



Time for action on perinatal mental health care in Northern Ireland

A report on the perspectives of
health visitors and midwives

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with Mary Duggan and Shona Hamilton

In partnership with



EVERY CHILDHOOD IS WORTH FIGHTING FOR

Time for action on perinatal mental health care in Northern Ireland: A report on the perspectives of health visitors and midwives

This report sets out the findings of a study exploring health visitors' and midwives' roles and experiences of identifying and responding to perinatal mental illness in Northern Ireland. For the purposes of the research, the term 'perinatal mental illness' covers a spectrum of mental health problems, including anxiety, depression and postnatal psychotic disorders. The perinatal period includes pregnancy and up to one year after childbirth. This report documents the findings of a survey of health visitors and midwives who provide a universal service to women during the perinatal period in Northern Ireland. It describes their perspectives about their roles in the recognition, referral and management of perinatal mental illness; training and skillsets; and opportunities and challenges for improving the early identification of perinatal mental illness, and the response provided to women and their families in Northern Ireland.

The findings affirm that health professionals in Northern Ireland experience similar challenges in identifying and responding to perinatal mental illness as their counterparts in the rest of the UK. Within both health visiting and midwifery the main challenges are regarded overwhelmingly as systemic with underfunding, overwork and growing levels and complexity of demand undermining the face to face time and continuity of care required for early recognition and response. It also highlights issues around policy and practice in the use of screening tools, and the need for closer alignment between infant mental health and perinatal mental health practice. The report concludes with a number of recommendations.

The study was jointly undertaken by NSPCC Northern Ireland, the Community Practitioners and Health Visitors Association and the Royal College of Midwives in Northern Ireland.

An Executive summary of this report is available on the NSPCC Learning website, learning.nspcc.org.uk.

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Foreword

by Dr Alain Gregoire, Chair, Maternal Mental Health Alliance UK

The NHS invests in care to all mothers and babies during pregnancy and postnatally because it is well established that healthcare at this time has a profound impact on morbidity and mortality for both mothers and children. However, maternity and early years care has until recently largely ignored the mental health needs of women and babies, despite the facts that maternal mental health problems are the most common major health complications of maternity, a main cause of maternal deaths, have long term adverse consequences for child health and development, and cost the UK £8.1 billion per annual cohort of births.

As a consequence of this neglect by the NHS, and despite widespread agreement about what services are needed, most women with perinatal mental illness go unrecognised, undiagnosed and untreated. This report is based on a survey of over 300 midwives and health visitors, the key professionals with daily experience of the realities on the front line, which has obtained previously unavailable information on the state of perinatal mental health care across Northern Ireland.

This valuable report has been produced by NSPCC Northern Ireland, the Community Practitioners and Health Visitors Association and the Royal College of Midwives – three member organisations of the Maternal Mental Health Alliance. The MMHA is a coalition of over 90 patient and professional UK organisations with a collective vision to see all women across the UK get equitable, accessible, evidence based support and care for their mental health during the perinatal period.

Following the MMHA's 'Everyone's Business' campaign for specialist perinatal mental health services, we have been encouraged by excellent progress that has been made in England, Scotland and Wales, with national investments rapidly leading to excellent new services. This has not been the case in Northern Ireland, where only one of five health and social care trusts offers even the most basic specialist perinatal mental health care, and where women are forcibly separated from their new babies if they require in-patient care as there is no inpatient mother and baby unit (indeed there is none in the whole island of Ireland). Almost two years have passed since the Regulation and Quality Improvement Authority, the independent body which regulates and inspects quality and availability of health and social care services in Northern Ireland, issued its review of perinatal mental health services. The report published in January 2017 included eleven formal recommendations to the Department of Health, with clear timescales attached for addressing the inequalities in provision. In the same month that the review was published, the NI Assembly was suspended, and no action has been taken by residual authorities. Women, babies and families have been avoidably suffering as a result of this inaction, and will continue to do so every day until responsibility is taken to reverse this disinterest and neglect.

This report shines a powerful light on the urgent need for action on perinatal mental health in Northern Ireland: despite awareness and concern about the issue amongst professionals, lack of resources and underdeveloped policy and

practice are impacting on face to face time and continuity of care. Lack of training, and absence of effective care pathways with dedicated services emerge as factors that must contribute to the well documented avoidable suffering and death.

Women and babies in Northern Ireland should receive the evidence based perinatal mental health care they need, in both universal and specialist services. I am sure that the results in this report will be widely disseminated and, for the sake of women, babies and families in

Northern Ireland, I hope the recommendations are acted upon, as they offer opportunities for dramatic reductions in suffering and long term disadvantage in this generation and the next.



Dr Alain Gregoire

Chair, Maternal Mental Health Alliance
(MMHA) UK

Further information about the MMHA can be found at:
maternalmentalhealthalliance.org/

Joint foreword

by NSPCC Northern Ireland, the Community Practitioners and Health Visitors Association and the Royal College of Midwives

Perinatal mental illness is a major public health issue. Health visitors and midwives in Northern Ireland should be in a strong position to play their part in addressing the challenges that it brings. Together with their counterparts in primary care, this means identifying women who are at risk of, or are already experiencing, mental illness during the perinatal period, and ensuring that women and their families get the care they need at the earliest opportunity. They also have a role to play in highlighting a lack of services for referral, where none exist.

Midwives in Northern Ireland work to ensure that women have a safe and satisfying pregnancy, childbirth and post-natal period. From their first antenatal visit, midwives can ensure that women, their partners and wider family know how to look after their mental wellbeing, the signs and symptoms to look out for, and who to approach for support. Midwives can raise awareness of the emotional development of the baby and educate about early attachment. They should have the opportunity to build trusting relationships with women to support open discussions about mental health. They have a role in reducing stigma, providing emotional support, and identifying risks to mental wellbeing through screening and good clinical assessment. They should also be in a position to signpost women to additional services when needed, or refer women who require additional care.

Health visitors have contact with all families in Northern Ireland. They complete a holistic assessment of family needs, including both maternal and paternal mental health. Health visitors play a significant role in raising awareness, reducing stigma and identifying women at risk of developing mental health difficulties, as well as those already experiencing mental illness.

Screening at regular intervals and having regular conversations with mothers, while applying good clinical judgement, are key elements of health visitor assessments. They can offer intervention in the form of listening visits, and provide education about mental ill health. A crucial element of their role is to observe and enhance parenting, with a key focus on supporting the parent-infant relationship.

An independent report published in 2014 confirmed that the majority of costs (72 per cent) associated with perinatal depression, anxiety and psychosis in the UK relate to the adverse impact *on the child*, not the mother. Yet funding for perinatal mental health care is yet to be ring-fenced in Northern Ireland, despite major investment having been pledged via the Barnett formula under the former Prime Minister, David Cameron. Northern Ireland is now the only part of the UK which has not committed to investment of funds.

The research presented in this report was about capturing the voices of health visitors and midwives within ongoing debates about the mental health care provided to women during the perinatal period in Northern Ireland and its impact on children and families. There has been an important focus in campaigning efforts in Northern Ireland on the need to redress the lack of specialist support for women in Northern Ireland, namely the lack of specialist perinatal mental health services and lack of a mother and baby unit. In undertaking this project, NSPCC NI, the Community Practitioners and Health Visitors Association and the Royal College of Midwives have taken a step back, exploring how perinatal mental health needs are being dealt with in primary care. Research has established that the majority of women who experience perinatal

mental illness are at the mild to moderate end of the spectrum. This is why it is so important that we get provision right within primary care. It is also why we need to listen carefully to primary care professionals about the impact of a lack of specialist services for referral.

With the right action by the multidisciplinary team of professionals involved in the care of families, much of the harm associated with perinatal mental illnesses can be appropriately addressed, and in many cases, prevented. The value of high quality therapeutic relationships, alongside continuity of care and face to face time, cannot be overestimated. Many of the challenges highlighted in this report relate to systemic issues such as underfunding, and a need to challenge the culture in which health visitors and midwives work in Northern Ireland. The importance of addressing mental health during pregnancy and in the year after birth has been underplayed and undervalued for too long in Northern Ireland.

We, the Community Practitioners and Health Visitors Association, NSPCC Northern Ireland and the Royal College of Midwives, commend this report summarising our learning from health visitors and midwives to all our colleagues and partners who share our belief that families in Northern Ireland deserve better.

Neil Anderson

National Head of Service, NSPCC Northern Ireland

Sinead Toner

Northern Ireland Chair, Community Practitioners and Health Visitors Association

Karen Murray

Director for Northern Ireland, Royal College of Midwives

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.**

Chapter 1: Introduction

This report sets out the findings of a study aimed at exploring the views and experiences of health visitors and midwives in Northern Ireland of identifying and responding to perinatal mental illnesses (PNMIs). 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).

Perinatal mental health (PNMH), another term used in this report, refers to the mental health of a woman during the perinatal period. Reference to perinatal mental health problems or difficulties therefore means the presence of perinatal mental illness(es) of some type.

