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Services to support mothers and fathers with mild to moderate perinatal mental health problems:

Clinical implications and recommendations

Services to support mothers and fathers with mild to moderate perinatal mental health problems: Clinical implications and recommendations

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This paper interrogates the literature on services to support mothers or fathers with perinatal mental health problems. It highlights the need for robust assessment tools, training and continuous support to empower professionals and voluntary sector workers to identify perinatal mental health problems. These problems can be overlooked when professionals are too stretched to tackle issues for which they fear they do not have adequate solutions, and when parents-to-be and new parents are wary of revealing mental health problems which they see as deviating from expectations of being a perfect parent. A second paper, to be published in a later issue of the IJBPE, will present the findings of a qualitative study of the views of parents, practitioners and commissioners on the best ways to implement perinatal mental health services.
Keywords: perinatal mental health, PMH, perinatal mental health problems, PMHPs, midwives, commissioners, practitioners, fathers, mothers

Perinatal depression affects approximately 10% to 15% of women (O' Hara et al., 2014). The prevalence of perinatal anxiety has been found to be 15.2% (Dennis et al., 2017). The prevalence rates of perinatal depression with a comorbidity of anxiety have been estimated to be 9.3% during pregnancy and 8.2% during the postpartum period (Falah-Hassani et al., 2017). In the United Kingdom (UK), the annual cost to society of perinatal depression, anxiety and psychosis is estimated to be about £8.1 billion with much of the long-term cost falling on child services (Bauer et al., 2014). A range of negative outcomes for infants results from perinatal mental health problems (PMHPs) including preterm birth, low birth weight, adverse effect on cognitive, behavioural, psychomotor and socio-emotional development, and child and adult psychiatric mental health conditions (Kingston et al., 2012; Grote et al., 2010)

Martin and colleagues (2017) emphasise that childbirth offers professionals who come into contact with women the opportunity to make a positive impact on negative obstetric and mental health outcomes which are known to be associated with PMHPs (Alderdice et al., 2013). Universal and statutory services accept perinatal mental health (PMH) care as being a part of their remit (Hauck et al., 2015) but providing it remains a difficulty for midwives (Hauck et al., 2015; McCauley et al., 2011; Jomeen et al., 2009; Ross-Davie et al., 2006).

BARRIERS TO IDENTIFICATION AND TREATMENT

Many women with perinatal mental health problems fail to seek support from services (e.g., Fonseca et al., 2015) and services are relatively poor at identifying women who need support (Austin & Marcé Society Position Statement Advisory Committee, 2014). Women may be reluctant to disclose what they are feeling, and professionals reluctant to identify women due to their lack of knowledge or lack of available resources (Jones et al., 2012; McCauley et al., 2011; Rothera & Oates, 2011; Edge, 2010; Lees et al., 2009; Mivšek et al., 2008; Priest et al., 2008; Elliot et al., 2007; Ross-Davie et al., 2006; Saunders et al., 2006).

NEGATIVE STEREOTYPING AND STIGMA

Noonan et al. (2017a) identified six studies indicating a negative attitude on the part of health professionals towards women with PMHPs (Hauck et al., 2015; McCauley et al., 2011; Jomeen et al., 2009; Lees et al., 2009; Gibb & Hundley, 2007; Skocir & Hundley, 2006). Some midwives considered that women with PMHPs were difficult to manage (McCauley et al., 2011). Conversely, midwives may feel driven to try to protect women from feeling uncomfortable and/or receiving a 'label' (e.g., Jomeen et al., 2018; McCauley et al., 2011).

LACK OF PRACTITIONER KNOWLEDGE AND TRAINING

Noonan et al. (2017a) highlighted the findings from studies which showed that midwives, as well as those with specialist PMH roles, report lacking knowledge of how to manage PMHPs and specifically knowledge around managing women from diverse cultural backgrounds (Edge, 2010). There is a lack of culturally sensitive assessment tools and access to skilled interpreters (Higgins et al., 2018; Nithianandan et al., 2016; Borglin et al., 2015; Almond & Lathlean, 2011; Edge, 2010; Baldwin & Griffiths, 2009). Women of colour, and women living in deprived areas, are less likely to be asked about their mental health (Redshaw & Henderson, 2016).

