Time for action on perinatal mental health care in Northern Ireland

A report on the perspectives of health visitors and midwives

Executive summary

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In partnership with

EVERY CHILDHOOD IS WORTH FIGHTING FOR
Introduction and background

This paper summarises the key results of survey research concerned with health visitors’ and midwives’ views and experiences of identifying and responding to perinatal illnesses in Northern Ireland. Perinatal mental illness is an umbrella term for “a range of mental health problems, including anxiety, depression and postnatal psychotic disorders” (Hogg, 2013, p. 8). The perinatal period is defined in this study as pregnancy and the postnatal period (up to one year after childbirth) (National Institute for Health and Care Excellence (NICE), 2014). Mental illnesses during the perinatal period are common, with between 10 to 20 per cent of women affected (Public Health Agency (PHA), 2017).

Figure 1, overleaf, sets out estimated figures on the number of women affected by perinatal mental illnesses in Northern Ireland.

The research presented in this report involved a survey of health visitors and midwives in Northern Ireland who provide a universal service to women in the antenatal and postnatal periods. The project was undertaken as a partnership between NSPCC Northern Ireland, the Community Practitioners and Health Visitors Association (CPHVA) in Northern Ireland and the Royal College of Midwives (RCM) in Northern Ireland.

The report is timely as it has been completed within the wider context of a growing recognition of the need to address clear deficits in perinatal mental health provision for women and families in Northern Ireland, which continues to be the poorest within the UK (Maternal Mental Health Alliance, 2017). This was most recently documented in the independent review conducted by the Regulation and Quality Improvement Authority (RQIA, 2017), which regulates and inspects the quality and availability of health and social care (HSC) services in Northern Ireland.

The full research report is available on the NSPCC Learning website, learning.nspcc.org.uk.

Research aim and objectives

The survey research aimed to explore the views and experiences of health visitors and midwives in Northern Ireland of identifying and responding to perinatal mental illnesses.

The objectives were to:

• Explore the awareness of health visitors and midwives in Northern Ireland of the importance of early identification of perinatal mental health problems.

• Explore the screening tools, skills and techniques that health visitors and midwives in Northern Ireland use to identify perinatal mental health needs.

• Describe the supports that health visitors and midwives in Northern Ireland have to assist them with early identification and response, and their awareness of these supports.

• Explore the views of health visitors and midwives in Northern Ireland about the challenges and future development of early identification and response to perinatal mental health needs.

• Describe how views about early identification and response to perinatal mental health needs differ across professions, roles, experience, length of service and location.
How many women are affected?

Estimated number of women in Northern Ireland affected by perinatal psychiatric disorders, 2016

- **Postpartum psychosis**: 48
  - Postpartum psychosis is a severe mental illness that typically affects women in the weeks after giving birth, and causes symptoms such as confusion, delusions, paranoia and hallucinations. Rate: 2/1000 maternities.

- **Chronic serious mental illness**: 48
  - Chronic serious mental illnesses are longstanding mental illnesses, such as schizophrenia or bipolar disorder, which may be more likely to develop, recur or deteriorate in the perinatal period. Rate: 2/1000 maternities.

- **Severe depressive illness**: 722
  - Severe depressive illness is the most serious form of depression, where symptoms are severe and persistent, and significantly impair a woman’s ability to function normally. Rate: 30/1000 maternities.

- **Post-traumatic stress disorder**: 722
  - PTSD is an anxiety disorder caused by very stressful, frightening or distressing events, which may be relived through intrusive, recurrent collections, flashbacks and nightmares. Rate: 30/1000 maternities.

- **Mild to moderate depressive illness and anxiety states**: 2,408-3,611
  - Mild-moderate depressive illness includes symptoms such as persistent sadness, fatigue and loss of interest and enjoyment in activities. It often co-occurs with anxiety, which may be experienced as distress, uncontrollable worries, panic or obsessive thoughts. Rate: 100-150/1000 maternities.

- **Adjustment disorders and distress**: 3,611-7,223
  - Adjustment disorders and distress occur when a woman is unable to adjust or cope with an event such as pregnancy, birth or becoming a parent. A woman with these conditions will exhibit a distress reaction that lasts longer, or is more excessive than would normally be expected, but does not significantly impair normal function. Rate: 150-300/1000 maternities.

Note: There may be some women who experience more than one of these conditions.

The importance of early identification and support

Perinatal mental illness is a major public health issue (Hogg, 2013). The long-term cost is estimated to be approximately £8.1 billion for each one-year cohort of births in the UK (Bauer, Parsonage, Knapp et al, 2014). The majority of this cost (72 per cent) relates to the adverse impacts of these illnesses on children. Early identification and provision of appropriate and timely expert care can minimise the harm to women, children and families, and in many cases, prevent it from occurring in the first place.