The objectives of the study were to:

1. Explore the awareness of health visitors and midwives in Northern Ireland of the importance of early identification of perinatal mental health problems.
2. Explore the screening tools, skills and techniques that health visitors and midwives in Northern Ireland use to identify perinatal mental health needs.
3. 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.
4. 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.
5. Describe how views about early identification and response to perinatal mental health needs differ across professions, roles, experience, length of service and location.

This research involved a survey of health visitors and midwives in Northern Ireland who together provide a universal service to women and families in the antenatal and postnatal periods. The project was undertaken as a partnership between the 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 PNMH 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.

This study by the NSPCC, CPHVA and RCM gives an essential voice to health visitors and midwives in the debate, for the first time focusing in on their roles in identifying and responding to women experiencing perinatal mental illness.

Chapter 2 explores the background and surveys literature concerned with the early identification and response to perinatal mental illness. Chapter 3 details the methodology employed to conduct the study and describes a range of demographical information about the survey respondents. The results of the survey are presented in Chapter 4. In Chapter 5, these results are discussed and a number of recommendations presented.

Chapter 2: The importance of early identification

The significance of perinatal mental health

Perinatal mental illnesses are common during pregnancy and the postpartum year, with between 10 to 20 per cent of women developing mental ill health during this time (Public Health Agency (PHA), 2017). In Northern Ireland, a recent analysis of data from the NI Maternity System (NIMATS) from 2010 to 2015 indicated that almost one fifth (18.9 per cent) of women reported during pregnancy a history of mental disorder (Mongan, Lynch, Mullholland et al, 2018)¹. Figure 1 (page 13) sets out estimated figures on the number of women affected by perinatal mental illnesses in Northern Ireland using prevalence figures in guidance for commissioners of perinatal mental health services produced by the Joint Commissioning Panel for Mental Health (2012) and data on live births in Northern Ireland (NISRA, 2017).

Some women may experience mental health problems for the first time in relation to pregnancy and childbirth, and others may have a pre-existing mental health condition which persists, deteriorates or reoccurs during pregnancy or after the birth of a baby. Perinatal mental illness is now recognised as a public health issue with a considerable cost to society (Hogg, 2013). The long-term cost of perinatal mental illnesses is estimated to be approximately £8.1 billion for each one-year cohort of births in the UK (Bauer, Parsonage, Knapp et al, 2014). Most of this cost (72 per cent) relates to the adverse impacts of these illnesses on children².

A wide range of mental health problems can occur at this crucial time for women and their families, including anxiety, panic disorder, depression, anxiety disorders, bipolar disorder, postpartum psychosis and post-traumatic stress disorder. Depression in the postnatal period is distinguishable from 'baby blues', which is common in the first few weeks but which has few negative consequences (O'Hara and Wisner, 2014).

The Royal College of Psychiatrists (2015) estimates that anxiety and post-traumatic stress disorder occur in approximately 3 per cent of maternities and 6 per cent of women following emergency caesarean section. Postpartum psychosis, one of the most severe forms of postnatal mental illness, occurs in two in every 1000 maternities (0.2 per cent). If perinatal mental illnesses go untreated they can have a devastating impact on women and their families. In extreme cases, PNMI can be life threatening and it remains one of the leading causes of maternal death in the UK (MBRRACE-UK, 2017).

The extent of mental ill-health amongst fathers in this period should not be overlooked; one review suggests that 24 to 50 per cent of fathers whose partners experience depression in the postpartum period, also experience depression themselves (Goodman, 2004). Findings from the Millennium Cohort Study show 8 per cent of fathers in Northern Ireland with a baby aged around nine months presented with a high probability of depression and anxiety³, alongside 15 per cent of mothers (Bunting and Galloway, 2012). The entire family unit is often under great pressure at this time (Royal College of Psychiatrists, 2017).

1 Based on an analysis of data on self-reported mental disorder in 140,569 singleton pregnancies.

2 The Early Intervention Foundation has estimated the cost of late intervention spending on children and young people in Northern Ireland annually as £536 million (Fitzsimons and Teager, 2018).

3 The Malaise Inventory (Rutter et al, 1970) a measure of psychological distress and depression was used with parents of babies born in the UK in 2000/01 and who were part of the Millenium Cohort Study.

How many women are affected?

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



48



Postpartum psychosis

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.

48



Chronic serious mental illness

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.

722



Severe depressive illness

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.

722



Post-traumatic stress disorder

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.

2,408-3,611



Mild to moderate depressive illness and anxiety states

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.

3,611-7,223



Adjustment disorders and distress

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.

Impact on babies

A considerable body of international evidence points to the impact of maternal mental illness on the child, from in utero until late adolescence (Stein, Pearson, Goodman et al, 2014). This includes a range of negative outcomes consistent with psychological and developmental disturbance, including foetal and neonatal, behavioural, attachment, cognitive, emotional and social development outcomes (Stein et al, 2014). In Northern Ireland, women who report a history of mental disorder during pregnancy have been found more likely to result in premature deliveries and babies born with low birth weight, as well as lower APGAR scores, compared to women with no reported history of mental disorder (Mongan, Lynch, Mullholland et al, 2018).

Negative impacts on children are not inevitable and the effect sizes mostly moderate or small (Stein et al, 2014). Understanding the complex pathways through which these impacts occur, particularly around the intergenerational transmission of trauma, so that effective interventions can be developed, has become an important field for academic inquiry (Goodman and Gotlib, 1999; Shonkoff, 2010; Plant, Barker, Waters et al, 2012; Pawlby, Plant and Pariante, 2018). There is strong evidence that the risks to children are highest in the most socio-economically disadvantaged populations experiencing multiple adversities, with high levels of parental education and resources operating as a mediating factor (Lovejoy, Graczyk, O'Hare, and Neuman, 2000; Ban, Gibson, West et al, 2012; Pearson, Evans, Kounali et al, 2013). The importance of the antenatal period, and the substantial short and longer term effects of prenatal stress and anxiety on the developing fetus and child is now better understood (Glover and O'Connor, 2002; Glover, 2016).

The parent-infant relationship is one of the most important pathways between perinatal mental

illness and child outcomes (Atkinson, Paglia, Coolbear et al, 2000; Hogg, 2013). Maternal mental illness during pregnancy and the first phase of a child's life can undermine the maternal bonding and the development of the infant attachment relationship which is the foundation for future child development (Hogg, 2013). If unrecognised and untreated, PNMH difficulties can persist for years, with well evidenced negative impacts on children (Wisner, Perel, Peindl et al, 2004).

During the first year of life, children should develop their first attachment relationship – a significant and stable emotional connection with their primary care giver (Galloway and Hogg, 2015). The nature of this early attachment sets the template for later relationships, and can predict many physical, social, emotional and cognitive outcomes. Clinical depression in pregnancy and postnatally undermines this and is associated with insecure attachment (Hayes, Goodman, and Carlson, 2013) and in particular, disorganised or avoidant attachment (Atkinson et al, 2000, Martin and Gaffan, 2000).

To develop a secure attachment, babies need their primary caregiver to be able to recognise and understand their behaviour and feelings, and respond appropriately. This capacity is known as parental reflective function, and can be impaired in women who have a mental illness. Of course, not all women with a mental illness will lack reflective capacity, but for those who do, treatment for their mental health needs alone will not address this. This is why we need primary care practitioners equipped and with the capacity, backed by specialist support, to detect issues in mother-infant interaction and to help mothers become more attuned and responsive to their babies' needs. The perinatal period presents a unique opportunity to deliver preventative mental healthcare for not one, but two generations at once, with potential benefits for future generations to come (Gregoire, 2018).

The importance of early identification of perinatal mental illness

Early detection of PNMI by universal services is critical to enable the appropriate help to be put in place, including specialist support, and to mitigate the risks of longer term problems arising for babies and mothers (Galloway and Hogg, 2015). There is now greater awareness of the importance of the ante-natal period as an opportunity for detection and prevention (Biaggi, Conroy, Pawlby and Pariante, 2016). Anxiety is more prevalent during pregnancy than depression and is an important predictor for postpartum depression (Ross and McLean, 2006). Anxiety in the antenatal period is also regarded as a predictor of childhood behavioural and emotional problems at 47 to 81 months, especially in boys (O'Connor, Heron, and Glover, 2002).

The personal and social circumstances of individuals provide some vital early signs for practitioners. Based on the evidence base, NICE (2014) identifies a range of risk factors for PNMI including a personal or family history of mental health problems. Psychosocial factors figure highly and these include socioeconomic deprivation and disadvantage, social isolation, domestic abuse and unresolved trauma from abuse, including undisclosed sexual abuse in childhood. Women's experiences of pregnancy and birth including birth trauma, miscarriage and bereavement, and their emotional response and attitude towards the pregnancy are also critical factors. However, there will be women who experience PNMI and yet do not display any of these warning signs.

Universal screening for PNMI has been in place across the UK for some time, nevertheless, in Northern Ireland the timing of its introduction

and its history within individual Trusts has varied. The revised NICE guideline (2014) recommends that at first contact with primary care or at the booking visit, the Whooley questions⁴ (Whooley, Avins, Miranda, and Browner, 1997) are asked to detect depression, not in isolation, but as part of a general conversation with a woman about her emotional wellbeing and mental health. NICE also recommends that consideration be given to asking about anxiety using the 2-item General Anxiety Detection scale (GAD-2). If either of these are positive then a full clinical assessment, including use of the Edinburgh Postnatal Depression Scale (EPDS) (Cox, 1987) or the Patient Health Questionnaire should be considered, or the woman referred to her GP, or a mental health specialist if a severe mental health problem is suspected. The same procedure is recommended for every subsequent contact with primary care during the ante and post-natal period.

