointment with a woman during pregnancy and after birth, but all healthcare professionals should approach the conversation in an open way, encouraging dialogue and listening to a woman's concerns. Conversations should be conducted in appropriate locations, where the woman can feel comfortable and confident that the discussions will be private.

During appointments, healthcare professionals should also ascertain the mother's family history, i.e. whether a grandmother, mother or sister had experienced mental health problems during and/or after pregnancy.

Enquiries about mental wellbeing should not be seen as a tick box exercise and, although depression identification questionnaires can be helpful in guiding conversations, they should not be relied upon as the only means of enquiry into a woman's mental health. Most importantly, healthcare professionals should facilitate personalised care and shared decision making, especially where medication is recommended.

Healthcare professionals involved in the care of women during and after pregnancy should pay special attention to the mental health of women who have had difficult pregnancies or births. The consequences these have on mental health should be treated as seriously as the physical impacts are.

When discussing breastfeeding with a woman, healthcare professionals should understand the impact that problems with feeding could have on a mother's mental health. All women, especially those experiencing perinatal mental health problems, should be made aware of the benefits of breastfeeding but ultimately supported in whatever method of feeding they choose.

1 Introduction

The Royal College of Obstetricians and Gynaecologists (RCOG) wanted to explore women's experiences of perinatal mental health problems in an effort to break down the barriers to high-quality care. By surveying women with lived experience, the College aimed to understand the current provision of perinatal mental health care to identify gaps, to provide better training where necessary and to advocate for change.

The survey was designed in consultation with the RCOG's Women's Network, a group of lay women who provide a patient and public perspective on the RCOG's work, and with the Maternal Mental Health Alliance, an organisation committed to improving the mental health and wellbeing of women and their children in pregnancy and the first postnatal year, of which the RCOG is a member.

Women were asked to complete the survey whether or not they had experienced perinatal mental health problems in order to understand whether all women felt supported around their mental health during and after pregnancy.

The survey was launched in March 2016 at the RCOG's International Women's Day event 'Joining up Care in Maternal Mental Health' and it was hosted for 6 weeks on SurveyMonkey. A number of women's organisations as well as specific perinatal mental health organisations were asked to share the survey with their networks, and it was also shared widely on social media. Although women were asked to answer the survey whether or not they had experienced perinatal mental health problems, the respondents self-selected to take part and they were therefore likely to already be engaged in issues surrounding perinatal mental health and the provision of care.

Complete anonymity was assured to allow women to feel comfortable answering the questions honestly. No personal data were collected and the only demographic questions asked were regional and age-based to allow for better analysis.

The terms 'perinatal' and 'maternal' are often used interchangeably when talking about a mother's mental health. This report uses the term 'perinatal mental health problems' to refer to the conditions women experience during pregnancy and the first year after birth.

The survey received 2323 responses. Respondents were able to skip any questions that they did not feel comfortable answering. There were 21 questions in total, with four of them being open-ended comment boxes and the other 17 being multiple choice questions that sometimes allowed respondents to select multiple answers.

The survey was extended to women across the UK, which has allowed for closer analysis at a regional level. The number of responses from each region was more or less in accordance with that region's share of the female population.*

To ensure that the results were relevant, only women who had given birth in the previous 5 years were asked to fill out the survey. Data on how recently the respondents had given birth have allowed for a better analysis and understanding, with an indication of which areas of care have improved in recent years and which areas still have some way to go.†

* Data on the number of respondents from each region can be found in Appendix C.

† Data on how recently respondents had given birth can be found in Appendix C.

2 *Women's experiences of perinatal mental health problems*

Before, during and after pregnancy, women can experience a wide range of mental health problems. The impact these conditions have on the woman and her family are wide ranging, particularly if they are left untreated. Many people are familiar with postnatal depression but are not aware of the other mental health conditions that many women experience, ranging from anxiety conditions such as post-traumatic stress disorder to postpartum psychosis.

It has been estimated that, across the UK, up to 1 in 5 women develop some form of mental health problem during their pregnancy or in the year after birth. The majority (81%) of women who responded to this survey experienced at least one perinatal mental health condition during or after their pregnancy. While all women who had given birth in the previous 5 years were invited to take part, the topic and self-selecting nature of the survey meant that it was anticipated that women with experiences of perinatal mental health problems would be far more likely to respond.

As shown in Figure 1, low mood was experienced by over two-thirds (69%) of the survey respondents, anxiety by around half (49%) and depression by just over one-third (37%). Psychosis was experienced by 4%, with another 4% experiencing other symptoms such as anger and absentmindedness.* A number of women also reported exhaustion and tiredness that impacted on their mental health and ability to get through everyday tasks.

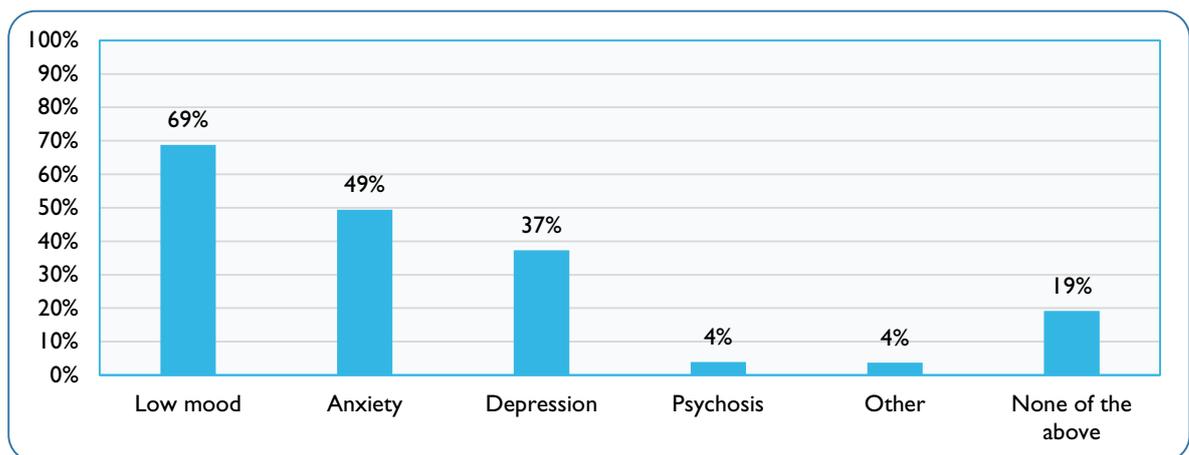


Figure 1 Mental health problems experienced by the survey respondents during or after any pregnancies in the previous 5 years (survey question 7; respondents could tick more than one option, as appropriate)

* Broad categories of perinatal mental health conditions were used as it was anticipated that the actual range of conditions experienced would be too wide to be meaningful. The lists of symptoms within each category can be seen in question 7 in the actual survey questions in Appendix A.

A history of mental health problems is commonly used by healthcare professionals to assess a woman's risk of developing mental health problems during the perinatal period. Overall, almost three-quarters (74%) of the respondents had no previous history of mental health problems.

95% of women in the survey who had a previous history of mental health problems went on to experience them during or after pregnancy, highlighting that a previous history is indeed a useful tool in assessing a woman's perinatal mental health risk. However, of those with no previous history of mental health, 76% went on to experience perinatal mental health problems (Figure 2). This number is higher than would be expected in the general population because respondents self-selected to take part in the survey. Despite this, it still highlights the importance of healthcare professionals enquiring about every woman's mental wellbeing, as the majority of women in the survey did not have a previous history.

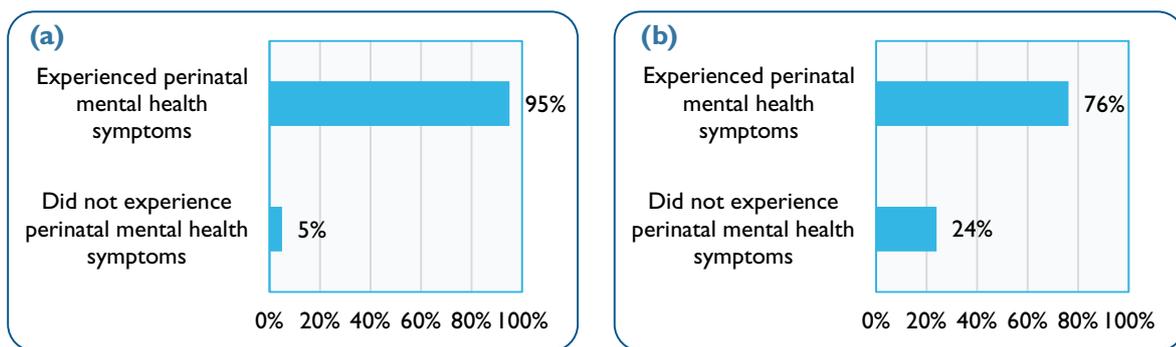


Figure 2 The proportion of respondents who experienced perinatal mental health problems: (a) those respondents who did have a history of mental health problems; (b) those respondents without a history of mental health problems (survey questions 5 and 7)

The survey found that, among women who had pre-existing mental health problems, there was no consensus from healthcare professionals as to whether or not to stop, reduce, change or continue with medication. Some women on medication for mental health problems before pregnancy told us that they were urged to stop completely, while others were advised to continue. Some respondents had their medication adjusted or were switched onto something that was considered safe for the baby. A number of women reported being given unhelpful advice or no advice at all about their medication.

Some women were given conflicting advice about the continuation of their medication from different doctors. One respondent reported that her perinatal psychologist considered that the benefits of her medication outweighed the risks to the baby, while a crisis team psychiatrist told her that her medication was hurting her baby. She also faced difficulties when trying to obtain her medication, with her GP reluctant to prescribe her medication and one pharmacist refusing to fill the prescription.

A number of women were taken off medication and were not offered any alternative treatment or support, which had potentially dangerous implications for their mental health. One woman explained how her medication was abruptly stopped by her GP, with no discussion of the risks and benefits, including of the impact on her and the two children she already had. She later relapsed with depression, anxiety and extreme rebound symptoms but still had to convince her GP to restart her medication. Other women described how they had to return to medication because of relapses after being taken off it, but continued to be urged by healthcare professionals to stop taking it.

The National Institute for Health and Care Excellence (NICE) clinical guideline on *Antenatal and Postnatal Mental Health** provides recommendations to healthcare professionals for pregnant woman who are taking medication. The advice varies for each perinatal condition but for women with

* National Institute for Health and Care Excellence. *Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance*. London and Manchester: NICE: 2014 [www.nice.org.uk/guidance/cg192].

more severe symptoms it recommends that healthcare professionals should take into account her previous response to treatment, the stage of her pregnancy, the risk of relapse, the risk associated with medication and her preference among the treatments available.

When asked why medical treatment was not sought in relation to mental health during previous pregnancies, almost a quarter reported thinking it was normal or not realising the extent of how unwell they were. Some women felt that it was only on reflection that they could see how ill they had been, or that they believed all mothers were going through the same but were just getting on with it.

“It was so subtle. I didn’t realise at first it was happening. I thought I wasn’t coping, not depressed. I thought it was a bad day, not serious. It didn’t happen every day or even all day of one day. It was riding a roller coaster blindfolded and being asked to hold a box of eggs. I was trying so hard to keep it together. No one seemed to notice until I was actually getting better. Including me.”

3 *Women's experiences engaging with healthcare professionals*

The survey aimed to understand the provision of mental health care given to women during and after their pregnancy. All women who had given birth in the UK within the previous 5 years, regardless of whether or not they had experienced perinatal mental health problems, were asked to complete the survey in order to understand whether healthcare professionals were asking every woman the right questions, not just those who might have had a history or were showing outward signs. Because of the self-selecting nature of the survey, the majority of respondents had indeed experienced perinatal mental health problems.

The NICE clinical guideline on *Antenatal and Postnatal Mental Health*^{*} states that a pregnant woman should be asked about her emotional wellbeing at her first contact with primary care or at her booking visit, as well as during the early postnatal period. Healthcare professionals should also ask about a woman's mental wellbeing with each subsequent contact, with the guideline suggesting standardised questions to use to identify possible depression or anxiety.