Historically, a low level of identification by universal services has been one of the greatest barriers to families receiving help (Hearn, Iliff, Jones et al, 1998; Khan, 2015). An over-stretched health service means a heavy burden of work pressures on practitioners, mitigating against the time and continuity of care needed to develop trusting relationships (Health Education England, 2016). Screening tools offer an important aid to identification. However, experts caution against an overreliance on screening, and urge appropriate training for primary care professionals so that tools are used as part of a wider psychosocial or clinical assessment and that, where identified, support and treatment are made available (Leverton and Elliott, 2000; Oates, 2003; Milgrom and Gemmell, 2013; Austin, Priest, and Sullivan, 2008).

Primary care professionals must be enabled to develop professional skills, judgement and confidence in spotting signs of mental health adversity. While negative impacts on children or parenting are not inevitable, primary care professionals need to be able to detect issues in the mother-infant interaction where they exist, and to be able to help mothers become more attuned and responsive to their babies’ needs (Hogg, 2013).

Where support for perinatal mental illness can be provided within primary care, timely and appropriate care must be made available. When specialist support is required, primary care professionals must have effective care pathways in place and appropriate services to refer to. However, for women in Northern Ireland, specialist provision continues to operate as a postcode lottery (Maternal Mental Health Alliance, 2017). The Belfast Health and Social Care Trust is the only Trust which provides a specialist service, and this is small scale in nature. There also continues to be no Mother and Baby Unit in Northern Ireland, nor on the island or Ireland.

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Chronic serious mental illness are longstanding mental illnesses, such as schizophrenia or bipolar disorder, which may be more likely to develop, recur or deteriorate in the perinatal period. Rate: 2/1000 maternities.

Severe depressive illness is the most serious form of depression, where symptoms are severe and persistent, and significantly impair a woman’s ability to function normally. Rate: 30/1000 maternities.

PTSD is an anxiety disorder caused by very stressful, frightening or distressing events, which may be relived through intrusive, recurrent collections, flashbacks and nightmares. Rate: 30/1000 maternities.

Mild to moderate depressive illness and anxiety states include symptoms such as persistent sadness, fatigue and loss of interest and enjoyment in activities. It often co-occurs with anxiety, which may be experienced as distress, uncontrollable worries, panic or obsessive thoughts. Rate: 100-150/1000 maternities.

Adjustment disorders and distress occur when a woman is unable to adjust or cope with an event such as pregnancy, birth or becoming a parent. A woman with these conditions will exhibit a distress reaction that lasts longer, or is more excessive than would normally be expected, but does not significantly impair normal function. Rate: 150-300/1000 maternities.

Note: There may be some women who experience more than one of these conditions. Source: Estimated using prevalence figures in guidance for commissioners of perinatal mental health services produced by the Joint Commissioning Panel for Mental Health in 2012, and data on live births in 2016 provided in the Registrar General Northern Ireland Annual Report 2016, published by the Northern Ireland Statistics and Research Agency in 2017.
Methodology

This research employed an online survey which was completed by a total of 332 respondents, including 130 health visitors and 202 midwives, of which 141 were hospital midwives and 37 were community midwives. A cautious estimate based on 2016 workforce headcount data puts the final survey sample at approximately 23 per cent of the health visitor population and 15 per cent of the midwife population (rounded to the nearest percentage) (Department of Health and Northern Ireland Statistics and Research Agency, 2016). The survey comprised mostly closed multiple choice questions investigating health visitors’ and midwives’ professional experience in the following areas: recognition, referral and management of perinatal mental illness; training; and opportunities and challenges in the area of perinatal mental health in Northern Ireland. An introductory round of questions also gathered demographic information. One open question was used to gather respondents’ broad perspectives about the challenges faced by their profession in seeking to improve the early identification and response to women with perinatal mental illnesses in Northern Ireland.

Key insights

The results reported in this survey research affirm that health visitors and midwives in Northern Ireland experience similar types of challenges in identifying and responding to perinatal mental illness as their counterparts in the rest of the UK. However, at the time of writing, Northern Ireland remains the only part of the UK which has not committed to investment of funds, despite major funding on perinatal mental health pledged via the Barnett formula.

The strong message from professionals in Northern Ireland is that when it comes to disclosure of perinatal mental illness, relationships matter: time and continuity of care are essential. While the report is focused on early detection and response, the respondents express a general frustration with lack of funding, overwork, and high levels and complexity of demand. Overwhelmingly there is a need to ensure these professions feel valued and that the issue of perinatal mental illness is invested in.