Many countries have adopted similar universal screening processes and the efficacy and cost effectiveness of screening and screening tools has been evaluated within and beyond the UK (O'Connor, 2016; Littlewood, Dyson, Keding et al, 2018). However, a screening process may not in itself be sufficient to ensure detection. To date, 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). Studies have found that the identification of PNMH can be poor, with fewer than 50 per cent of postnatal depression cases detected in routine clinical practice (Gavin, Meltzer-Brody, Glover, and Gaynes 2015).

As a result, much attention has been given to understanding the enablers and barriers to detection, including where universal screening is already in place. A summary of these, based on the literature, is presented in Table 1.

4 During the past month have you often been bothered by feeling down, depressed or hopeless? Yes/No, and During the past month have you often been bothered by little interest or pleasure in doing things? Yes/No.

Table 1: Enablers and barriers to identifying perinatal illnesses

Enablers	Barriers
<ul style="list-style-type: none"> • Non-judgemental ante-natal support attuned with mothers' specific circumstances (Downe, Finlayson, Walsh, and Lavender, 2009) • Trusting relationship with a professional (Parker, Beresford, Clarke et al, 2008) • Knowledge, skills and confidence of professionals (Hogg, 2013; Khan 2015) • Providers' characteristics: asking in an empathic and interested way, receiving a meaningful and sensitive response (Byatt, Biebel, Friedman et al, 2013; Khan, 2015; Kingston, Austin, Heaman et al, 2015; RCOG, 2017) 	<ul style="list-style-type: none"> • Stigma: shame, embarrassment, fear of judgement (NHS Improving Quality Improvement 2015; BabyCentre UK, 2016; Royal College of Obstetricians and Gynaecologists (RCOG), 2017; RCM, 2017) • Fear of consequences including child protection processes (Parker, Beresford, Clarke et al, 2008) • Lack of or no consistent relationship with professionals/time pressures on appointments (Boots Family Trust, 2013; Hogg, 2013; Khan, 2015) • Reduced contact between GPs and women during pregnancy and fragmented primary health care team working between GPs, midwives and health visitors (Khan, 2015) • Knowledge, skills and confidence of professionals (Hogg, 2013; Khan 2015; NHS Health Education England, 2016) • Women not recognising the significance of PNMH and their own mental health needs or importance of these (Boots Family Trust, 2013; Khan, 2015) • Professionals' anxieties due to lack of resources and the availability of specialist support (Chew-Graham, Sharp, Chamberlain et al, 2009)

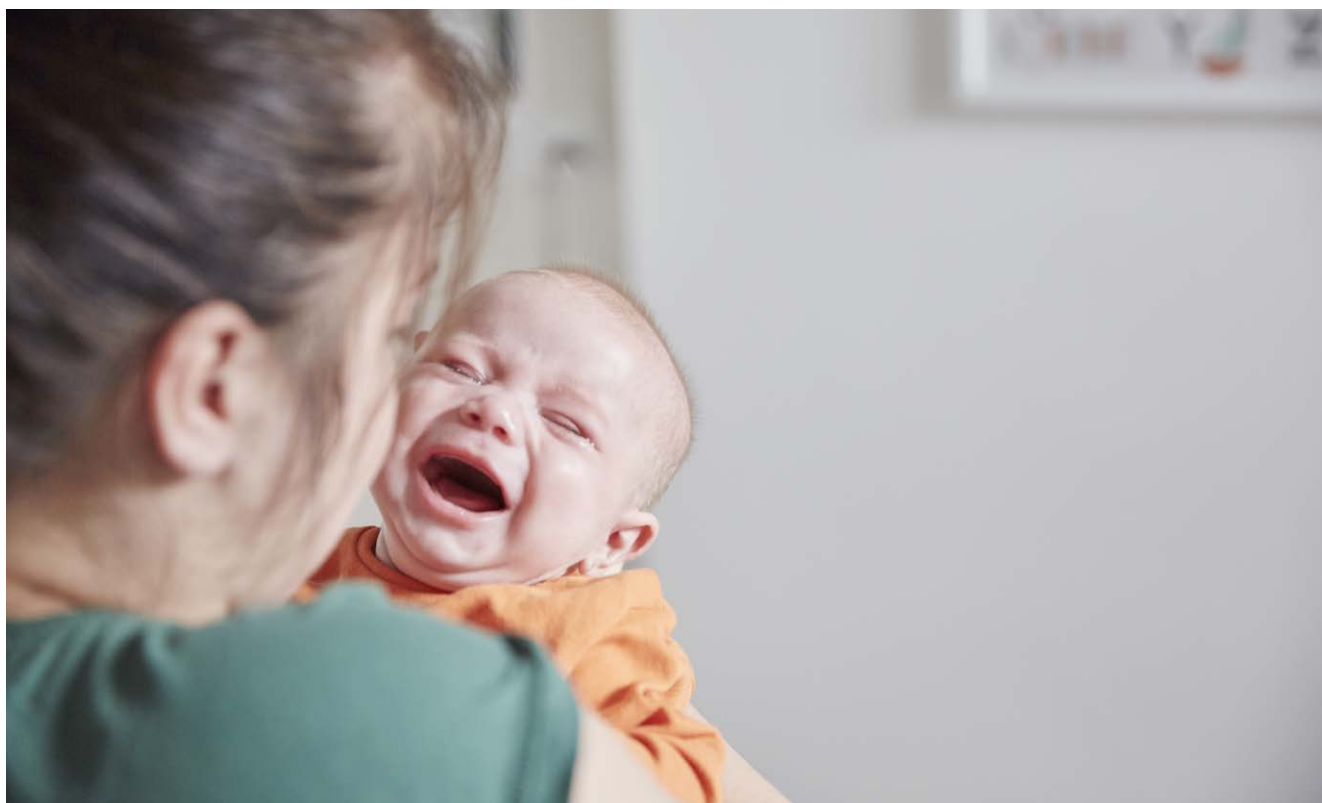
In addition to academic studies, many UK surveys and polls have provided insights into women's experiences of PNMH screening. These surveys have helped to evidence some of the complex external and internal barriers to disclosure which, in turn, can help inform efforts to improve detection by enhancing the screening process⁵.

One significant issue to emerge is the difference between professionals' and mothers' perceptions of screening. While professionals report always having asked, surveys of mothers suggest that many women do not recognise having been asked about their emotional wellbeing, do not recognise their mental health history as important, or do not recognise their mental health needs (The Boots Family Trust, 2013;

Khan, 2015; NHS IQ 2015). More positively, a recent UK-wide survey of mothers (n=2,300) for the RCOG (2017) recorded improvements over the past five years in the proportion of women who recalled being asked by a health professional about their mental wellbeing.

Self-reporting and disclosure is critical to the effectiveness of screening during the perinatal period and the literature suggests that women are reluctant to disclose due to guilt, embarrassment, fear of being judged or of having their children removed (Parker et al, 2008; BabyCentre UK, 2016). The NHS Improvement Service in England suggests health professionals need to be sensitive to this and their confidence in talking with women about

5 This includes those conducted by online parenting networks such as Netmums, BabyCentre UK and market research initiatives such as 'Bounty – the Parenting Club 'Word of Mum Panel™' (a partnership with Ipsos Marketing).



these issues improved through training (NHS IQ, 2015, p. 7). Awareness and understanding of PNMI amongst parents also plays an important part. Studies have shown that women and their families often struggle to differentiate between 'normal' adjustment difficulties with becoming a new parent, and those symptoms warranting treatment and support (The Boots Family Trust, 2013; Bayrampour, Hapsari and Pavlovic, 2018).

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 (HEE), 2016; RCOG, 2017). Many women report experiences of rushed health visitor, midwifery and GP appointments (Hogg, 2013; Plotkin, 2017; Khan, 2015).

Added to this is the need to develop professional skills, judgement and confidence in spotting signs of mental health adversity. The importance of training for primary care professionals has been repeatedly emphasised (Hogg, 2013; NHS IQ, 2015; RCGP, 2016), and is a key call of the UK Maternal Mental Health Alliance. It forms part of the case for having specialist PNMH posts within midwifery and health visiting (MMHA, 2013; HEE, 2016; RCM, 2015)⁶. Lack of confidence due to poor or insufficient training in PNMH is one of the main issues reported by health professionals (Rowan, McCourt, and Bick, 2010).

The NSPCC calls for primary care practitioners to be equipped not only to detect and respond to signs of PNMI but also to detect issues in mother-infant interaction and to be able to help

6 The RCM (2015) produced a standards and competency framework for specialist PNMH midwives in response to perceived deficits in confidence and skills in detecting problems. The RCM has also developed a training module to support midwives on understanding the importance of nurturing infant mental health as part of an online learning programme launched in 2017.

mothers become more attuned and responsive to their babies' needs (Hogg, 2013).