The majority of respondents (85%) had been asked about their mental wellbeing by at least one healthcare professional, with two-thirds (67%) having been asked by a health visitor (Figure 3). Only 4% had been asked about their mental wellbeing by an obstetrician.[†]

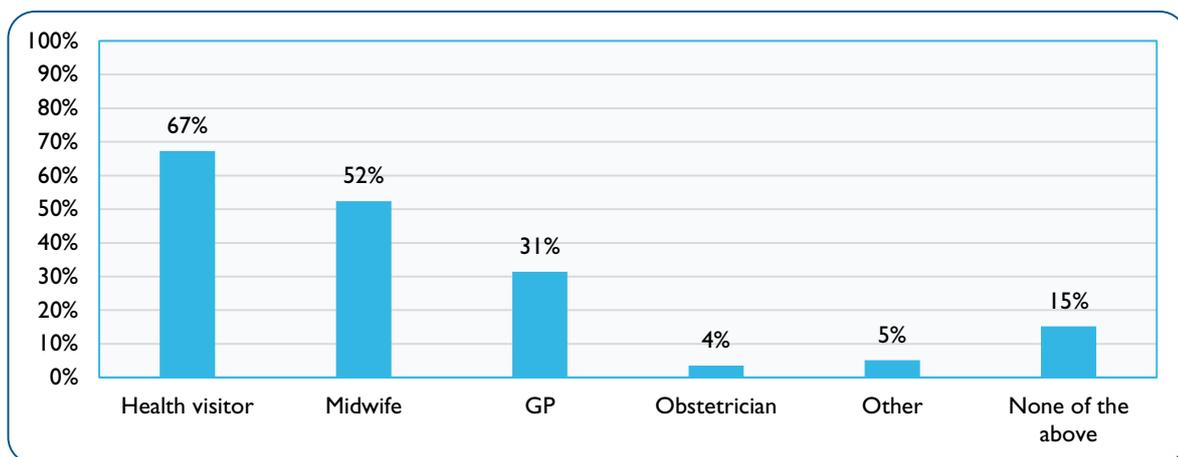


Figure 3 Percentage of respondents who reported that the indicated healthcare professional had asked them how they were feeling in relation to their mental wellbeing and whether they felt they needed any support, during and after their pregnancy (survey question 9; respondents could tick more than one option, as appropriate)

* National Institute for Health and Care Excellence. *Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance*. London and Manchester: NICE: 2014 [www.nice.org.uk/guidance/cg192].

† It is important to note that a large proportion of women will not be looked after by an obstetrician during their pregnancy and birth, and the survey did not gather data on whether or not they were under the care of an obstetrician.

By looking at how recently the women have given birth, it is possible to see that there have been improvements in recent years of the number of women asked about their mental wellbeing by at least one healthcare professional (Figure 4). 24% of women who had given birth 4–5 years previously had not been asked by any healthcare professional about their mental wellbeing, compared with just 8% of those who had given birth in the last year. Improvements were seen among all the healthcare professionals groups, demonstrating that recent awareness campaigns have had an impact in encouraging conversations about mental wellbeing, particularly in the last 3 years. Despite this, it is still vital that women are asked about their mental wellbeing by all healthcare professionals, not just one.

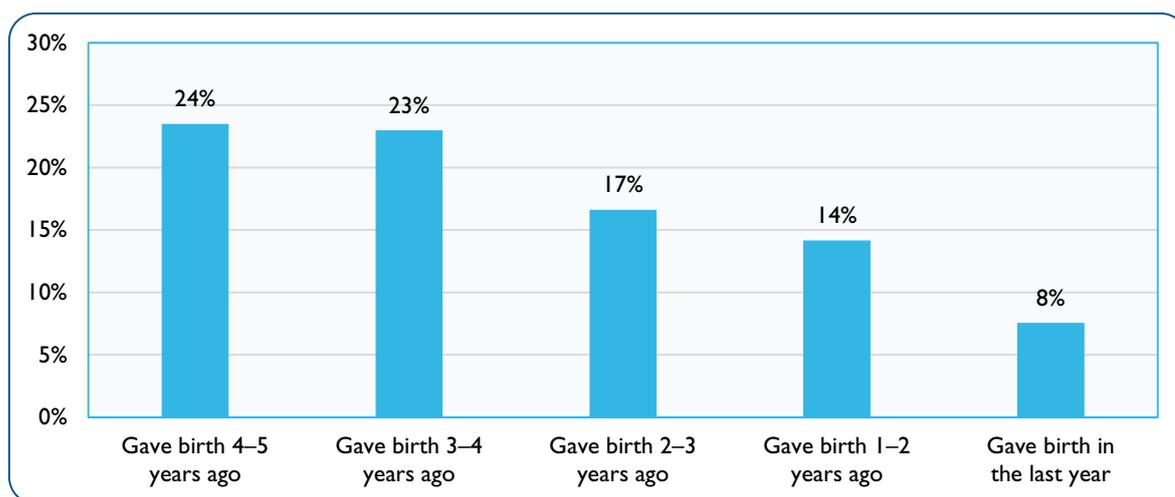


Figure 4 Percentage of respondents who were not asked about their mental wellbeing by any healthcare professional, according to how many years previously they had given birth (survey question 4)

The NICE clinical guideline on *Antenatal and Postnatal Mental Health*^{*} also recommends that, when a mental health problem is suspected, healthcare professionals should ask the woman questions about her history (and her family history) of mental health, as well as questions about her personal circumstances (such as whether she has experienced domestic violence) and her social circumstances (such as her employment or immigration status).

Over half of women who had been asked about their mental wellbeing were also asked about their history of mental health (56%) and their personal circumstances (53%). However, a large number were not asked any of these background questions (26%).

It is well known that women sometimes minimise or completely deny having symptoms of perinatal mental health problems, not just to friends and family but also to healthcare professionals. The majority of women in the survey would have been comfortable talking to at least one healthcare professional, with only 16% saying that they had done so or would not have felt comfortable doing so (Figure 5). The highest proportion of women were most comfortable talking to a midwife, followed by a health visitor and a GP. With a large proportion of women feeling comfortable talking about their mental health, it is vital that healthcare professionals use every visit as an opportunity to enquire about how a woman is coping.

A number of women explained that the most important factor in them feeling able to confide in healthcare professionals was not their job role but the individuals themselves and the relationship that the women had with them. Many women reported not seeing the same healthcare professionals throughout their care, which meant that they were not able to develop a relationship in which they felt comfortable disclosing how they were feeling. Often, women also felt that not enough time was

^{*} National Institute for Health and Care Excellence. *Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance*. London and Manchester: NICE: 2014 [www.nice.org.uk/guidance/cg192].

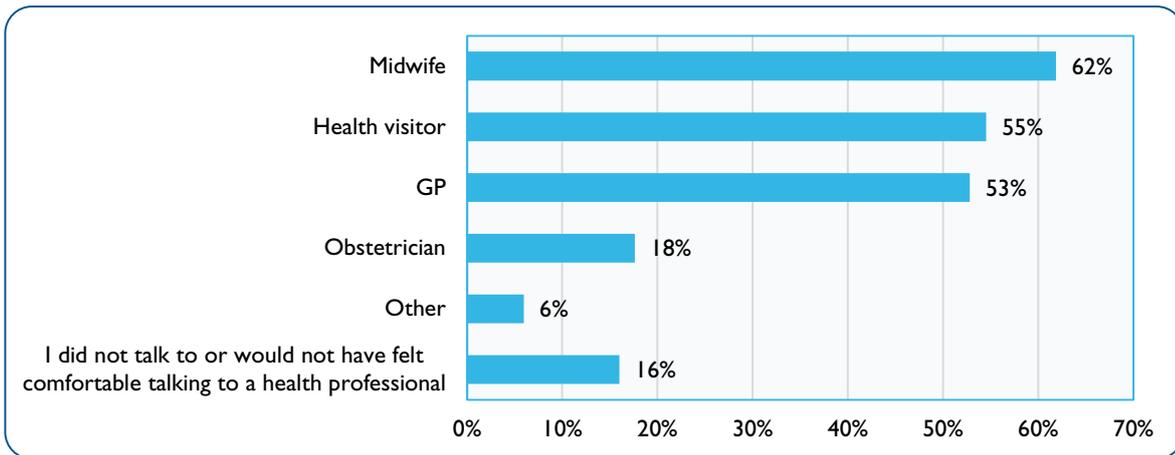


Figure 5 Percentage of respondents who did talk to, or would have felt comfortable talking to, a particular healthcare professional about how they felt (survey question 11; respondents could tick more than one option, as appropriate)

spent at each appointment with a healthcare professional to allow them to build up a relationship where they would feel comfortable disclosing mental health concerns.

The most common reason for not feeling comfortable talking to a healthcare professional (Figure 6) was concern about mental health problems being noted on their medical records (40%), followed by not believing that healthcare professionals could or would help (32%) and the stigma associated with mental illness (28%).

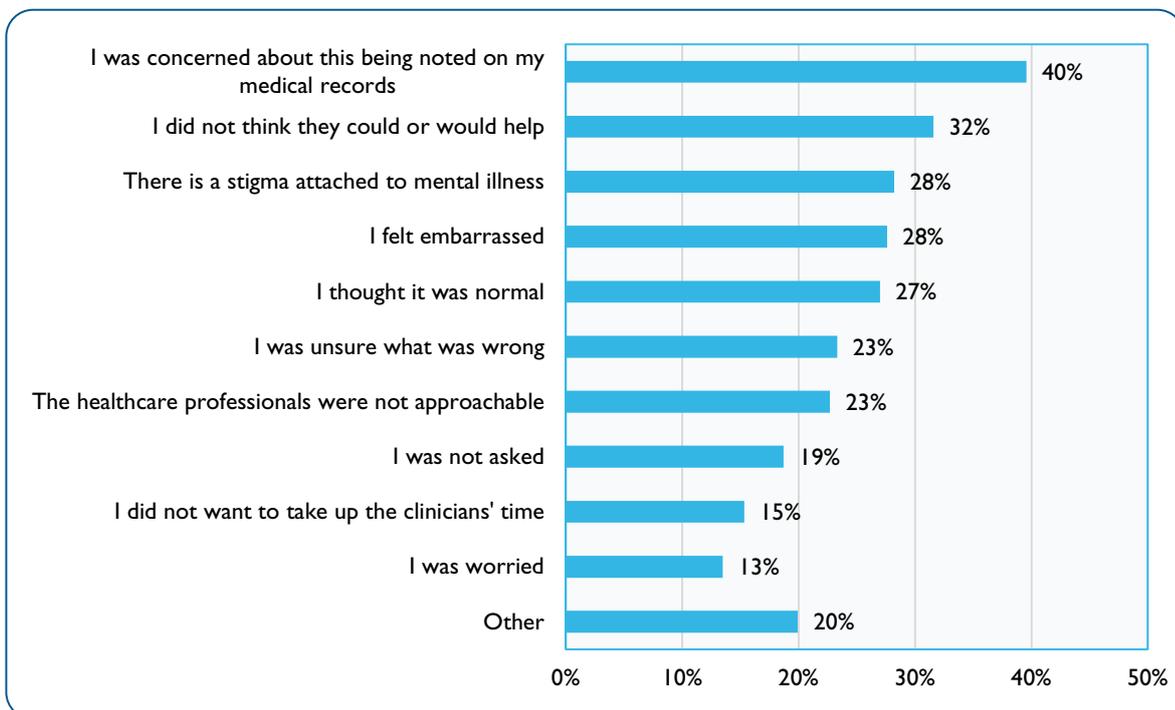


Figure 6 Reasons why the respondents would not have felt comfortable talking to a healthcare professional about how they felt (survey question 12; respondents could tick more than one option, as appropriate)

Following expert advice, social services involvement was not included as an option for why women may not have felt comfortable talking about their mental health, as there was a risk that it could reinforce or validate their fears. Despite this, a number of women reported that this was why they would not or had not talked to healthcare professionals. Some of these acknowledged that, when

looking back, these fears had been irrational, but they explained that at the time they had felt that there was a very real chance that their baby would be taken away from them.

Some women explained that they felt that their feelings were not being taken seriously, and that they were told it was 'normal' to feel down after having a baby. They felt like they had been shut down and this stopped them feeling comfortable to continue the conversation. Women also reported feeling that the healthcare professionals focused on the health of the baby, and that as long as the baby was fine they assumed that the mother would be too.