The findings also reveal inconsistencies between policy and practice on the use of screening tools across Health and Social Care Trusts, professional concerns about the response to perinatal mental illness once it is identified, and suggest a need for closer alignment between infant mental health and perinatal mental health practice.

Figure 2 on the following page illustrates health visitors’ and midwives’ respective views about what they find most useful to help identify a woman experiencing a perinatal mental illness in Northern Ireland. Figure 3, overleaf, presents the perspectives of these professionals about the greatest barriers to disclosure for women in Northern Ireland. Further reference and context is provided in the full research report, available at learning.nspcc.org.uk.
Spotting perinatal mental illness

We asked health visitors and midwives in Northern Ireland for their top three aids for identifying perinatal mental illness.

Both midwives and health visitors rank relationship continuity as the most useful aid to identification. After this, views diverge.

Health visitors:
1. Continuity of relationships
2. Home visiting
3. Screening tools

Midwives:
1. Continuity of relationships
2. Time during appointments
3. Communication from other health and social care professionals

Note: this infographic is based on responses to a survey question asking health visitors and midwives in Northern Ireland, ‘Overall, what do you find most useful to help you identify a woman experiencing perinatal mental illness?’ Respondents were asked to rank their top three preferences among a number of items in order of usefulness. The infographic presents the perspectives of health visitors and midwives who carried an individual caseload at the time of survey completion (n=167). Midwife respondents included both community midwives and hospital midwives. Views were consistent across both types of midwife respondent.
What barriers are women facing?

The three greatest barriers to disclosure of perinatal mental health difficulties for women in Northern Ireland, according to health visitors and midwives.

Health visitors:
1. Fear of consequences
2. Fear of labelling / lack of confidence to recognise difficulties with their mental health
3. Lack of relationship between professional and patient

Community Midwives:
1. Fear of consequences
2. Lack of continuity of health professional
3. Appointments too short

Hospital Midwives:
1. Lack of continuity of health professional
2. Fear of consequences
3. Lack of relationship between professional and patient

Note: this infographic is based on responses to a survey question asking health visitors and midwives in Northern Ireland, 'What do you feel is the greatest barrier to disclosure [of perinatal mental health difficulties]?' Respondents (n=325) were asked to rank their top three preferences among a number of items.
Recommendations

1. Training standard on perinatal mental illness
A training standard for perinatal mental illness should be introduced in Northern Ireland for all professionals who care for women during the perinatal period. This should set out the competencies required across the range of health and social care occupations, both in practice and management roles. As a minimum, it should ensure that professionals receive mandatory training in perinatal mental illness and receive regular updates and continuous professional development.

2. Face to face time and continuity of care
Midwives and health visitors stress that face to face time with mothers and babies is crucial for improving identification and support. Ways of working within midwifery and health visiting services should be reviewed to improve continuity of care, as well as ensure, where possible, that appointments allow parents and professionals sufficient time together.

3. The detection of perinatal mental health needs: use of screening tools and the professional-service user relationship
Reported inconsistencies in the use of screening tools must be addressed, in tandem with a strengthening of skillsets to enhance how midwives and health visitors work with women. The Public Health Agency should provide clarification on the use of screening tools in accordance with the 2017 Regional Perinatal Mental Health Care Pathway, and also review regional training needs including advanced practice skills around disclosure.

4. Alignment of perinatal mental health with infant mental health and the parent-infant relationship
Work to implement the 2017 Regional Perinatal Mental Health Care Pathway should address the dual role of professionals in detecting and responding to perinatal mental health needs, and also supporting the parent-infant relationship and infant’s mental health. This should include further investigation of professionals’ understanding of, identification of, and response to problems in the parent-infant relationship.

5. Provision of specialist services and establishment of a mother and baby unit in Northern Ireland
Improved identification must be matched by provision of specialist services. However, Northern Ireland continues to have the poorest level of service provision in the UK. The 2017 report of the Regulation and Quality Improvement Authority (RQIA) on its Review of Perinatal Mental Health Services in Northern Ireland, identified necessary steps and timescales to improve the state of services. Key deadlines have already lapsed. The RQIA recommendations must be implemented without further delay and in the absence of a NI Assembly, to progress both the development of specialist perinatal mental health services in every HSC trust, and the development of a mother and baby unit.


Maternal Mental Health Alliance (2017) Northern Ireland Perinatal Mental Health is Everyone’s Business. London: MMHA.


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