Some experts warn against an overreliance on screening tools, 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). A Cochrane review found evidence that psychosocial assessment undertaken during pregnancy results in higher levels of detection of risk factors for PNMI including family violence, when compared to routine care (Austin, Priest and Sullivan, 2008). There is some limited evidence that promotional interviewing may improve identification by practitioners. This is a structured way of working in partnership with parents pre- and post-natally to explore their situation and problem-solving skills (Davis, Dusoir, Papadopoulou et al, 2007).

The inverse care law in maternity care is well evidenced, and means that the most socially disadvantaged mothers tend to benefit least from services intended as universal (RCM, 2011)⁷. A large scale study of general practice records from a UK-wide database found a considerable primary care burden of maternal PNMI and confirmed the higher risk of PNMI amongst women living in deprived circumstances (Ban et al, 2012). On this basis, the authors argue that progressive universalism is required in the detection of PNMI, with more targeted efforts and resources provided towards identifying high risk women, including trials of methods of detection most effective with this population. Lower rates of detection and treatment amongst black and ethnic minority mothers has also been highlighted for attention (Edge, 2010; NHS IQ, 2015).

Where PNMI is detected, the importance of timely and appropriate services being available is clear. However, a recent UK-wide survey found 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 only one in five accessing support from services (RCOG, 2017).

This body of knowledge has informed recent recommendations by a range of bodies aimed at improving detection in practice:

- NICE Guidance was updated in 2014 to reflect the growing knowledge about the enablers and barriers to disclosure and detection, and now recommends practitioners are aware of and adjust their practice to take account of the feelings of stigma, fearfulness and embarrassment that are common amongst women.
- The NHS Improvement Service recommended that advanced training is needed for health care professionals to give them the skills and confidence to elicit information about mental health issues (NHS IQ, 2015).
- The Royal College of General Practitioners produced recommendations and an action plan to improve detection rates and responses by GPs, based upon the evidence of its Falling through the Gaps report (Khan, 2015; RCGP, 2016). These include enhanced training, continuing professional development (CPD), resources and support in PNMH for GPs, proactively building positive relationships with midwives and health visitors, campaigning for longer patient consultation times, GPs being equipped with knowledge of the local pathway and information about sources of local support for women, and improving access to specialist services.

⁷ A survey of mothers (n=1,391) by Netmums in partnership with the RCM found that 75 per cent of expectant mothers in low-income households receive no antenatal education at all, supplementary to standard midwifery appointments (RCM, press release 2011).



- The RCM (2012) produced a good practice guide for midwives providing advice on helping women to strengthen their bonds with their babies across the perinatal period, and on how to recognise signs that women need extra support.
- The Joint Commissioning Panel for Mental Health (2012) recommended that:
 - GPs and other primary care staff receive additional training in PNMH
 - GPs and other primary care staff be made familiar with PNMH integrated care pathways
 - Health visitors receive additional training in PNMH.

Early identification and response in Northern Ireland

Northern Ireland continues to have the poorest level of service provision for perinatal mental health within the UK. The Maternal Mental Health Alliance (MMHA) Everyone's Business campaign has developed maps illustrating the alarming gaps in services⁸. The Belfast Health and Social Care Trust is the only trust which provides a specialist service. This is small scale in nature. There also continues to be no mother and baby unit in Northern Ireland, nor on the island of Ireland.

The need for action to address the lack of specialist services and mother and baby unit was most recently documented in the independent review conducted by the Regulation and Quality

8 Available at: maternalmentalhealthalliance.org/campaign/ [last accessed 3 September, 2018].

Improvement Authority (RQIA, 2017), which regulates and inspects the quality and availability of health and social care (HSC) services in Northern Ireland. The Review made eleven formal recommendations to the Department of Health, with timescales attached. Seven concerned immediate practical actions to be undertaken within six months of the review. These focus on improving the effectiveness of existing arrangements for meeting women and babies' needs, whilst initiating regional and Trust level processes to plan the specialist provision needed for Northern Ireland to fully meet the 2015 NICE guidelines. In response, the Public Health Agency (PHA) established a regional perinatal mental health group to examine and develop PNMH services⁹.

While much of the focus of efforts in NI has been around highlighting the dearth of specialist PNMH services, the fundamental issue of early identification by universal services remains. In common with the rest of the UK, health visitors and midwives are at the forefront of contact with mothers and babies. Midwives are responsible for women's care from the antenatal period to the first ten days postpartum. Health visitors in some areas have antenatal contact with pregnant women, particularly first-time parents with known vulnerabilities or risks. This is in line with *Healthy Child, Healthy Future* (Department of Health, Social Services and Public Safety (DHSSPS), 2010). In areas where this is not the practice, health visitors assume care from midwives in the early postpartum period.

At the time of this study the original Regional Perinatal Mental Health Care Pathway (PHA, 2012; 2017) was in place¹⁰. To support the introduction and embedding of the pathway, training was developed and is delivered to Trust

staff by the Clinical Education Centre. Standard practice, as set out by the 2012 care pathway, is to ask the Whooley Questions (Whooley et al, 1997) for prediction and detection of depression to all women at the first booking clinic, utilising prompts on NIMATs. It should be noted at the time of this study screening was for depression, and not anxiety. The regional pathway has since been updated to take account of revised NICE guidance (2014) which recommends screening for anxiety during pregnancy.

While a statutory care pathway is in place, its emphasis is on two categories, that of (1) women who either have prior known significant adult mental health provision/known family history of adult mental health provision, or (2) women who become acutely unwell. However, health visitors in Northern Ireland also undertake a Family Health Assessment (FHA) with each new mother and her partner. This assessment of the family circumstances is intended to identify strengths but also to detect any underlying psychosocial risk factors which could affect mental wellbeing. Assessment of maternal mental health is integral to the FHA, which includes the Whooley Questions for depression. If response to either question is positive, the regional care pathway recommends that health visitors consider further exploration as appropriate using the Edinburgh Postnatal Depression Scale (EPDS), the Hospital Anxiety and Depression Scale (HADS), or the Patient Health Questionnaire (PHQ9).

Across the UK, issues of training and concerns about consistency and continuity of care, capacity and time, are not new. However, there is a need to establish how these factors impact on the service provided to women by midwives and health visitors in Northern Ireland, which is the aim of this study.

9 This group is accountable to and overseen by the Maternity Strategy Implementation Group and the Department of Health.

10 The updated version of the regional care pathway was published in July 2017 after the study fieldwork had concluded.

Chapter 3: Methodology

An online survey comprising 30 questions was informed by a review of best practice evidence (Downe, Finlayson, Walsh, and Lavender, 2009; Hogg, 2013; NICE, 2014; Galloway with Hogg, 2015; RQIA, 2017) and developed in consultation with both an advisory group of professionals and two mothers with 'lived experience' of perinatal mental illness (see appendix 3 for details). The survey was also piloted with 17 health visitors (n=10) and midwives (n=7) in practice and management roles, and subsequently refined and finalised. The following topics were covered in the survey: recognition, referral and management of PNMI; training; and opportunities and challenges. An introductory round of questions also gathered demographic information.

The survey included mostly closed multiple choice questions. On occasion, respondents were offered the opportunity to expand on a response or choose an 'other, please specify' option. In a small number of instances, respondents were asked to provide quantitative information, including caseload details, age and years' service. One open-ended question was included to gather respondents' broad opinions about the greatest challenges faced by their profession in seeking to improve the early identification and response to women with PNMI in Northern Ireland. SNAP survey technology was used to collect the data.

Fieldwork

All health visitors and midwives in Northern Ireland who were members of the CPHVA or the RCM were initially invited to complete the survey¹¹. An email invitation was circulated in March 2017 by CPHVA and RCM headquarters to all Northern Ireland midwife and health visitor members. The invite included a flyer and project information sheet, as well as a link to the online

survey. Options to complete the survey by hard copy or telephone were also highlighted. Identified leads from the five HSC trusts also subsequently agreed to circulate the invitation to complete the survey. The PHA also assisted in promoting the survey, as did a number of supporters of the PNMH agenda in Northern Ireland. Reminder emails were sent throughout the period of data collection and promotion was conducted by CPHVA and RCM branch leads and via social media platforms.

Data collection was preceded by a round of presentations to promote the research. This included presentations to the Healthy Child, Healthy Future Programme Board, facilitated by the PHA; to midwifery leads from all health and social care trusts; and to health visitors. A flyer to promote the research was also widely circulated, offering health visitors and midwives the opportunity to register their interest in the survey.

Data collection ended in June 2017. The final sample included 332 respondents. Two hundred and sixty-six surveys were completed online, 65 on paper, and one by telephone. The medium of survey delivery does affect responses. However, the difference is greatest between telephone or face to face delivery and other mediums and in this case just one of the 332 survey responses was by telephone.

Governance and ethics

Research governance approval for the study was granted by the NSPCC Children's Services Directorate Research and Development Sub-Group, and by the NSPCC Head of Strategy, Policy and Evidence. A subsequent partial application to the independent chair and independent deputy chair of the NSPCC Research Ethics Committee confirmed a non-

11 At the time of the research, CPHVA has 313 members listed as health visitors in Northern Ireland, while the RCM has 1,213 full members who are midwives.

requirement for full ethical approval due to the non-sensitive nature of the research (NSPCC, 2012; Economic and Social Research Council, 2015). However, good practice guidelines (NSPCC, 2016) were followed to ensure that respondents' informed consent was obtained and the data was stored, used and reported in a manner that protected participant anonymity (Kelley, Clark, Brown, and Sitzia, 2003; The British Psychological Society, 2013).