4 Referrals and services for perinatal mental health

The majority of women (55%) who reported experiencing mental health problems were not referred on to services or given any advice about organisations to contact for further help (Figure 7). 19% were referred on to services and 18% were given information about where to go for further support.

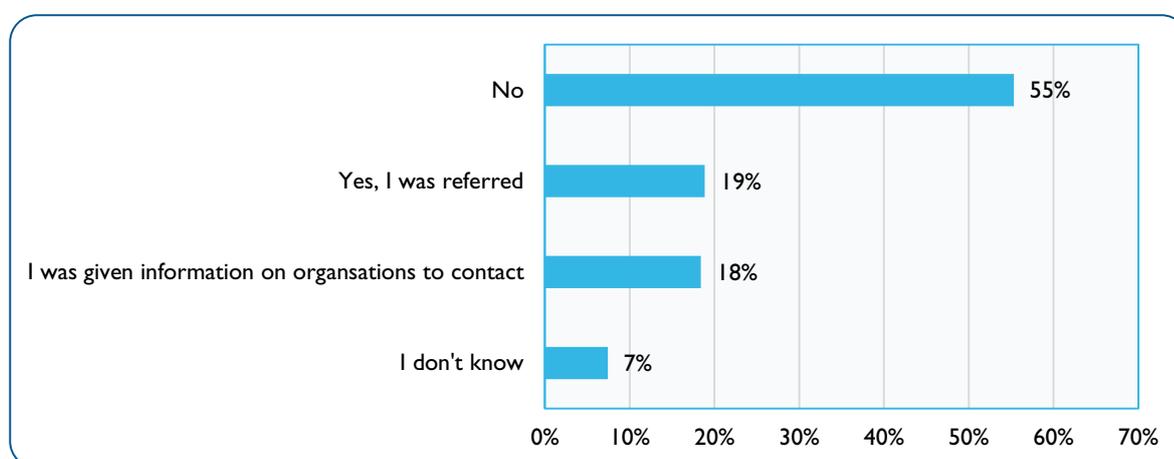


Figure 7 Whether respondents with perinatal mental health problems had been referred on to support services (survey question 13)

Women who also had a history of mental health were more likely to be referred, with 32% going on to be directly referred to services, compared with only 13% of those who had no history. Perhaps unsurprisingly, women who experienced psychosis were the most likely to be referred (46%) but a large proportion (40%) of women who reported psychosis were not given any further support (Figure 8). Closer inspection of these women who experienced psychosis but were not referred revealed that some were already in hospital settings following their births and were treated there, while others already had psychiatrists in place who took over their care. However, a number of these women never disclosed their symptoms to a healthcare professional.

Of those women who were referred for any perinatal mental health condition, the majority (55%) were seen by outpatient mental health services (Figure 9). Eight percent of those who were referred went to mother and baby units, which are specialised self-contained units where women can receive care and treatment alongside their baby.* Thirty-one percent were seen by other specialised perinatal mental health services, such as specialised perinatal mental health therapists. Referral rates over the last 5 years have stayed the same, with the same proportion of women being referred.

Three percent of the referred women reported being referred to an inpatient psychiatric ward where they were separated from their babies at a critical time. This often causes huge distress

* Across the UK there are only 17 mother and baby units (<http://everyonesbusiness.org.uk/wp-content/uploads/2015/12/Accredited-Mother-Baby-Units.pdf>), with NHS England announcing in 2016 that it was commissioning another four.

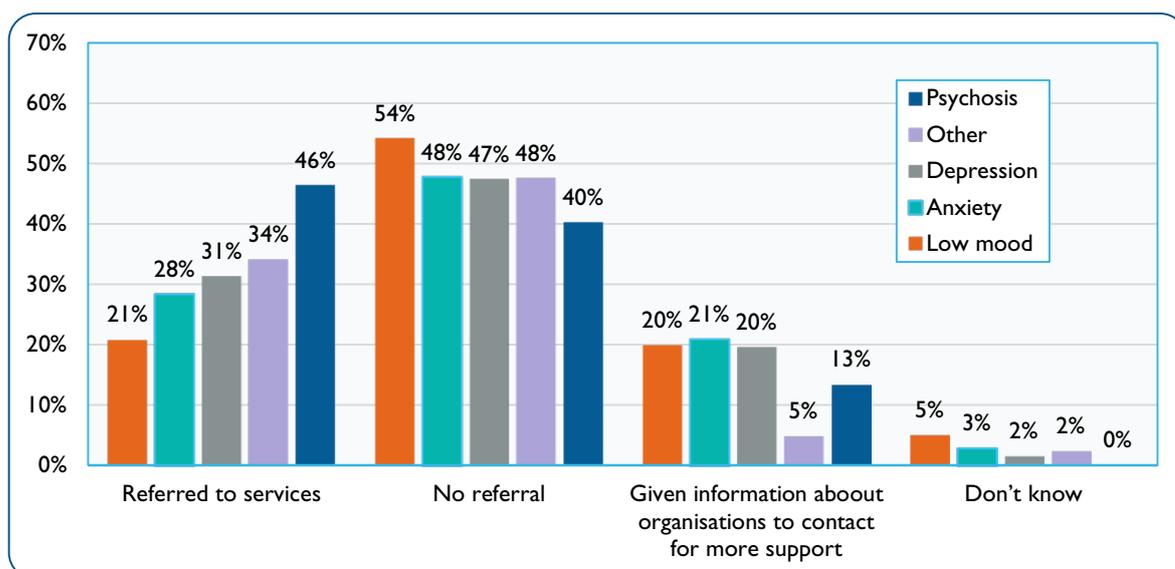


Figure 8 Percentage of respondents referred, according to their specific perinatal mental health condition (based on survey questions 7 and 13)

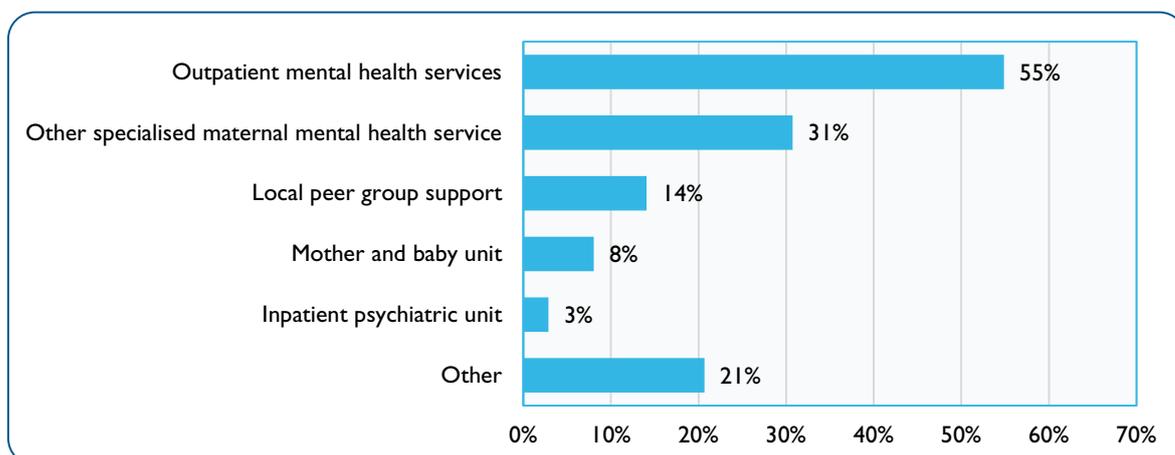


Figure 9 The services to which referred respondents were referred (survey question 14; respondents could tick more than one option, as appropriate)

for the mother, which can interfere with her treatment and recovery. Furthermore, this enforced separation at this critical time can have a serious impact on her bonding and relationship with her baby, and this in turn may have long-lasting effects for mother and child. Half of these women went on to mother and baby units, while the other half received no specialised perinatal mental health interventions after their admission.

“I was referred the next day by the crisis team to the inpatient psychiatric wing of Bedford Hospital where I was well looked after and began my recovery when my daughter was just 5 weeks old. When discharged a week later, the crisis team visited for about 2 weeks but then after I was discharged by them I was seen once by the community team and not offered any counselling.”

Among the women who were referred, those who had a history of mental health problems, especially those who had taken medication for it, were more likely to be referred to mother and baby units (17%) and to other specialised perinatal mental health services (45%) than those with no history (4% and 25%, respectively).

Given the importance of women making full recoveries, for their own health and that of their families, it remains important that women get specialised treatment, whether or not they have a pre-existing history of mental health problems.

Overall, when considering all women who reported experiencing a perinatal mental health problem, only 7% were referred on to specialised care, either attending a mother and baby unit or seeing other specialised perinatal mental health services.

Perinatal mental health problems are unique and require specialised services that understand and can support the needs of women before, during and after childbirth. These services have the knowledge and skills to understand the risks and benefits of different treatments, including medication in pregnancy and during breastfeeding, and to care for the emotional needs of the women and their babies. It is vital that more women are not only referred on to services but that they receive care from the specialised services that are best placed to help them recover.

Speedy access to services and early treatment is important to improve outcomes for women and their families. In 2014, the Government announced a target that, by April 2016, 75% of people referred for talking therapies would start their treatment within 6 weeks and 95% would start within 18 weeks.

The NICE clinical guideline on *Antenatal and Postnatal Mental Health** recommends that, when a woman with a known or suspected mental health problem is referred in pregnancy or the postnatal period, assessment for treatment should take place within 2 weeks of referral and psychological interventions should take place within 1 month of initial assessment. Despite this, for 38% of the women who were referred it took over 4 weeks to be seen (Figure 10). Some women reported waiting over a year, with a number who responded to the survey still waiting to be seen (Figure 11). Several respondents did not attend their referrals or the referrals never came through and were not chased up.

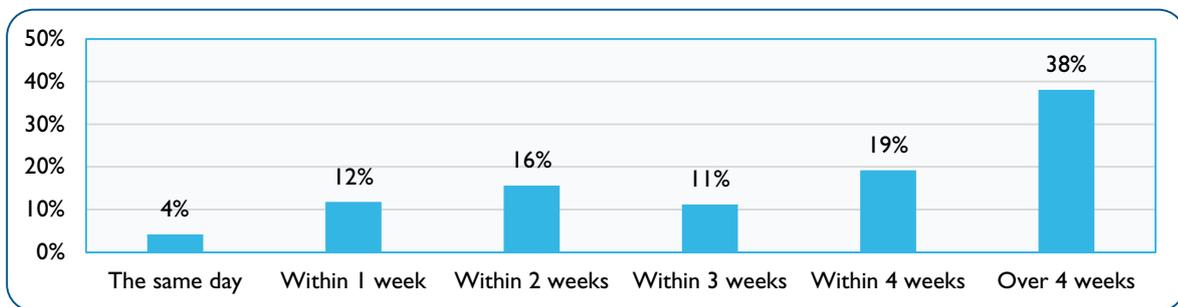


Figure 10 How long it took for women to be seen once they had been referred (survey question 15)

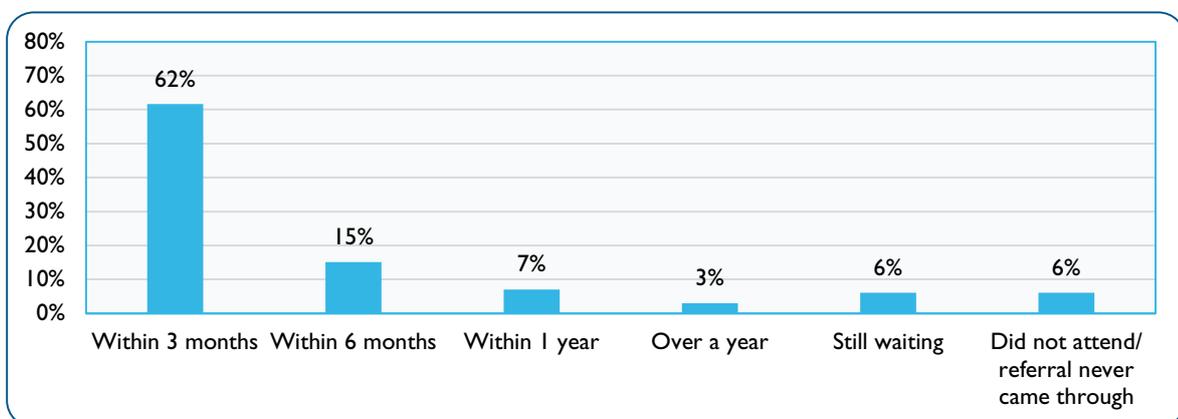


Figure 11 Waiting times for those women who waited more than 4 weeks to be seen once they had been referred (survey question 15)

* National Institute for Health and Care Excellence. *Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance*. London and Manchester: NICE: 2014 [www.nice.org.uk/guidance/cg192].