IDENTIFICATION AND SCREENING

The identification of women who are vulnerable to developing a PMHP is a priority (Carroll et al., 2018; Department of Health, 2016; NICE, 2014). NICE (2014) guidelines recommend the use of the Whooley questions. However, there are a number of other validated assessment tools which midwives may also use such as the Edinburgh Postnatal Depression Scale (EPDS) and the Beck Depression Inventory (BDI), or un-validated instruments. Bauer et al. (2015; 2014) suggest that fewer than 50% of women are identified in routine clinical settings and screening measures may be poorly understood (Hauck et al., 2015; Jones et al., 2011; McCauley et al., 2011) with the EPDS being recognised as a screening tool by only 13.4% of midwives (Hauck et al., 2015).

Carroll and colleagues (2018) found that midwives would typically ask only women whom they believed had risk factors for mental health conditions about their experiences of mood disorders, anxiety and their trauma history. Such an approach to screening can result in women who are at risk of PMHPs not being identified and treated.

PATERNAL PERINATAL DEPRESSION (PPND)

O'Brien and colleagues (2017) highlighted a significant body of research investigating the prevention of perinatal anxiety and depression in couples (e.g., Pilkington et al., 2015; Pilkington et al., 2015a). However, there is relatively little research exploring the treatment of fathers who are experiencing depression and/or anxiety (O'Brien et al., 2017) although fathers, independently of mothers, are found to have the potential to impact significantly on the development of their children (Rominov et al., 2017a).

Leach and colleagues (2016) found that during the prenatal period, the prevalence of anxiety disorders in men is in the range of 4.1%-16%, and 2.4%-18% during the postnatal period. In an often-cited meta-analysis of international studies, it was found that approximately 10% of fathers experienced prenatal and postpartum depression with the rate being greater three to six months postpartum (Paulson & Bazemore, 2010). Depression in men is probably under-diagnosed and under-reported as men may consider help-seeking behaviour contrary to traditional notions of masculinity (Levant, 2011). Therefore, the 'true' prevalence is probably higher (e.g., Martin et al., 2013).

Studies have also found a moderate positive correlation between maternal postnatal depression (PND) and paternal postnatal depression (PPND) (Anding et al., 2016; Paulson & Bazemore, 2010). PPND and poor relationship satisfaction are associated with maternal mental health issues (e.g., Wee et al., 2011). About 24% to 40% of male partners of women who are diagnosed with PND report PPND (Goodman, 2004).

CLINICAL IMPLICATIONS AND RECOMMENDATIONS

1. Routine assessment

The findings from this review of the literature indicate that routine assessment for perinatal mental health problems would be clinically useful with caution being exercised to prevent excessive screening, over-pathologising pregnancy, labelling woman, and over-referring to mental health services (Noonan et al., 2017a).

2. Better information for women about PMHPs

Better information for women is needed to increase awareness and understanding of PMHPS and decrease stigma and fear about disclosing negative feelings, as well as to provide details of support services (Higgins et al., 2018a; Millett et al., 2018; Borglin et al., 2015; Tammentie et al., 2013; Glavin et al., 2010). Higgins and colleagues (2018) have also recommended that information is provided to the woman's partner or other significant family member(s) who may provide a link to identification and support (Higgins et al., 2017; Stein et al., 2014).

3. Greater links between services

Universal perinatal service providers (midwives, health visitors, general practitioners) need to be able to link to specialist services such as children and adolescent mental health services (CAMHS), clinical psychology services linked to maternity hospitals, perinatal mental health services, staff

from children's centres and the extended primary care team (Bambridge et al., 2017; Noonan, 2017a; Marks, 2017; Hauck et al., 2015; Knight, 2014; Ross-Davie et al., 2006), and also the voluntary sector.

4. Facilitating access to therapy
There is the need for greater flexibility to be able to deliver a 'combination of individualized, flexible home visits, telephone consultations and clinic based visits' (Noonan et al., 2017:553). Suitable venues to accommodate the needs of the baby, longer sessions, flexible visiting schedules and postpartum home visits would be helpful (Millett et al., 2018; Viveiros & Darling, 2018; O'Mahen et al., 2014).

5. A safe space to discuss the impact of past trauma
Principles of trauma-informed care may be useful to include in perinatal and infant mental health (PIMH) service evaluation, development and delivery (Coates et al., 2017; Myors et al., 2015; 2014).

6. Culturally specific validated tools and culturally sensitive PMH information
Culturally specific validated tools and information should be developed (Higgins et al., 2018).