Data analysis

Analysis of the data was completed with the support of SPSS 20 software. Full details of the statistical tests used, the thresholds for statistical significance, and their results are provided in appendix 2. Where differences are referred to in reporting findings (chapter 4) these are statistically significant unless otherwise stated.

A content analysis approach was used to analyse and interpret the narrative data generated from the open-ended responses (Taylor-Powell and Renner, 2003). This involved an iterative process of categorising the data, "starting with pre-set categories and adding others" as they became apparent, to identify "patterns and connections between categories both within and between the categories" and interpret the data (p. 5).

It should be noted in the presentation of results that percentages have been rounded to the nearest percent. Therefore, some percentages may not sum to 100.

The respondents

Key characteristics of the respondents are provided in appendix 1.

The 332 respondents include 130 health visitors and 202 midwives, of whom 141 are hospital midwives and 37 are community midwives. They are located across all five HSC Trusts and the

distribution of respondents by role and trust is provided in appendix 1.

Headcount data from the Northern Ireland Health and Social Care Workforce Census, showed that there were a total of 556 registered health visitors and a total of 1,351 registered midwives in Northern Ireland at March 2016 (Department of Health and NISRA, 2016), although these figures likely represent a larger population than the actual total available sample, given that they represent the registered health visiting and midwifery headcount, rather than the number of practice and management staff employed within HSC trusts. Notwithstanding the latter, a cautious estimate based on the 2016 workforce census 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 percent).

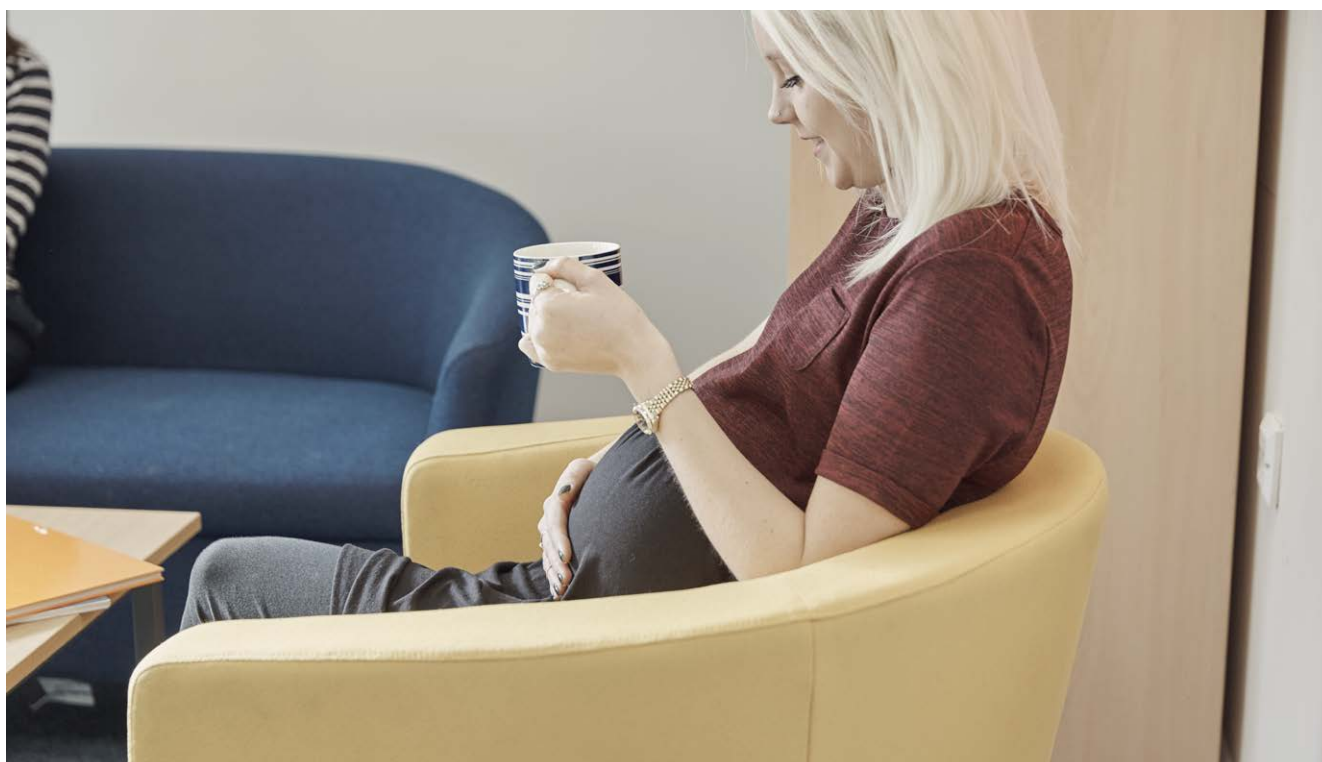
A personal caseload is held by 174 respondents. This includes 101 health visitors and 66 midwives, of whom 27 are community midwives. Seven community midwives and eight health visitors reported not having a personal caseload and reasons for this include cases being held by teams rather than individuals, and having recently started or returned to work.

The average (median) number of years' service of respondents is 14, and their median age was 45 years. The age profile of respondents is very similar to that of health visitors and midwives recorded in the March 2017 Northern Ireland Health and Social Care Workforce Census (Department of Health, 2017)¹².

Limitations

The respondents have different roles in relation to the Regional Perinatal Mental Health Care Pathway and differ in the extent to which they have contact with women ante- and post-natally, and in the nature of that contact. Health visitors and community midwives are the two

12 Although it should be noted that the HSC Workforce Census includes student midwives and health visitors.



occupations most directly involved in women's care. Most midwives who responded work in hospital settings, as do most midwives in Northern Ireland¹³. However, the relatively small number of community midwives within the sample (n=37) is a limitation. Unlike most hospital midwives they carry a personal caseload and are most closely involved in the care of individual women. Their low representation means the sample may not accurately reflect the variation of perspective and experience of health visitors and midwives across NI (Kelley et al, 2003). The overall sample size also restricts the potential scope of statistical analysis, particularly at Trust level.

The aims of the survey were broad. As these shaped the survey instrument, it meant that individual subject areas could not be explored in depth whilst also achieving a realistic survey

length. For example, data was collected regarding whether health visitors and midwives had ever undertaken training in perinatal mental health and infant mental health respectively, and about their satisfaction with training undertaken. The survey did not explore the level, duration, content or accreditation status of the training received. Consequently, information which may have shed light on some of the survey findings is lacking.

It must be acknowledged that the focus on health professionals means the research does not capture the views and experiences of mothers, or of fathers and partners, an important but often overlooked group.

As the focus is on the identification and response to women with PNMI generally, the research also does not consider specific groups of women with additional needs, for example, women who have pre-existing mental health conditions.

13 Unfortunately the HSC Workforce Census does not provide a breakdown of the number of midwives who are community or hospital-based.

Chapter 4: Results

The results are presented in the following sections:

- Training
- Confidence in recognition, referral and management of perinatal mental illness (PNMI)
- Screening tools and methods for encouraging disclosure
- Support services most frequently offered
- Opportunities and challenges for early detection and treatment

Where differences are referred to, these are statistically significant unless otherwise stated¹⁴. The figures reported in the charts presented in this chapter refer to percentage response, unless otherwise stated.

Training

Training in perinatal and infant mental health is vital for understanding the importance of early detection. The study explored whether professionals had received training and when, but not the level, duration, content or accreditation status of this training.

Training in perinatal mental health

The great majority of professionals who responded¹⁵, 80 per cent (n=265), have received training in perinatal mental health at some point. However, this varies both by role, and in how recently training has been received.

Overall, one in five respondents (n=64) has never received training in PNMH. As illustrated in Figure 2, this includes 31 per cent of hospital midwives (n=43), 22 per cent of community midwives (n=8) and 40 per cent of midwifery managers (n=8). In contrast, very few health visitors in practice are untrained (n=5, 5 per cent).

Professionals who have never received PNMH training are fairly evenly split in terms of when their pre-registration professional education was completed: 42 per cent (n=27) have less than 10 years' service; 17 per cent (n=11) have between 11-20 years' service; and 41 per cent (n=26) have more than 20 years' service.

When professionals last received training on perinatal mental health may indicate whether they are equipped with information based on

Key points

- A large majority of professionals have received training in perinatal mental health and in more than two thirds of cases this included the impact on infants.
- In general, midwives are less likely than health visitors to have received training in PNMI, are less likely to have received this recently, and their training is less likely to have covered the impact on the child. Levels of satisfaction with training received are also lower amongst midwives.
- Managers in both midwifery and health visiting also appear less likely than those in other roles to have received recent training in PNMI and four in ten midwifery managers who responded have never received training in PNMI.