A number of women told us that they had experienced mental health problems during or after more than one of their pregnancies and that the time it took for them to be seen varied greatly between each case.

“For my first pregnancy (2013) it took 4 months to get a phone appointment. For my second pregnancy (2015) I was seen face to face within my GP surgery by a psychologist for CBT within 2 weeks. My experiences of care both times could not have been more different.”

It is likely that improvements in care over time or being flagged within the system are reasons for the differing experiences of care and timely access to support during subsequent pregnancies. However, high standards of timely care should be available to all women, not just those who have already been flagged in the system.

A number of women reported that their referral took so long to come through that in the mean time they had opted for private treatment as they did not feel they could wait that long. Some women who experienced prenatal mental health problems did not get referrals before they gave birth so, when the referrals came through, the support was too late.

The majority (88%) of respondents who were referred did not have to travel more than an hour to get support. Those who had to travel more than an hour were often placed in mother and baby units that were not close to their home, mostly because of the lack of full coverage across the UK. A number of women told us that they were able to receive treatment at home, over the phone, or at hospital in instances where they were already receiving treatment for physical complications of their pregnancy or birth.

Women who experience mental health problems during or after pregnancy, especially those who have not been referred, often seek support outside of NHS services (Figure 12). Almost half (48%) of the respondents who had had perinatal mental health problems and who answered this question had turned to friends and family for support, almost one-third (28%) had found help through online forums, and 12% had sought private counselling. Those who had a history of mental health problems were more likely to opt for private counselling (18%) than those who had no history (7%).

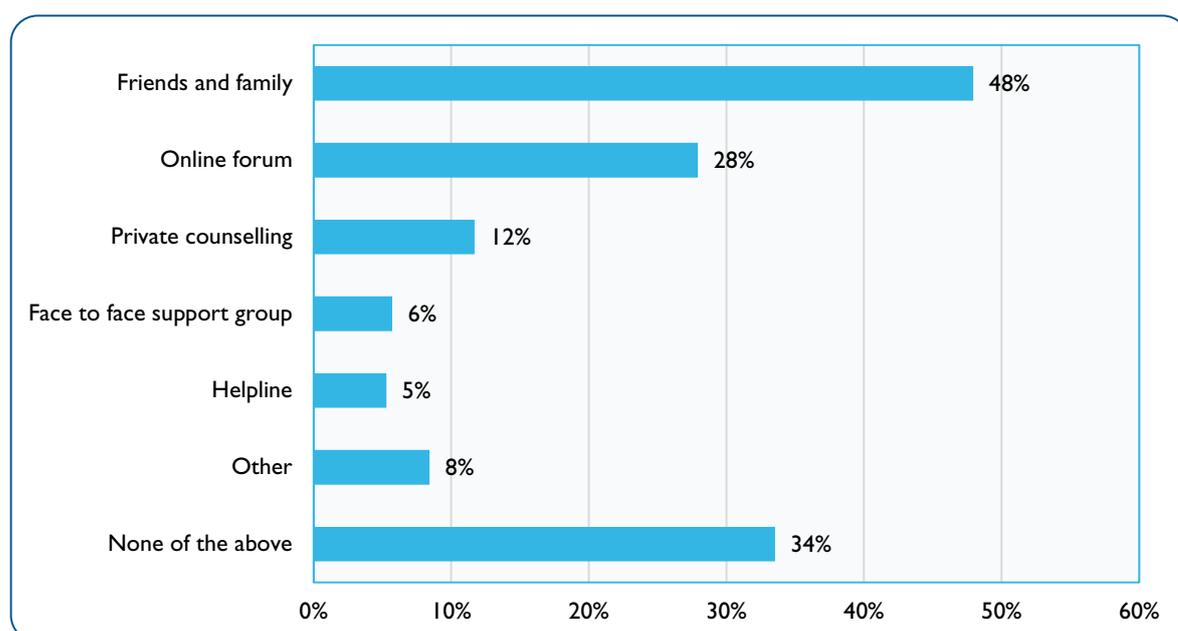


Figure 12 How women sought support themselves outside of the NHS (survey question 17; respondents could tick more than one option, as appropriate)

Of those who sought support outside of NHS services, a number were helped by charities, but other means of support included religious or community groups and activity groups such as yoga, as well as general mother and baby groups or breastfeeding groups. A large number of women reported that social media and online groups were a great source of support. They found it an easy way to find those going through similar problems and support each other. This was especially true for women who experienced specific but less common conditions, such as mental health problems relating to hyperemesis gravidarum, where many women feel isolated and alone.

Recommendations on referrals and services for perinatal mental health

Timely access to services is vital for the best outcomes for women, their babies and their families. Appropriate services should be available to all women who require them. Commissioners should ensure that NICE recommendations are followed. Women experiencing perinatal mental health problems should be assessed for treatment within 2 weeks of referral and psychological interventions should take place within 1 month of initial assessment.

As well as monitoring and publishing data on the new waiting time targets for mental health, the Government should consider setting specific targets for perinatal mental health conditions, which, owing to their unique nature, require prompt access to services.

5 *Partners' experiences of mental health problems*

Partners can also experience mental health problems during a woman's pregnancy and after the birth, yet they are often forgotten about. One in eight of our respondents (12%) said that their partner had experienced mental health issues during or after their pregnancy (Figure 13).

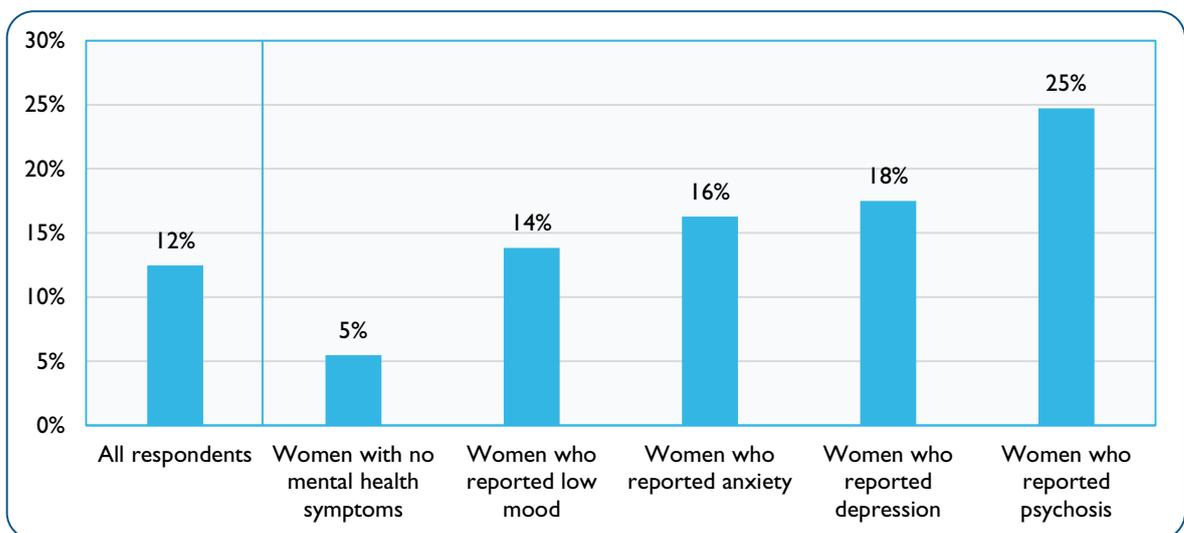


Figure 13 Percentage of respondents who reported that their partners had experienced mental health issues during or after their pregnancy (survey question 8)

Where respondents supplied more information, they most frequently reported that their partners experienced low mood and depression, followed by anxiety. Many respondents commented that the emphasis was always on the health of the baby and then them as the mother; the focus was seldom on the health or mental health of the partner.

Healthcare professionals ignoring or failing to ask questions about the mental health of men is problematic considering that they are less likely to seek help for mental health problems.* Many of the women who offered further details about their partners reported that they were reluctant to seek help proactively, with some only asking for help if they were pushed and others refusing to seek help at all.

In some instances where the mental health needs of the mother were addressed, their partners were left behind. Several women reported that, following distressing events such as recurrent miscarriages and traumatic births, both the woman and her partner requested support but were told that there was only provision for the mother. Overall, only 20% of those women who reported mental health problems in their partners mentioned that the partner had received help for this.

* Oliver MI, Pearson N, Coe N, Gunnell D. Help-seeking behaviour in men and women with common mental health problems: cross-sectional study. *British Journal of Psychiatry* 2005;186:297–301 [<http://bjprcpsych.org/content/bjprcpsych/186/4/297.full.pdf>].

The impact of mental health problems on the whole family unit can be overwhelming. A number of women reported feeling that their condition directly affected their partners' mental health. The survey found that those respondents who themselves had no mental health problems were less likely to have partners experiencing mental health problems during or after the pregnancy (5%). Those women who experienced the most severe conditions, such as psychosis, reported having partners with a higher incidence of mental health problems.

Furthermore a number of women felt that their and their partners' mental health put a strain on their relationship that not only impacted their ability to support each other but, in some cases, led to the breakdown of the relationship. The effects that a relationship breakdown can have on the whole family unit are severe and wide ranging, and providing timely and specialised support for the mother will improve the wellbeing and health of the whole family.

“My partner had a breakdown and severe depression after the birth. We tried to get help for him from the mental health services but it did not come to anything – he was not ‘serious’ enough. Our relationship broke down as a direct response to both of our mental health states at this time and we are no longer together.”

Recommendations from partners' experiences of mental health problems

Healthcare professionals should acknowledge and understand the impact that pregnancy and birth can have on a woman's partner, especially if the woman herself is experiencing mental health problems.

Services should explore mechanisms to diagnose and offer appropriate treatment to partners experiencing mental health problems before and after the child's birth, as part of a wider approach to treating perinatal mental health problems and limiting the impact it can have on the whole family.

The importance of the whole family's mental health needs during the perinatal period are currently overlooked. The Government should develop a strategy to support the mental health of partners, whether through digital platforms or community-based support.

6 *Regional variations in perinatal mental health services*

The Maternal Mental Health Alliance's* Everyone's Business Campaign has highlighted the 'postcode lottery' of specialist community perinatal mental health services available to women across the UK.† They found that pregnant women and new mothers across almost half of the UK did not have access to specialist perinatal mental health services (see their map in Appendix A).

Because of the large number of NHS clinical commissioning groups and local health teams across the UK, it was not possible to gather enough respondents from each of them to draw meaningful conclusions, so respondents were instead asked to respond regarding their wider region.

Overall throughout the 12 regions, the women who responded to the survey had experienced similar levels of perinatal mental health problems, with the proportion of respondents who had experienced at least one condition being fairly consistent across the UK.‡ This suggests that the variations in regional experiences were due to the care the women received, and not the severity of their mental health problems.

Experiences engaging with healthcare professionals

There were large variations in the proportion of women from each region who were not questioned by any healthcare professional about their mental wellbeing. In Wales 26% of women were not asked by any healthcare professional compared with 10% in the North West (the average across the UK was 15%).

Most regions had relatively similar rates of respondents who were comfortable talking to healthcare professionals about how they felt; the North East was an exception, where as many as 32% of the respondents said they were not comfortable talking to healthcare professionals about their mental health (the UK average was 16%). The most common reason these particular respondents gave for not feeling comfortable was that they felt the healthcare professionals were not approachable (63%); as many as half of the respondents in this region also felt that healthcare professionals could not or would not help.

Referrals to services

When looking at regional variations on referrals, women from the North East had the highest referral rates, with 35% of respondents with perinatal mental health problems being referred on to further services (Figure 14).§ Scotland and the West Midlands had particularly high rates of women

* The Maternal Mental Health Alliance is an organisation committed to improving the mental health and wellbeing of women and their children in pregnancy and the first postnatal year; the RCOG is a member.