7. Involving partners/close family members
Millet and colleagues (2018) identified a need for partners and/or significant family members to be involved in intervention. Stein et al. (2014) have shown that the amount of support the woman receives can make a significant positive impact on outcomes for her, her infant and the rest of the family. Rominov and colleagues (2017a) have stressed the need for greater recognition of fathers, often the first to see the woman's distress and be in a position to respond (Carroll et al., 2018; Rominov et al., 2017a; Pilkington et al., 2015b).

8. Identifying and meeting specific treatment needs of new fathers
O'Brien and colleagues (2017) note that there is relatively little research exploring the needs of new fathers despite growing recognition of the prevalence of PPND (Edward et al., 2015). Clinical guidelines targeted on the identification and treatment of perinatal anxiety in fathers are few and far between (Leach et al., 2016). According to O'Brien et al. (2017:873), PPND would be most effectively addressed by the 'adoption of father-inclusive and father-specific models of care that creatively encourage help-seeking behaviour in a notoriously hard-to-engage population, offer flexible delivery options that do not overburden already distressed men, and provide a safe and informal environment for male only groups to share experiences and concerns'. New fathers may feel isolated and marginalised, so support groups would have the potential to be helpful (O'Brien et al., 2017).

9. Training and information for professionals and voluntary sector workers
All professionals as well as voluntary sector workers involved in the care of women perinatally need access to continuous professional development to help them challenge negative attitudes and beliefs (Noonan et al., 2017a). Traditionally, training has tended to focus on depression at the expense of other mental health issues (Almond & Lathlean, 2011; Jomeen et al., 2013) including previous adverse experiences which could be a trigger for problems in the perinatal period. Education relating to the specific support needs of fathers is also required (Rominov et al., 2017).

10. Supporting staff
An organisational culture which both provides support to staff who are involved in PMH care, and also contains their needs must be fostered (Marks, 2017). Support may include counselling (Austin et al., 2013; Mollart et al., 2009) and supervision/ reflective practice groups (Marks, 2017).

FUTURE RESEARCH DIRECTIONS

a) Investigating fathers' experiences of support and identifying their support needs
It is increasingly recognised that there is a need for services which specifically target fathers during the perinatal period. However, research is lacking to identify their exact needs (Rominov et al., 2017a) and especially the support needs and experiences of fathers from a range of cultural backgrounds.

b) Referral pathways
Further research is needed into referral pathways, including the voluntary sector, in order to support health visitors more effectively in their role in PMH care. Noonan and colleagues (2017:546) recommend that referral pathways available to health visitors should comprise 'a range of health service initiatives including counselling, listening visits, cognitive behavioural therapy, culturally appropriate community support groups, referral to general practitioners and referral to perinatal mental health specialists for severe mental health problems'.

c) Mode of PMH screening
Postpartum women have reported that online screening is an 'unintimidating and easy way' to screen for depression (Drake et al., 2014). However, good practice would suggest that the opportunity for a health professional to reflect with the woman on her answers would be more effective than the woman merely completing a checklist, especially in relation to red flag issues such as suicidal thoughts. Kingston and colleagues (2015) conclude that women feel most comfortable with paper-based screening and that telephone-based screening is the least comfortable approach to screening. Future research should investigate preferred mode of PMH screening in different subgroups of women (e.g., women with a history of mental health problems).

CONCLUSION

Despite decades of research into and concern about perinatal mental health, and growing recognition of its importance as a public health issue, much work is still needed to improve practice, particularly around cultural diversity, fathers and the role of trauma in PMHPs, and to address the issue of busy professionals being fearful of identifying problems which they have neither the skills to address nor referral options to specialist support. The injection of new government funds into mental health is welcome, as are the efforts being made by the All Party Parliamentary Group to ensure that the critical importance of the first years of life is recognised by all political parties. In the charitable sector, the Maternal Mental Health Alliance's 'Everyone's Business' campaign which calls for all women throughout the UK who experience a perinatal mental illness to receive the care they and their families need, wherever and whenever they need it, has a strong voice as does The Royal Foundation which is campaigning in the area of mental health, early years and women and girls. All of these are positive moves. It is essential now to maintain the momentum and for policy-makers, health and social care managers and professionals, and the voluntary sector to consolidate and build on the progress that has been made.

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