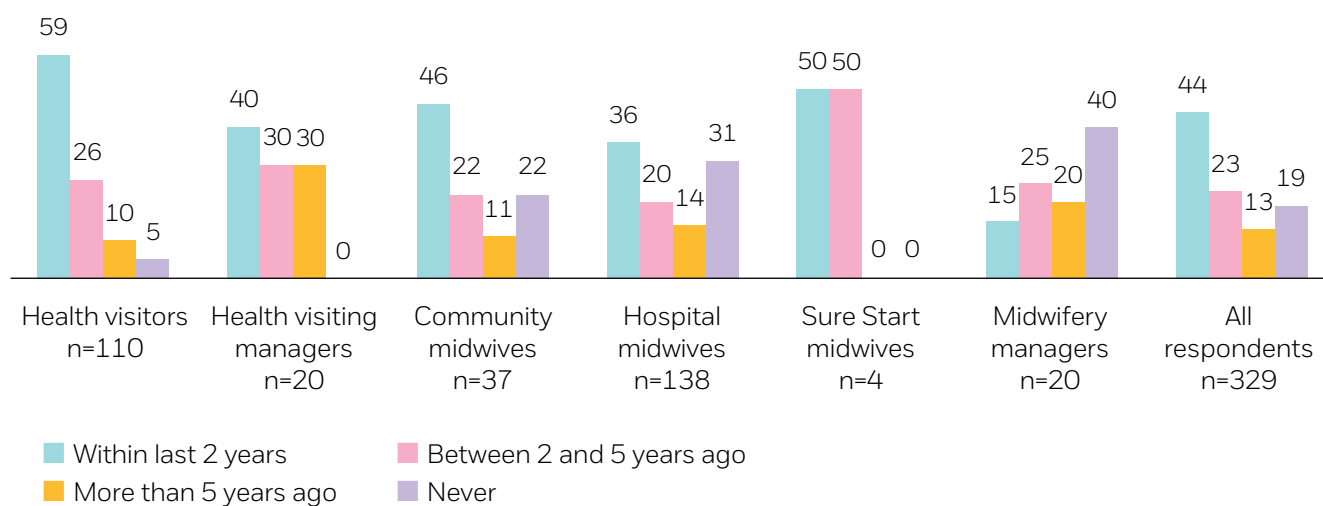
14 For full information on the types and results of statistical tests used please refer to appendix 1.

15 Based on 329 responses to this question.

Figure 2: Have you ever received training in perinatal mental health? (n=329)



Figure 3: When did you last have training in perinatal mental health, including 'never'? (n=329)



the *latest* evidence. Forty four percent of all respondents (n=144) have received training in PNMH *within the past 2 years*. This includes 59 per cent of health visitors (n=65) and 46 per cent of community midwives (n=17), the occupations most closely involved in the care of individual women.

Those with the shortest service in their profession (less than ten years) last received training more recently than those with the longest service (20 years or more). However, for those with service between 11-19 years, there is little difference in how recently individuals last received PNMH training.

Satisfaction with training

Of those who have received training in PNMH (n=265), 73 per cent were very or somewhat satisfied (n=193) with the training received, while 27 per cent were very or somewhat dissatisfied (n=72). There is a difference between midwives and health visitors (who have received PNMH training) in their levels of satisfaction with their training. Health visitors report higher mean levels of satisfaction than midwives¹⁶.

There are no differences in levels of training satisfaction between professionals from different Trusts, or professionals with different lengths of service.

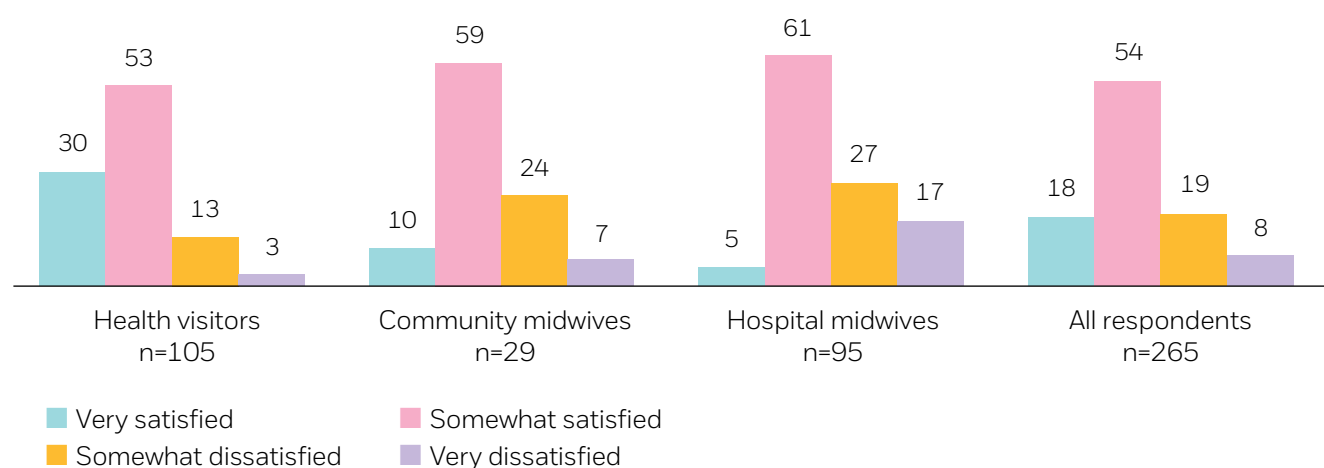
Training in infant mental health

The PHA (2016, p. 12) defines infant mental health as follows:

“The study of mental health as it applies to infants and their families. It focuses on the social and emotional development during the first three years of life for an infant and their family. This includes a child’s ability to form relationships with other children and adults; to recognise and express emotions; and to explore and learn about their environment in a safe and happy way”.

Half of the professionals who responded *have* received training in infant mental health. This

Figure 4: Satisfaction with training received on PNMH, by role (n=265)



16 For full information on the types and results of statistical tests used please refer to appendix 1.

total includes more than three quarters of health visitors and health visiting managers and just over half of community midwives (including Sure Start midwives). In contrast, a much smaller proportion of respondent hospital midwives and managers have received training in infant mental health. The study did not explore the level, duration, content or accreditation status of this training and so we do not know what the training consisted of.

Encouragingly, of those who have received training in perinatal mental health, the majority (71 per cent, n=189) say it covered the impact on the child, as illustrated in Figure 5. This is significantly higher for health visitors and health visiting managers (90 per cent) than for midwives (66 per cent of community midwives and 52 per cent of hospital midwives).

Figure 5: Percentage by occupation who have received any training in infant mental health (n=332)

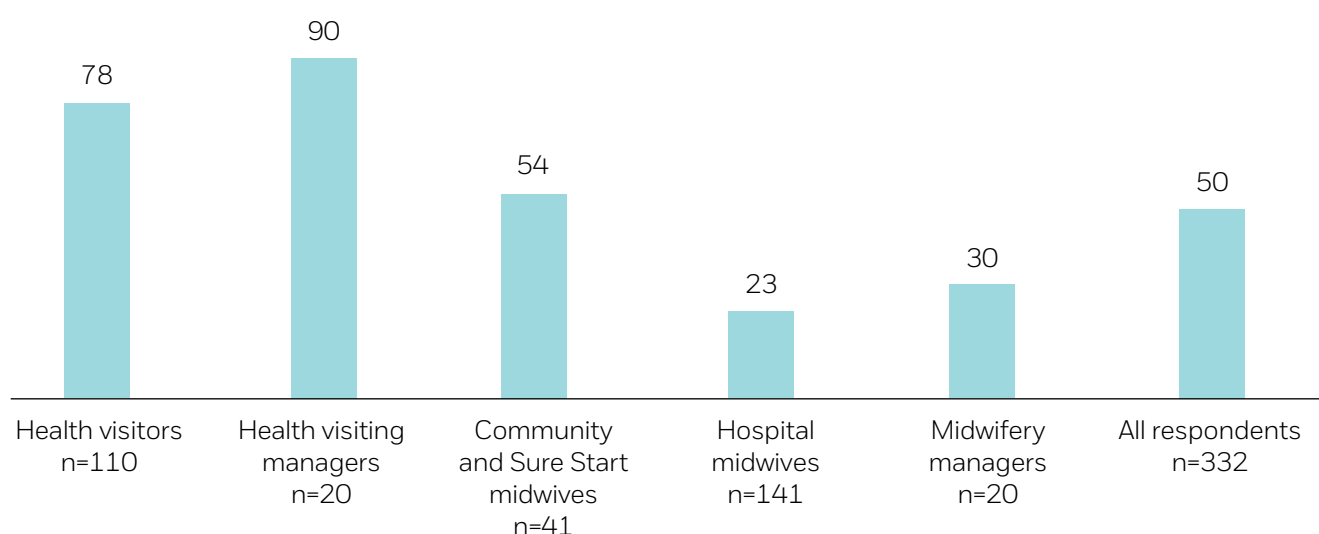
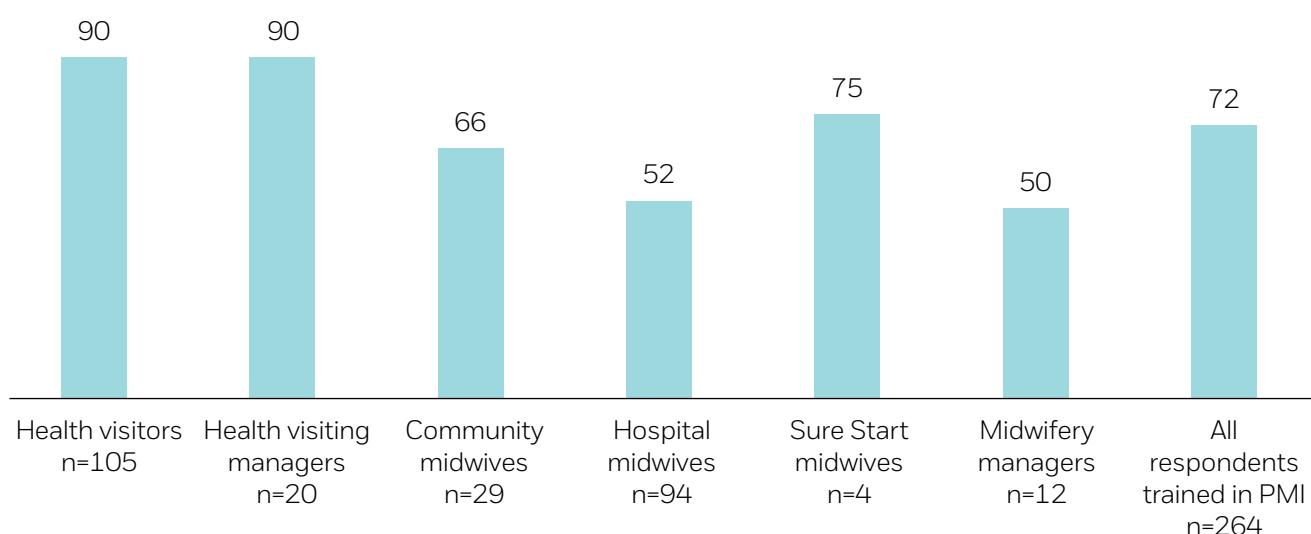