† Maternal Mental Health Alliance. *UK Specialist community perinatal mental health teams (current provision)* [http://everyonesbusiness.org.uk/?page_id=349].

‡ One exception was Wales, where 91% of respondents had experienced at least one perinatal mental health condition, compared with the overall UK average of 81%.

§ This could partly be explained by the fact that the North East had the highest proportion of respondents (13%) who had experienced psychosis (UK average 4%).

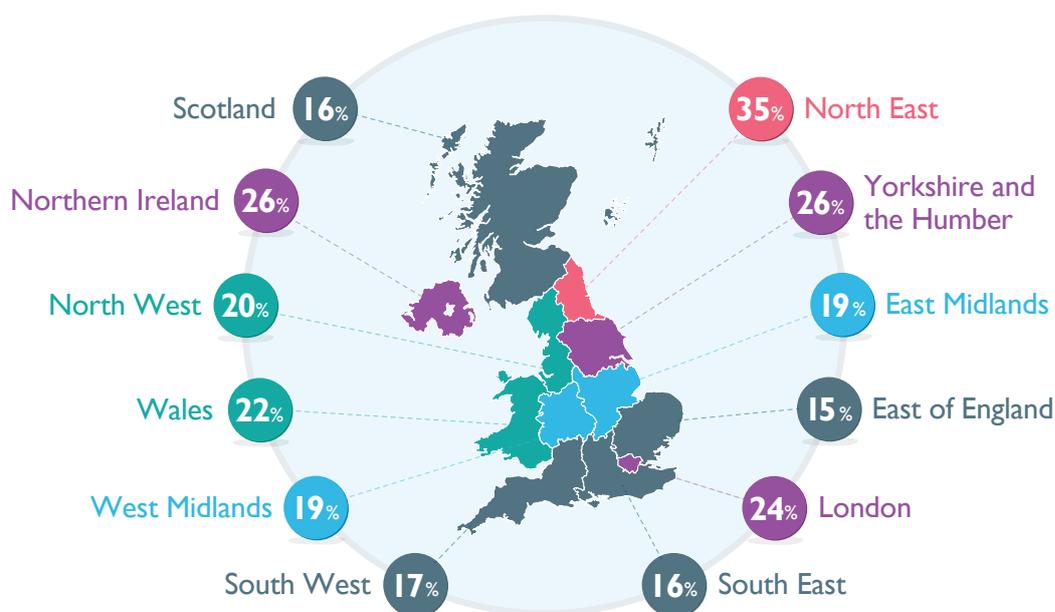


Figure 14 Rates of referral to support services for women with perinatal mental health problems in each region (survey question 13)

not offered any further support (both at 61%), with the East of England having the lowest rates of women referred on to services at 15%.

Yorkshire and the Humber had the highest referral rates to mother and baby units, at 17% (the average across the UK was 8%). Neither Wales nor Northern Ireland have mother and baby units, which was reflected in the survey in that none of the respondents from those regions were referred to one.

The biggest variations were for 'other specialised perinatal mental health services', where the referral rates ranged from 8% in the East of England to 50% in the West Midlands (Figure 15).

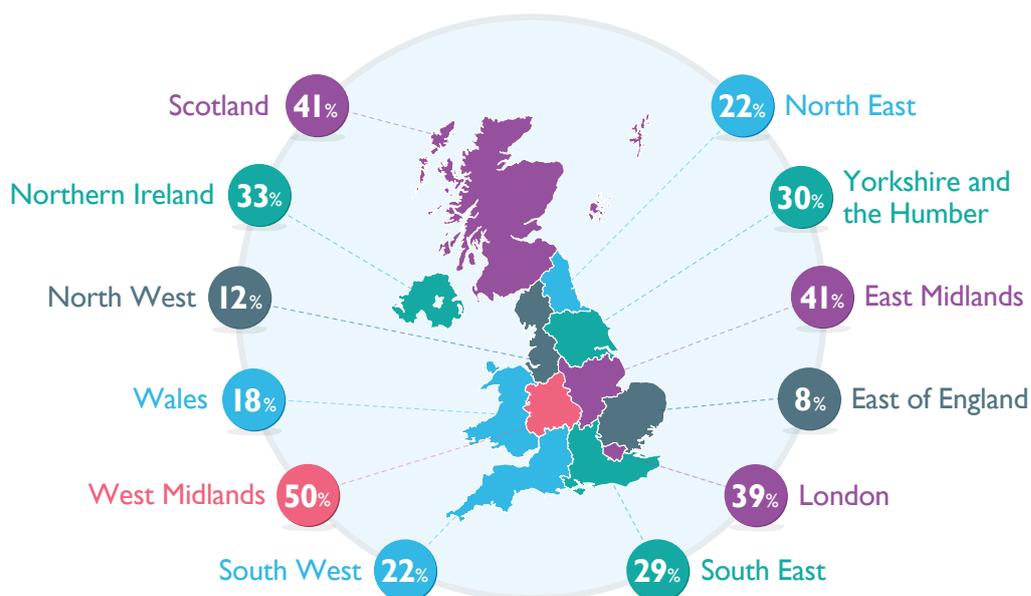


Figure 15 Rates of referral to 'other specialised maternal mental health services' (such as a specialised maternal mental health therapist) in each region; excludes referrals to mother and baby units, outpatient mental health services, inpatient psychiatric units or local peer group support (survey question 14)

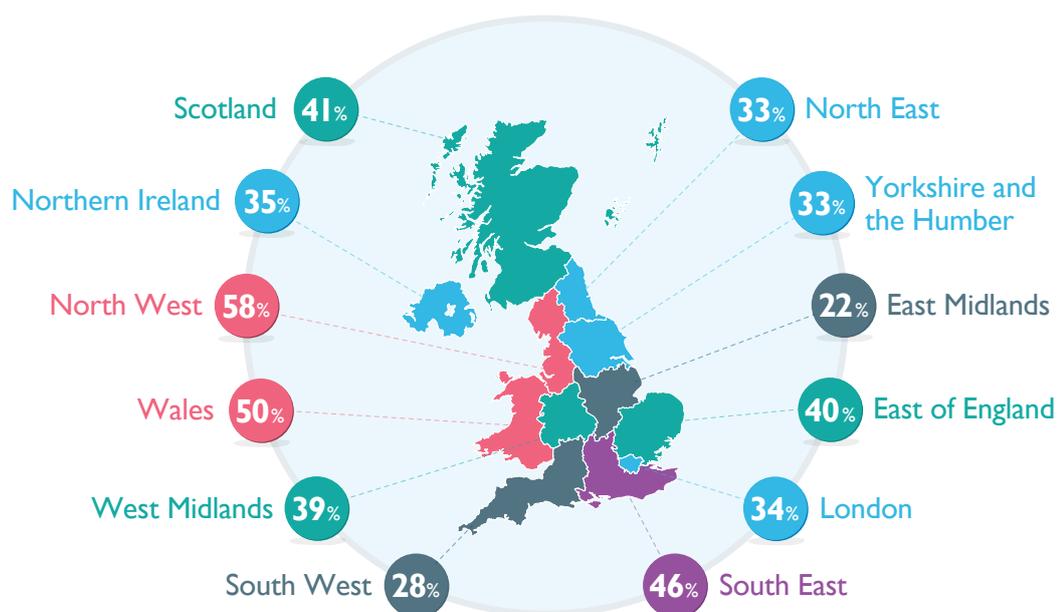


Figure 16 Proportion of women in each region who had to wait more than 4 weeks to be seen after being referred to support services for perinatal mental health problems (survey question 15)

Six of the regions made referrals to inpatient psychiatric units; the referral rates ranged from 2% to 9%. Following the publication of *The Five Year Forward View for Mental Health* report,^{*} NHS England committed to £365m in funding to increase access to specialised perinatal mental health support, so that by 2020/21 an additional 30 000 women would be able to receive local specialised treatment.

There was also significant regional variation in the time it took women to be seen after being referred (Figure 16). In the East Midlands only 22% of women said it took over 4 weeks after referral to be seen but in the North West 58% of women waited over 4 weeks.

Recommendations on reducing regional variations in perinatal mental health services

All women, irrespective of their location, should have access to specialist community perinatal mental health services if they need them. Clinical commissioning groups should conduct a needs assessment of the available services in their area and work with NHS England to improve access to care and apply for funding.

Although NHS England's funding for perinatal mental health services is welcome, commissioners in the devolved nations should also urgently address specialist community perinatal mental health services, including wider provision of mother and baby units.

* Mental Health Taskforce. *The Five Year Forward View for Mental Health*. A report from the independent Mental Health Taskforce to the NHS in England. February 2016 [www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf].

The final question of the survey was an open text box that asked what gaps, if any, the respondents felt there were in the mental health support given to women before, during and after pregnancy. More than 1100 women answered the final question, sharing a huge variety of experiences and identifying a range of gaps. The word cloud in Figure 17 highlights the most common words and phrases used by the women when responding to this question.



Figure 17 Word cloud showing the most common words and phrases used by women responding to the question ‘What gaps, if any, do you feel there are in the mental health support given to women before, during and after pregnancy?’ (survey question 21)

What is clear from the variety of responses received is that each woman’s level of care and experience was different. Some women felt very supported and were frequently asked about their mental health, whereas others who might have needed the support most were not asked or not listened to. Care from woman to woman is not consistent.

Women have highlighted that, when their mental health problems have been left untreated, or have been treated inadequately, they often continue and get worse through subsequent pregnancies.

Knowledge and understanding

One of the major recurring themes throughout the respondents’ answers to gaps in the system was that of knowledge and understanding of perinatal mental health conditions. Apart from depression, healthcare professionals often failed to recognise or look for signs of other perinatal mental health

conditions. This can lead to them missing many women whose symptoms do not fit in with their perceptions of perinatal mental health.

“I think there was a lot of awareness of postnatal depression but, even though I think I was depressed and anxious during my pregnancy, nobody ever asked or checked up on that.”

Many women explained that they had heard of postnatal depression but did not know the symptoms to look out for, let alone having heard of other conditions that they might experience.

“There was no mention in NHS antenatal classes of symptoms of anxiety and depression. I did not really know what was wrong with me but I knew something was wrong and requested help as I felt desperately ill. This vacuum makes women like me feel so alone in their experience that they can't see any hope to get better.”

Many felt that a realistic picture of motherhood was needed alongside a real destigmatisation of mental health conditions. A number of women highlighted that there needs to be an acceptance that motherhood is experienced differently by different women and that, while many will settle down well, others will find it hard even without experiencing perinatal mental health conditions.

The survey received a number of responses from healthcare professionals who themselves had experienced perinatal mental health and thus could offer insights from both lived and professional experience. The pressure to enjoy motherhood leads to those who find it harder feeling isolated and guilty for not being happy, which in turn impacts on their mental health.

“I think it's really normal to experience fluctuations in mental wellbeing after birth which is not explained or supported really. I'm a CBT therapist so could understand my thoughts and feelings but I think more education is needed.”*

On the other hand, some women felt that there needed to be a wider understanding that mental health problems during and after pregnancy are not an inevitable part of becoming a mother. While women who feel that they should be enjoying motherhood might be struggling with their own expectations, there are others who feel that their perinatal mental health symptoms are being dismissed as 'normal'. One consultant clinical psychologist reported that, after giving birth, her mental health needs were never discussed and the assumption that her moods were a normal part of motherhood meant that the opportunity for discussion was lost. She felt that if she, with her professional background, struggled to acknowledge and discuss her feelings, it may be far more difficult for other women.

There appears to be a fine balancing act in raising awareness among women of what to expect during motherhood while not over-normalising mental health symptoms. One midwife explained that previous history of mental health in a woman is often misunderstood by midwives and other healthcare professionals, and they focus on safeguarding and ticking boxes instead of referring the woman on to specialised services. She felt that services needed to fully involve women in their own care. Experiencing mental health problems is hugely disempowering and involves loss of control, and often women's voices are not heard, yet during pregnancy and after the birth it is vital that women feel empowered and are given the confidence they need to get support.

* Cognitive behavioural therapy.

Greater awareness is needed of the range of perinatal mental health problems that women may experience, especially in relation to lesser known anxiety conditions such as post-traumatic stress disorder, perinatal obsessive–compulsive disorder (OCD) as well as postpartum psychosis. Greater public knowledge and recognition will also lead to more acceptance and destigmatisation of perinatal mental health problems, allowing more women to feel comfortable in coming forward when they experience problems.