Figure 6: Of those who have received training in perinatal mental health, percentage whose training included the impact on the child (n=264)



Confidence in recognition, referral and management of perinatal mental illness

The self-reported confidence of professionals was explored in relation to: their ability to recognise a woman with perinatal mental illness; referring a woman to a GP; the multi-disciplinary management of the mental illnesses of the women within their service, and; whether women, within their service, receive the treatment they need. In this context 'management' refers to how services work together to manage the care of individual women, while 'treatment' encompasses medical, psychological and social treatments, interventions and care. All 332 respondents answered these questions.

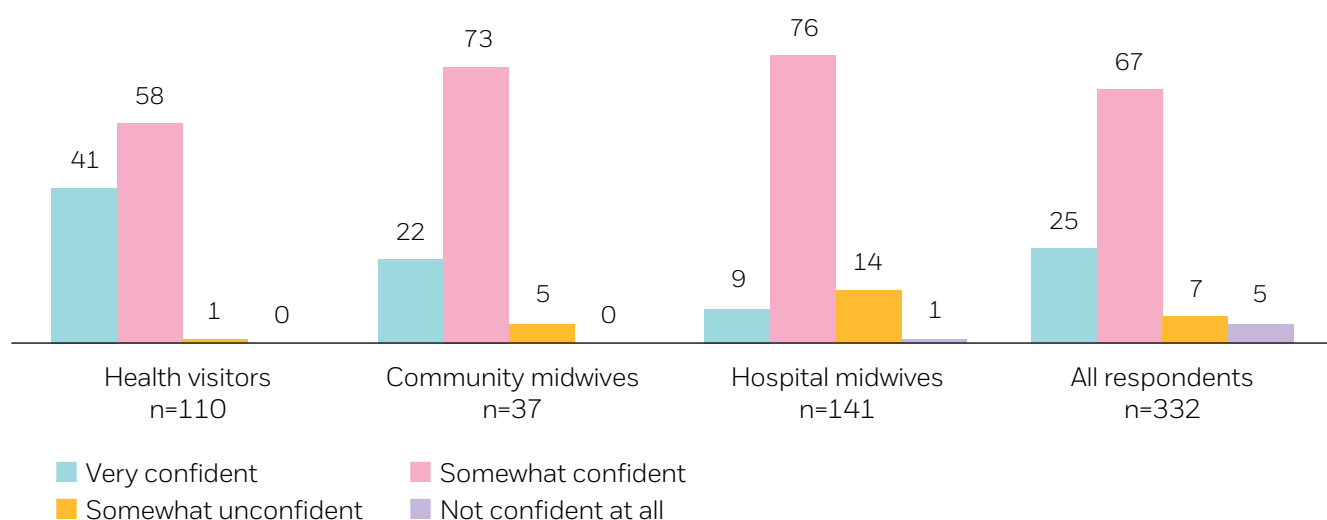
Confidence in recognising perinatal mental illnesses

Figure 7 shows that among the frontline professionals involved in the ante- and post-natal care of mothers, health visitors report higher mean levels of confidence than midwives. This difference is statistically significant. More than 40 per cent of health visitors report being 'very confident' in their ability to recognise PNMI, compared with 22 per cent of community midwives and 9 per cent of hospital midwives.

Key points

- Overall, professional confidence is stronger in identifying and referring than in managing and treating PNMI.
- There is no significant difference between practitioners from the five Trusts in their levels of confidence in the recognition, referral, management or treatment of women with PNMI.
- Health visitors are more confident than midwives in their ability to recognise when a woman is experiencing a PNMI.
- Confidence in recognising PNMI is associated with length of service (professional experience) rather than training.
- Practitioners who have received training in PNMI are more confident about referring to a GP than those who have not received training.
- Overall, only half of respondents are confident that women's illnesses will be managed appropriately in their own service and less than half are confident women will receive the treatment they need.

Figure 7: How confident do you feel that you would recognise a woman who is experiencing a perinatal mental illness? (n=332)



The low level of confidence amongst hospital midwives most likely reflects their much briefer interaction with women; antenatal contact may involve a single contact at booking or brief contact during an antenatal appointment in the context of consultant led obstetric care. The assessment of emotional wellbeing, including knowing when concerns are warranted, is especially challenging for hospital midwives because of the other circumstances occurring in hospital, such as labour and delivery, postnatal discomfort, pregnancy related anxiety or receiving bad news.

However, the results suggest the majority of frontline professionals perceive a need for improvement in their skills of recognition. Seventy-three percent of community midwives, 76 per cent of hospital midwives and 58 per cent of health visitors describe themselves as 'somewhat confident' in recognising PNMI, rather than 'very confident'.

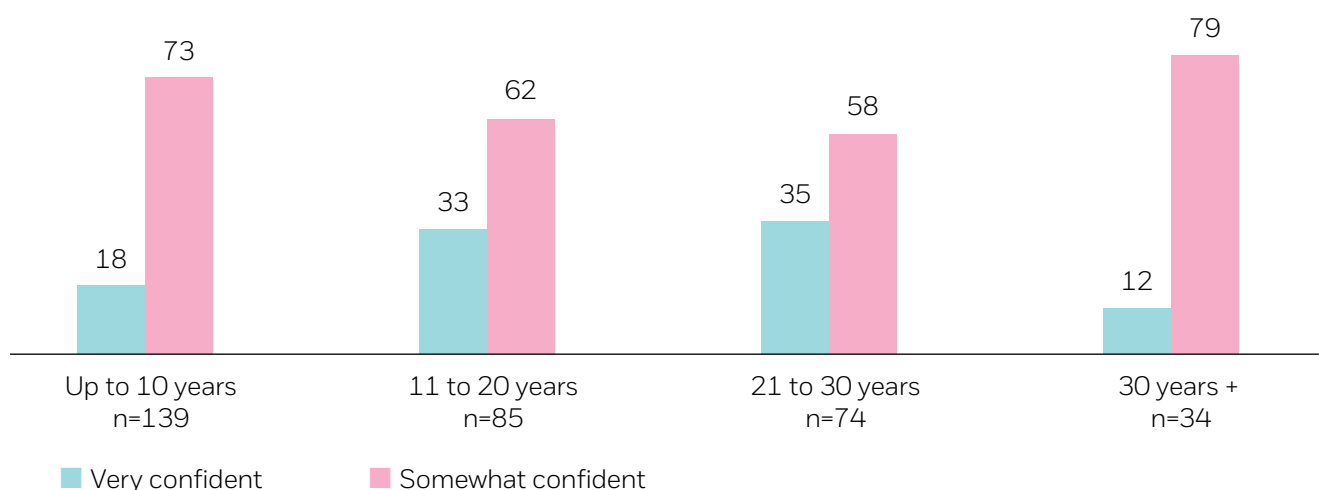
There is no difference in practitioners' levels of confidence in recognising PNMI based on whether they have received training in PNMI. For

example, 72 per cent of individuals (46 out of 64) who had 'never received' training, reported being 'somewhat confident' that they would recognise a woman with PNMI, compared with 63 per cent who had received training in the past 12 months (n=41) and 71 per cent who had received training between 1-2 years ago (n=56).