Recommendation on knowledge and understanding of perinatal mental health

Women and their families need information on the effects that pregnancy and childbirth can have on mental wellbeing, including the signs of perinatal mental health problems to look out for. Commissioners should review and update the information currently available to women and include discussions on perinatal mental health and on where to go for help in antenatal classes.

Experiences of and access to support

A number of women reported that, following the birth of their child, they felt like their needs were no longer important and that the focus was almost entirely on the health of the baby. When there were checks into the mothers' health, many felt that the focus then was solely on physical aspects. This left many women feeling dispirited and that their concerns over their own wellbeing were not valid and would not have been welcomed by healthcare professionals if they had decided to raise them.

The current system relies too heavily on women coming forward and disclosing their own conditions. The lack of understanding of various perinatal mental health conditions means that, without women coming forward and disclosing, symptoms are being completely missed and are damaging women's confidence in the system.

A number of women reported how it was all too easy to evade healthcare professionals' questions and hide symptoms. Many women are reluctant to talk about how they are feeling and about their history of mental health, and simple tick box 'yes' and 'no' questions do not encourage a dialogue that allows a woman to open up. This means that only those who are confident and able to speak up are doing so, leaving many vulnerable women to fall through the gaps.

“I received a lot of assistance but have good understanding and awareness of mental health. If I hadn't been proactive, knowledgeable and comfortable discussing it, I would not have received the same assistance.”

Some respondents felt that they lost contact with health services too soon. Many women do not experience any symptoms of perinatal mental health conditions until months after they have given birth, and a number of these women do not understand what they are feeling until much later down the road. While health visitor and midwife appointments are helpful, as is the 6-week check-up from GPs, many women reported that they did not feel like this was enough and they were left without any support too quickly. When a woman has left the remit of these services, it becomes harder to proactively approach healthcare professionals for help.

When women do come forward and are promised support, this support often isn't forthcoming in a timely manner, with many respondents reporting that they felt referrals took too long to come through. One woman explained how she was referred but that waiting lists were so long that her baby was considered too old by the time her appointment came through and she then no longer qualified for support. Waiting times are not just lengthy for one-to-one sessions but also for group therapies, with many women not being able to access any timely form of support other than medication.

“I am still waiting 6 months later for a space in a group setting that is less than an hour away from me. I do not want to take medication, but I may have to as I don't have access to the right therapy quickly.”

Medication was another concern for the respondents. Many felt that it was offered too quickly and that it was too readily relied upon instead of other interventions such as talking therapies that many felt were more appropriate. A major concern for new mothers is whether or not they can breastfeed while on medication and many will avoid medication purely for this reason. The survey found large discrepancies in the information about medication, pregnancy and breastfeeding that is given to mothers, and this often left them in dangerous situations.

Where respondents did access specialised perinatal mental health services, they often praised how effective they had been in helping them to recover. On the other hand, many women reported that they felt that non-specialised mental health care had inhibited their recoveries and in some cases made them worse. The generalised nature of these services often means that they do not take into account the unique needs that women with perinatal mental health conditions have. Women reported having to visit psychiatrists in general mental health hospital units, which made them feel vulnerable and it was harder for them to attend. One respondent who had been attending general counselling in a sexual health clinic was taken to hospital after having a breakdown and was held in a cell used for prisoners awaiting treatment while they found the crisis team who could assist her.

A number of women argued that there needed to be more specialist community perinatal mental health services, but also that access to these needed to be improved.

“In my first and second pregnancies, referrals took a long time to come through and services were lacking in terms of specialism to perinatal mental health, availability and waiting time. By my third pregnancy, the local trust had launched a specialist perinatal team – referral was very prompt and services and subsequent outcome much improved. Access to a specialist service seems to be key.”

In other cases, women who have been referred are prevented from being able to access support therapy group sessions as many do not allow women to bring their babies or children with them. Arranging childcare is not the only obstacle; many women also explained that they felt uncomfortable leaving their babies for an hour or more at a time, especially while they were still being breastfed.

A number of women reported that they were anxious about social services involvement. Many felt it was a genuine possibility that their babies would be taken from them, or they were anxious at the thought of being closely monitored with their babies. Often these fears were combined with others, such as fears about losing jobs and worries over the stigma attached to mental health problems.

Many women highlighted the help and support they had received from the voluntary sector. A number of women singled out charities that had helped them recover and, in some cases, they credited their full recovery to them.

“I was not in a fit state to make effective decisions and struggled to find out who and what was available locally. Thank God for Mothers for Mothers in Bristol – they saved my life.”

Some of these women reported how they had gone on to volunteer for the charities that had helped them, in order to support women like themselves through the same experiences. A number of women commented on how effective they had found this peer support in helping them to recover, with some suggesting that trained peer support workers would be a valuable way of reaching and supporting more women.

Recommendation on access to support

Commissioners should consider introducing clinically supervised and trained local peer support networks and groups in partnership with the community and voluntary sector, which many women find particularly helpful in their recoveries. These should include provisions to remove barriers for women to attend, such as on-site crèches, to allow women to bring their babies with them.

Experiences of healthcare professionals

A number of women highlighted incidents of failings by healthcare professionals, ranging from bad experiences of not being listened to after repeatedly asking for help to being told that they were being referred but with no support then ever materialising. Women felt frustrated that their concerns had not been taken seriously and many only had access to support once they had found a healthcare professional who was willing to listen.

A lot of respondents commented that they did not feel that they had had enough time with healthcare professionals to discuss their mental health, or that appointments had been rushed. Many of these commented that they felt had been due to an overstretched service, not because the healthcare professional did not care. Where conversations about mental health were being had, they were often not held in a personal or an open way, or felt like simple ‘tick box’ exercises.

“Despite being asked by my health visitor and GP, both felt rushed and more of a ‘tick box’ exercise. Neither referred to my personal experience or circumstances (long labour followed by emergency C-section and numerous postnatal infections), which would have encouraged me to talk about how I was feeling.”

“It seemed as though the antenatal check-ups just ticked a box – I was asked, ‘You’re not feeling down all the time, are you?’ – phrased this way, it felt as though one would be reluctant to speak up, as the suggestion of an automatic ‘no’ had been given.”

In these instances, it is often all too easy for women to not want to answer truthfully, to dismiss the questions or to pretend that they are coping. One woman reported missing her check-ups after giving birth, with no one ever chasing her up or requesting her to come in. In other instances, questions were being asked in inappropriate places: some women reported being asked about domestic abuse in front of their partners and being asked about their mental health in front of other people.

“I was asked to complete the EPDS score in my living room with my partner, a friend and my friend’s child present. I felt there was no way that I could be honest about how I felt nor could I discuss it. I didn’t want the health visitor talking about my mental health in front of my partner (who I had a poor relationship with) nor my friend and their 7-year-old son.”*

On the other hand, some women had to repeatedly request help before they were offered any further support. Sometimes women were told that they were just experiencing ‘baby blues’ and to wait and see whether they would feel better. Others explained how they had to ask several times for support, and then had to go on medication for a trial time, or attend group courses before they were given the tailored support that they felt would help them to recover.

Many respondents felt that there needed to be better continuity of support during and after pregnancy. This would allow them to build up trust between key healthcare professionals and make them feel more comfortable disclosing how they were feeling. Others wanted to see a better joining up of mental health care between professionals after poor experiences where notes were not being passed along and healthcare professionals were not aware of the woman’s circumstances so she had to repeat painful experiences to each professional.

“I was receiving CBT during pregnancy for my anxiety. The services felt so disconnected to me. My psychologist didn’t consider that giving birth might trigger new anxieties and the midwives thought my mental health issues were cared for, that that box was ticked. Having a baby escalated my anxiety, but I was the one to ask for more CBT, the health visitor was only worried I might have postnatal depression.”

Women’s experiences of healthcare professionals were not all negative. In the survey there were lots of women praising specific healthcare professionals who they felt that without them they would not have got the support they needed. Many had built up trusting relationships over time with healthcare professionals who then fought for them to get support. Others just found someone who listened and encouraged them to open up. Some women with existing mental health conditions felt supported throughout their pregnancy and birth by professionals who understood them.

“My one-to-one midwife was exceptional and in the time I got to know her, I developed a relationship of trust.”

These experiences all emphasise how important building a relationship and open communications between the woman and healthcare professional are in understanding and assessing each woman’s needs.

* Edinburgh Postnatal Depression Scale.

Recommendations from women's experiences of healthcare professionals

Stretched and understaffed services not only affect the quality and safety of care but also impact on the time that healthcare professionals have to enquire about a woman's mental health. Current shortages of doctors and midwives have left many maternity units overstretched; additional investment in maternity services would help to ensure that women have the time to discuss their mental health needs and receive personalised care.

All healthcare professionals working to support women during and after pregnancy should be better trained in the range of perinatal mental health conditions to recognise and respond to potential signs of perinatal mental health problems – from the mild to the severe. This should include an understanding of how to treat and support pregnant and breastfeeding women on medication for their mental health, in line with NICE guidelines.

Commissioners need to ensure that all healthcare professionals working with women during and after pregnancy are aware of the referral pathways for local perinatal mental health services so that women can receive support without unnecessary delays.

How and where conversations about mental health are conducted are vitally important. Not only should mental wellbeing be enquired about at each appointment with a woman during pregnancy and after birth, but all healthcare professionals should approach the conversation in an open way, encouraging dialogue and listening to a woman's concerns. Conversations should be conducted in appropriate locations, where the woman can feel comfortable and confident that the discussions will be private.

During appointments, healthcare professionals should also ascertain the mother's family history, i.e. whether a grandmother, mother or sister had experienced mental health problems during and/or after pregnancy.

Enquiries about mental wellbeing should not be seen as a tick box exercise and, although depression identification questionnaires can be helpful in guiding conversations, they should not be relied upon as the only means of enquiry into a woman's mental health. Most importantly, healthcare professionals should facilitate personalised care and shared decision making, especially where medication is recommended.

As recommended in the National Maternity Review report, *Better Births*,* maternity services should ensure a smooth transition between midwife, obstetric and neonatal care, and ongoing postnatal care in the community provided by GPs and health visitors. Severe mental health problems in pregnancy, a previous history of mental health problems in pregnancy and a family history of poor mental health should all be 'red flagged', as should the circumstances of a difficult pregnancy or birth, so that care can be coordinated and planned with services centred around the woman. All healthcare professionals should be aware of their shared duty to protect a woman's mental health during the perinatal period.

* National Maternity Review. *Better Births: Improving Outcomes of Maternity Services in England*, A Five Year Forward View for maternity care. 2016 [www.england.nhs.uk/ourwork/futurenhs/mat-transformation/mat-review/].

Recommendations from women's experiences of healthcare professionals (continued)

Better data sharing of patient records between primary and secondary care will assist in ensuring that women who are at risk of mental health problems during and after pregnancy are known to maternity services and will enable timely treatment.

The National Maternity Review report, *Better Births*, recommends continuity of carer to ensure safe care. Services should also analyse the positive impact this can have on women's mental health, enabling women to develop trusting relationships with healthcare professionals where they feel more comfortable discussing mental health problems.

Specific perinatal mental health conditions

Respondents to the survey experienced a range of perinatal mental health conditions, as well as various circumstances and physical conditions that they felt impacted on their mental health and subsequent treatment.

A large number of women reported that they felt that the focus of perinatal mental health services, especially with regard to the knowledge of non-specialised healthcare professionals, was on depression. Many felt that their symptoms were ignored, or not treated seriously enough because they did not fit into the classification of postnatal depression (i.e. moderate to severe depression following childbirth that last longer than 2 weeks). This is of concern considering that, among the survey's respondents, more women had experienced anxiety conditions than they had depression. A number of women mentioned that, when they were asked questions or asked to complete questionnaires, the focus of these were on moods rather than on anxiety symptoms such as flashbacks.

“My husband and I attended birth choice and parenting classes during my pregnancy. There was a brief mention of baby blues and postnatal depression but no mention of postpartum psychosis or that fathers can have mental health issues. There is a lack of awareness of mental health issues during and after pregnancy. Staff lack the capacity on postnatal wards to be able to spend enough time with women and identify early symptoms of mental health issues such as psychosis.”

Post-traumatic stress disorder

Following particularly traumatic births, women reported that they were often left without any support and many felt that their experiences and feelings towards the events that had happened during childbirth were not taken seriously and even, in some cases, undermined. They felt that there was a general lack of understanding of the impact that traumatic births can have on the mental wellbeing of women, as well as that of their partners. Healthcare professionals are used to dealing with stressful births but what is a fairly regular occurrence to them can be a hugely traumatic experience for the woman and her partner going through it.

Although women are offered a debrief after traumatic births, there were suggestions that there should be a general assumption that a woman's, and her partner's, mental wellbeing will have been affected by a traumatic birth, and perinatal mental health services should automatically be offered.

“I feel that if a woman has had a traumatic delivery they should be given counselling, regardless of how well they appear to be coping, as I'm sure many women, like myself, will try to hide it from everyone. I had nightmares of my daughter's delivery for at least 6 months after her birth, but never told anyone except my husband when it nearly led to us splitting up. In reality, I know if the same situation happened again, I still probably wouldn't admit to it.”

Perinatal OCD

Women with perinatal OCD in particular felt that there was a lack of understanding about their condition and it was often missed. A number of respondents said they had never been asked about compulsions or obsessive thoughts. Others had never heard of perinatal OCD and felt that even hearing about its existence, or that it was a possibility during their pregnancy, would have been helpful in understanding for themselves that their anxiety was not normal.

“There is a fairly major gap in diagnosis, support and treatment when it comes to postpartum anxiety and OCD, in my experience. I was asked a few times about depressive symptoms but I wasn't depressed, rather extremely anxious and trapped in cycles of checking behaviour. I saw a private therapist after 2 years (at the suggestion of my partner who understood how anxious I was) and I have worked through a lot of the issues now. However, I would've personally really benefited from anybody mentioning to me that postpartum OCD is a thing and that my anxiety and compulsions weren't just normal or 'not coping'.”

Antenatal depression

Respondents who experienced antenatal depression again felt that there was an emphasis on postnatal depression that often ignored the antenatal period. Some women were flagged in the system and told that there was no help for antenatal depression, only postnatal, and that they would have to wait until after birth. On the other hand, when some women were referred during their pregnancy, they were put on waiting lists that were so long that their appointments came after they had given birth, and support was no longer needed.

A number of women were only given support once their mental health became severe and there were fears that they were at risk. In some rare cases, women who were not able to take medication for their condition owing to pregnancy and the health risks to the fetus, considered ending their pregnancy rather than continuing on without support.

“I felt that very few medical professionals understood antenatal depression – the discussion was focused on risk to fetus. I wanted a termination rather than continue without antidepressants – GP had to say that I was likely to 'self-harm' to get additional support, as focus was on postnatal depression.”

Postpartum psychosis

Women with psychosis often reported that they had never heard of postpartum psychosis before and did not know the warning signs. This was also true for their partners, who were more likely

to pick up unusual behaviour than the person experiencing the condition. There was also a lack of knowledge among healthcare professionals, who often failed to pick up the symptoms or to take them seriously enough until they became severe.

“I had no awareness of psychosis before it happened so didn't know the warning signs. There should be a mental health specialist on the maternity ward. There needs to be better training for all healthcare professionals around perinatal mental health. My midwife picked it up on day 4 but the other healthcare professionals (including a psychiatrist) didn't believe her – it wasn't until 2 weeks that I was referred to the mother and baby unit. My consultant believes it could have been picked up on day 1 had there been a specialist on the maternity ward.”

Hyperemesis gravidarum

A number of women who completed the survey had also experienced hyperemesis gravidarum (severe nausea or vomiting during pregnancy) and felt that their mental health conditions were a direct result of this. Many felt that there was a gap in knowledge from healthcare professionals about how this condition can affect the mental health of women, not just their physical health. Respondents reported not being asked about their mental health at all, despite the fact that their sickness meant that they couldn't leave the house and were incredibly isolated, anxious and often depressed. Most were given help and medication to treat the physical aspects of their health, and felt that more needed to be done to treat the impact on their mental health.

“I had hyperemesis gravidarum during both of my pregnancies. During my first pregnancy I experienced low mood and following it had PTSD symptoms. During my second pregnancy the hyperemesis gravidarum was much worse and I was repeatedly hospitalised and barely left my bed while at home. I felt extremely isolated and my mood was extremely low. At no point did any healthcare professional ask about my mood during the pregnancy. I had to find out about the local maternal mental health service for myself and request a referral from my midwife. Hyperemesis gravidarum has left such an impact on not only my mental health but also my life and my family's life – healthcare professionals must recognise this and not treat the dehydration it causes in isolation.”*

Because of the nature of the condition, many women with hyperemesis gravidarum will experience it in multiple pregnancies: a number of such women reported in the survey that support for their mental health had improved in subsequent pregnancies, but they still felt that there was some way to go in getting healthcare professionals to acknowledge and understand its effects.

Pelvic girdle pain

Similarly, respondents who experienced pelvic girdle pain (pain in the pelvis during pregnancy) had not been asked about their mental health and again did not feel that healthcare professionals understood the impact the condition was having on their wellbeing. Women reported that the pain left them feeling isolated and alone as they were often unable to leave the house or even their beds,

* Post-traumatic stress disorder.

with some being confined to wheelchairs for the duration of their pregnancy. There seemed to be little acknowledgement that this was isolating and in turn that it impacted on their mental wellbeing.

Miscarriage and stillbirth

Some respondents to the survey had experienced miscarriages and stillbirths, and did not feel that there had been enough support following these events, or in subsequent pregnancies. Some women reported not being offered any bereavement support, despite asking for it, or receiving it a long time after the event. On occasions where women were being offered support, often their partners were denied it. Many reported feeling that there was an assumption that these events do not affect men in the same way they do women.

“There is woefully poor acknowledgement of and support for women who have experienced miscarriage, especially those who, like me, have experienced multiple, recurring miscarriages after a successful earlier pregnancy.”

Women who had gone on to have further pregnancies following multiple miscarriages reported that they had been incredibly and understandably anxious during their pregnancy and for some time after giving birth. Despite this, they had felt that healthcare professionals were not acknowledging their concerns or offering support for the anxiety.

“Having had three previous miscarriages I was very anxious at times, particularly during my first pregnancy, but this wasn't acknowledged or anticipated by any of the professionals that I came into contact with apart from the early pregnancy clinic, who were excellent.”

Recommendations on specific perinatal mental health conditions

All labour wards should have a perinatal mental health lead who works in a team with a perinatal mental health specialist, a midwife and an obstetrician, and who can carry out quick assessments on a woman's mental health following childbirth. Any woman who has had a traumatic birth should be seen and assessed before being discharged and given information on where to seek help should perinatal mental health symptoms develop.

Bereavement support following a stillbirth should be automatically offered to a woman and her partner. Services should also take into account the impact that multiple miscarriages can have on a woman's and her partner's mental health, especially the effects that they will have on anxiety in subsequent pregnancies and births. Following a traumatic birth, recurrent miscarriages or a stillbirth, services should consider offering support for couples to attend together, such as couples therapy.

Healthcare professionals involved in the care of women during and after pregnancy should pay special attention to the mental health of women who have had difficult pregnancies or births. The consequences these have on mental health should be treated as seriously as the physical impacts are.

Breastfeeding and mental health

Breastfeeding was one of the most common issues raised by respondents when answering the final question in the survey. Overall, they felt that the pressure to breastfeed was sometimes overwhelming and the judgement and stigma that came along with not breastfeeding their babies was hard to cope with. This was especially true for women who had planned to breastfeed but were unable to because something had gone wrong. Rather than receiving support, many felt that they were being blamed and it became hard to cope with this alongside their own feelings of failure. Many women reported that this had an impact on their mental wellbeing.

“I spent less than 12 hours in hospital, which, as a first-time mum, I felt was not long enough. I was having trouble breastfeeding and become very down as I had to bottle feed. I believe if I'd stayed longer in hospital then I would have got to grips with breastfeeding and therefore wouldn't have been so down for at least 12 weeks afterwards. They push breastfeeding onto mums, which I so wanted to do, but they give no support if for some reason you can't. I felt like I'd failed and my baby wasn't even a week old.”

The NICE clinical guideline on *Antenatal and Postnatal Mental Health** recommends that healthcare professionals discuss breastfeeding with all women who need to take psychotropic medication in pregnancy or postnatally. This should include an explanation of the benefits of breastfeeding as well as the risks involved in taking medication and breastfeeding. Ultimately, it states that each woman should be supported in her choice of the feeding method that suits her and her family.

However, a number of women on medication reported receiving unhelpful advice about breastfeeding; they felt that both women and healthcare professionals did not understand the risks and that they were often given conflicting advice. Some women who were experiencing mental health problems were taken off medication because they wanted to continue breastfeeding and on occasions this led to a rapid deterioration of their condition.

Many respondents felt that, on the whole, more breastfeeding support was needed. When they were having difficulties breastfeeding, they felt that it impacted on their mental wellbeing, whether or not they had other perinatal mental health conditions. Rather than being judged and told that they had to continue no matter what, women wanted more constructive support.

“More help with breastfeeding before and after birth. Having trouble with breastfeeding can be very stressful. Knowing more before birth can help overcome problems after birth.”

* National Institute for Health and Care Excellence. *Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance*. London and Manchester: NICE: 2014 [www.nice.org.uk/guidance/cg192].

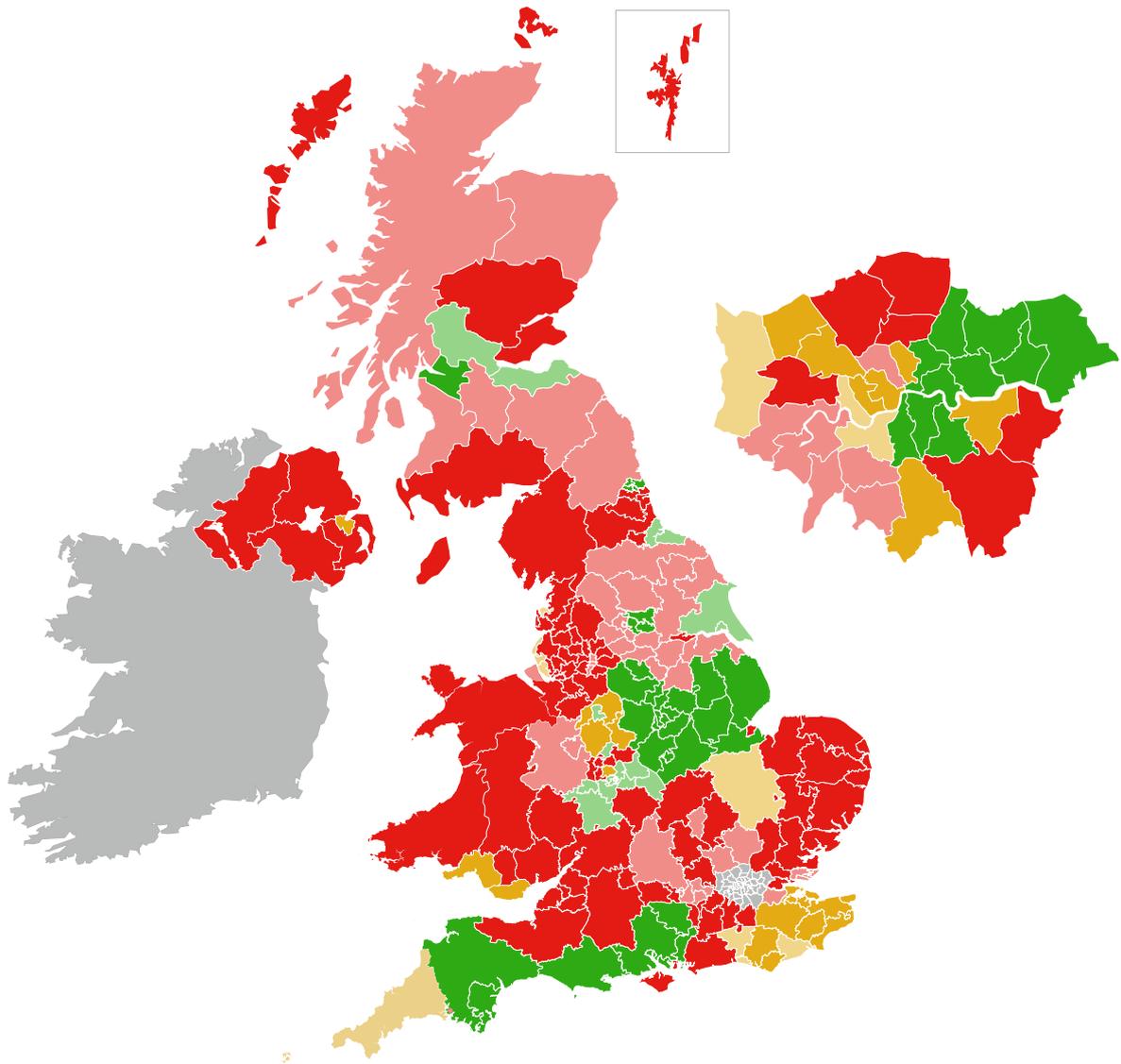
Recommendations on breastfeeding and mental health

When discussing breastfeeding with a woman, healthcare professionals should understand the impact that problems with feeding could have on a mother's mental health. All women, especially those experiencing perinatal mental health problems, should be made aware of the benefits of breastfeeding but ultimately supported in whatever method of feeding they choose.

Difficulties in breastfeeding can impact on a mother's mental health. Commissioners should examine opportunities for more breastfeeding support in communities. They should also consider opportunities to better link breastfeeding and perinatal mental health support services together; for instance, breastfeeding drop-ins and groups could provide opportunities to discuss and raise awareness for perinatal mental health services.

Appendix A

Provision of specialist community perinatal mental health teams in the UK



Red areas	no specialist team exists
Pink areas	Some extremely basic level of provision exists but currently falls short of national standards and needs expanding
Amber areas	Some basic level of provision exists but currently falls short of national standards and needs expanding
Green areas	Women and families can access treatment that meets nationally agreed standards

Source: Maternal Mental Health Alliance, Everyone's Business Campaign, 2015 [http://everyonesbusiness.org.uk/?page_id=349]

Appendix B

Survey questions



Royal College of
Obstetricians &
Gynaecologists

RCOG women's survey of maternal mental health

The Royal College of Obstetricians and Gynaecologists (RCOG) is looking at the training and guidance given to our doctors to help us to better identify and support women with maternal mental health needs.

As well as surveying our trainees, we think it is important to hear from you about your personal experiences and the barriers that you may have had while trying to access care.

This survey is for women who have given birth in the UK with the last five years and asks about your experiences before, during and after pregnancy. All responses to this survey will be completely confidential. The information you provide will paint a picture of the care given to women, and allow us to fill in any gaps in the training and guidance given to doctors. It will also help our policy department to propose service changes to Government.

We would appreciate it if you could complete this survey, which should take no longer than 10 minutes. Please skip any questions that you don't feel comfortable answering.

Thank you for your time.

This survey closes on Friday 15 April, 2016.

Should you have any other comments to make which are not captured in the survey, please let our policy & public affairs officer Karina Russell know on krussell@rcog.org.uk.



RCOG women's survey of maternal mental health

The following questions relate to any pregnancies you have had in the last 5 years, whether or not you experienced mental health issues.

Please answer the questions in regards to your most recent pregnancy.

If you have experienced mental health issues in the last 5 years during or after a pregnancy that wasn't your most recent, please answer in regards to that pregnancy.

1. Please tell us your location

- East Midlands
- East of England
- London
- North East
- North West
- Northern Ireland
- Scotland
- South East
- South West
- Wales
- West Midlands
- Yorkshire and the Humber

2. Please tell us your age

- 18-24 years old
- 25-34 years old
- 35-44 years old
- 45-54 years old
- 55 years old or older

3. Are you currently pregnant?

- Yes
- No



RCOG women's survey of maternal mental health

4. How recently did you give birth?

- In the last year
- In the last 2 years
- In the last 3 years
- In the last 4 years
- In the last 5 years

5. Before your pregnancy did you have any mental health issues?

- Yes, and I was taking medication for it
- Yes, but I was not taking medication for it
- No

6. If you were taking medication, what advice were you given about the impact of continuing or stopping your medication on you and your baby's health?

7. During or after any of your pregnancies in the last 5 years, would you say you had any of the following? (Please tick as many as apply)

- Low mood (*symptoms include but are not limited to: feeling sad, mood swings or crying episodes*)
- Depression (*symptoms include but are not limited to: persistent sadness, lack of pleasure in things that normally bring joy, feelings of inadequacy or guilt, thoughts of death or suicide*)
- Anxiety, obsessive thoughts or post-traumatic stress (*symptoms include but are not limited to: excessive worry, obsessions or persistent intrusive thoughts, compulsions or repetitive behaviours that are difficult to control, flashbacks or nightmares, intrusive re-experiencing of a traumatic experience*)
- Psychosis (*symptoms include but are not limited to: delusions or strange beliefs, hallucinations, hyperactivity, paranoia, rapid mood swings*)
- None of the above
- Other (please specify)



RCOG women's survey of maternal mental health

8. Did your partner have any mental health issues during or after your pregnancy?

- Yes
 No
 I do not know

Would you like to tell us more? Was your partner offered any support?

9. During and after your pregnancy, did any of these health professionals ask how you were feeling in relation to your mental wellbeing and if you felt you needed any support? (Please tick as many as apply)

- An obstetrician
 A midwife
 A health visitor
 A GP
 None of the above
 Other (please specify)

10. Did the health professional ask about: (please tick as many as apply)

- Your personal history of mental health
 Your family history (i.e. whether a first-degree relative such as your mother or a sibling had mental illness)
 Your personal circumstances (i.e. where applicable, questions such as if you were a victim of domestic violence or if you had substance misuse issues)
 Your social circumstances (i.e. where applicable, questions such as if you had housing, relationship, employment, financial or immigration difficulties)
 They did not ask about any of these
 I do not know



RCOG women's survey of maternal mental health

11. Did you talk to, or would you have felt comfortable talking about how you felt with any of these health professionals: (please tick as many as apply)

- An obstetrician
- A midwife
- A health visitor
- A GP
- I did not talk to or would not have felt comfortable talking to a clinician
- Other (please specify)

12. Is there a reason why you wouldn't have felt comfortable talking to a health professional about how you were feeling? (Please tick as many as apply)

- I felt embarrassed
- There is a stigma attached to mental illness
- I was unsure what was wrong
- I thought it was normal
- I was worried
- I was concerned about this being noted on my medical records
- I did not think they could or would help
- I did not want to take up the clinicians time
- I was not asked
- The clinicians were not approachable
- Other (please specify)



RCOG women's survey of maternal mental health

13. If you experienced mental health problems during or after pregnancy, were you referred to a support service (such as a mother and baby unit or counselling)?

- Yes, I was referred
- I was given information about organisations to contact for more support
- No
- I do not know

14. Which services were you referred to? (Please tick as many as apply)

- Mother and Baby Unit
- Other specialised maternal mental health service (*such as a specialised maternal mental health therapist*)
- Out-patient mental health services (*such as a general therapist*)
- In-patient psychiatric unit
- Local peer group support
- Other (please specify)

15. How long did it take after referral to be seen?

- The same day
- Within 1 week
- Within 2 weeks
- Within 3 weeks
- Within 4 weeks
- Over 4 weeks (please specify how long)



RCOG women's survey of maternal mental health

16. When you were offered support, how many hours did you have to travel to get support?

- Within 1 hour
- Within 2 hours
- Within 3 hours
- Within 4 hours
- Over 4 hours (please specify how long you had to travel to receive support)

17. Did you seek support yourself through any of the following? (Please tick as many as apply)

- Helpline
- Online forum
- Friends and family
- Face to face support group
- Private counselling
- None of the above
- Other (please specify)

18. Have you experienced mental health problems in more than one pregnancy?

- Yes
- No

19. Were you offered any of these treatments in regards to the mental health issues in previous pregnancies? (Please tick all that apply)

- Medication
- Talking therapies (*such as counselling or therapy*)
- ECT (*electroconvulsive therapy*)
- None of the above
- Other (please specify)



RCOG women's survey of maternal mental health

20. If medical help was not sought, why not?

21. What gaps, if any, do you feel there are in the mental health support given to women before, during and after pregnancy?

Thank you for taking the time to fill out this survey.

Your responses will help us identify gaps in the level of care given to women experiencing maternal mental health problems.

If you currently need to speak with someone about how you are feeling, please call one of the numbers below:

Samaritans – 116 123 (24hrs a day)
Mind – 0300 123 3393 (9am – 6pm Mon-Fri)
NHS Choices – 111 (24hrs a day)

Or visit these websites for details of how you can get further support:

Action on Postpartum psychosis - <http://www.app-network.org>
Association for Post Natal Illness - <http://apni.org/>
Birth Trauma Association - <http://www.birthtraumaassociation.org.uk>
Maternal OCD - <http://www.maternalocd.org/>
The Miscarriage Association - <http://www.miscarriageassociation.org.uk/>
Tommys - <http://www.tommys.org/pregnancy/your-life/mental-health>

Appendix C

Respondents' demographics

Table CI Number of respondents from each region compared with population estimates

Region	Survey respondents		UK female population estimates (2015)*	
	Number	Percentage of respondents	Number	Percentage of UK population
East of England	208	9%	3 083 085	9%
East Midlands	151	7%	2 367 841	7%
London	195	8%	4 364 201	13%
North East	36	2%	1 337 444	4%
North West	158	7%	3 639 439	11%
South East	458	20%	4 543 540	14%
South West	347	15%	2 783 084	8%
West Midlands	324	14%	2 906 242	9%
Yorkshire and the Humber	131	6%	2 732 165	8%
Northern Ireland	83	4%	942 492	3%
Scotland	163	7%	2 762 531	8%
Wales	59	3%	1 573 525	5%
No response to region question	10			
Total	2 323		33 035 589	

* Office for National Statistics. Population Estimates Analysis Tool [www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesanalysistool].

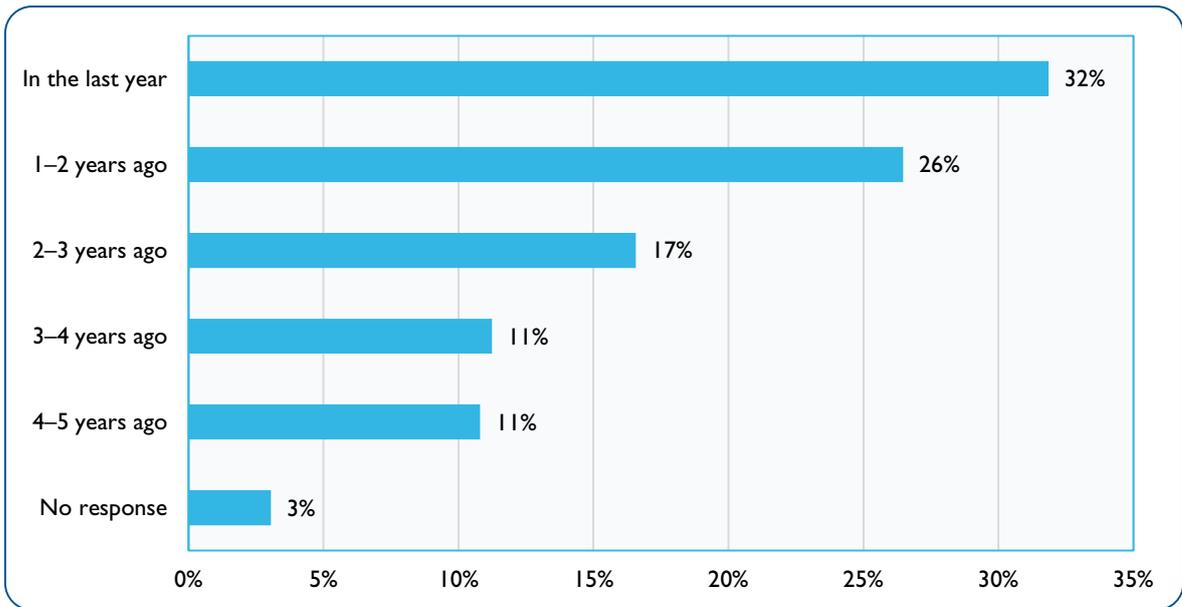


Figure C1 How recently respondents had given birth