There is a difference between practitioners with different lengths of service, a proxy for professional experience, and their confidence in recognising PNMI. Figure 8 shows that the percentage of respondents overall who are 'very confident' in their ability to recognise a woman with PNMI increases according to length of service, but only up until 30 years' service. Unfortunately, the low number of responses in some roles, and from those with the longest service, limits the possibilities for analysis.

Notably, while length of service appears to influence confidence in *recognition* of PNMI, there is *no* difference between practitioners with different lengths of service, in their levels of confidence in referral, management or treatment.

Figure 8: Confidence in recognising PNMI by number of years' service (n=332)



Confidence in referral to GP

Eighty-four per cent (n=92) of health visitors and 68 per cent of community midwives (n=25) said they were very confident about referring a woman to their GP. This compares with 31 per cent of hospital midwives (n=43). There are differences between health visitors and hospital midwives in their levels of confidence in referring a woman to her GP. Similarly, there is a difference between community and hospital midwives.

The difference in confidence between hospital and community midwives likely reflects the timing of the Whooley Questions and booking interview and the fact that, compared to hospital midwives, community midwives tend to have a greater continuity of care with women on which to base a decision to refer to a GP. They are also more likely than hospital midwives to have a relationship with the GP. In contrast, shift changes and brief postnatal hospital stays limit opportunities for

midwives on post-natal wards to have enough contact to form an opinion, and any concerns are more likely to be raised within the hospital.

There is a difference between practitioners who have and have not received training, in their levels of confidence in referring a woman to her GP. Respondents who have 'never received' training in perinatal mental health appear slightly less confident about referring to a GP, compared with those who have had training.

Confidence in management and treatment

Compared with their confidence in their own ability to recognise and refer, professionals' confidence in the management and treatment of PNMI *within their own service* is lower.

Overall, 92 per cent of respondents are very or somewhat confident in their ability to recognise a woman with a PNMI (n=307). However only half are 'very' or 'somewhat confident' that

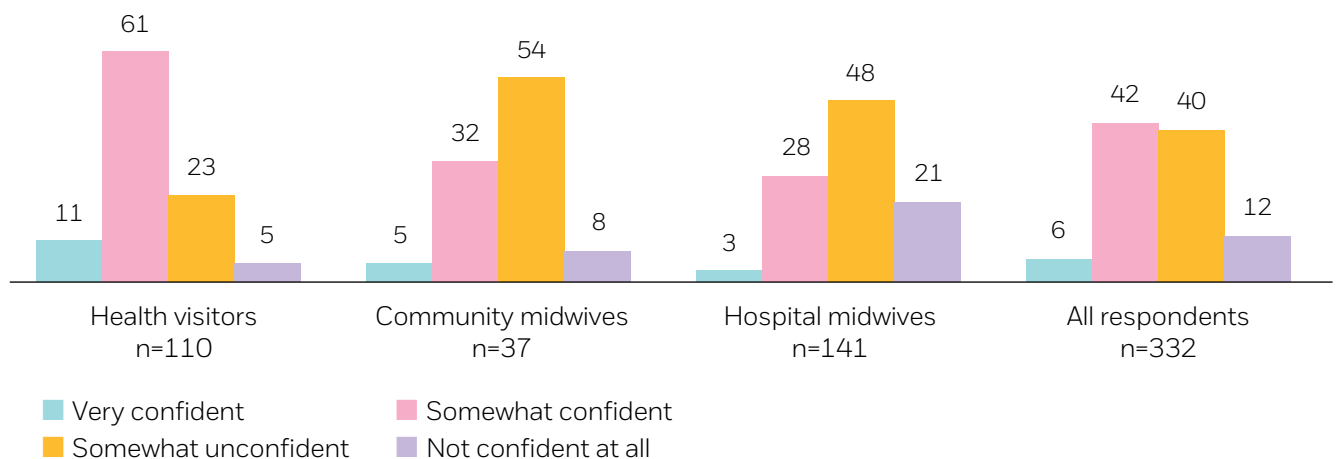


women's illnesses will be managed appropriately in their own service (n=166), and less than half (48 per cent, n=158) are confident women will receive the treatment they need.

When asked about the multi-disciplinary management of perinatal mental illness, and their confidence in how women's illnesses are managed within their service, health visitors expressed greater confidence than midwives. Sixty-eight per cent of health visitors were 'very' or 'somewhat confident' in the management of PNMI in their service compared with 35 per cent of hospital midwives and 48 per cent of community midwives. This is likely to reflect the longer period of contact and input which health visitors have in comparison with midwives and possibly also the training health visitors receive, which provides an overall understanding of the care pathway.

Health visitors also express greater levels of confidence than midwives about whether women with a perinatal illness *within their service* will receive the treatment they need. Figure 9 shows that 72 per cent of health visitors (n=79) are 'very' or 'somewhat confident' about this, compared with 31 per cent of hospital midwives (n=44) and 38 per cent of community midwives (n=14). More than half of community midwives are not confident that women will receive the treatment they need (n=23, 62 per cent). As before, these findings may reflect the relatively brief postnatal involvement of midwives compared with health visitors, which limits their awareness of the outcomes for women identified as experiencing PNMI. Alternatively, it could reflect midwives' experiences of having no specialist perinatal mental health services to refer women to during pregnancy.

Figure 9: Within your service, how confident are you that all women with a PNMI will receive the treatment that they need? (n=332)



Screening tools and methods for encouraging disclosures

Professionals were asked how often they use the Whooley Questions and the Edinburgh Postnatal Depression Scale (EPDS) to help identify psychological problems within their caseloads.

Whooley Questions

The 2012 Regional Perinatal Mental Health Care Pathway (PHA, 2012; 2017) states the Whooley Questions for predicting and detecting depression should *always* be asked by midwives at the booking-in appointment, using the prompts on NIMATS. Its use is also recommended at all GP contacts during pregnancy and in guided discussions undertaken by health visitors.

While 141 hospital midwives responded to the survey, they work in numerous roles and it is unknown how many undertake booking-in appointments.

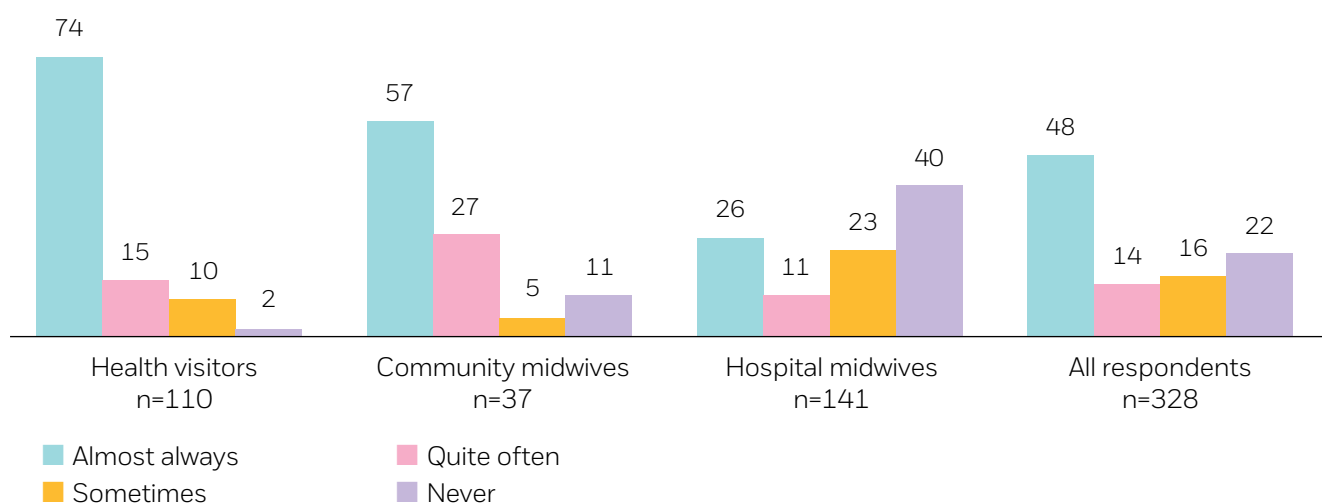
As illustrated in Figure 10, almost 90 per cent of health visitors (n=97) and more than 80 per cent of community midwife respondents (n=31) say they use the Whooley Questions 'almost always' or 'quite often' to help identify psychological

Key points

- Professionals' reported use of screening tools indicates variation in policy and practice in their use between Trusts.
- Continuity of care is ranked the most useful way overall to help identify perinatal mental illness followed by more time during appointments, with screening tools ranked third most useful.
- Professionals report the greatest barrier to women disclosing mental health difficulties is stigma and fear of the consequences of disclosing, such as the possibility of social work involvement with their babies.
- The second greatest barrier reported concerns the quality of the relationship between professionals and women in their care, including lack of continuity of health professional and lack of relationship between professional and patient.

problems. Respondents who answered 'never' were predominantly in roles where the Whooley Questions are not relevant.

Figure 10: How often would you use the Whooley Questions to help you identify psychological problems in your caseload?



Some variation between Trusts in their use of the Whooley Questions is indicated, with 54 per cent of respondents in one Trust ‘almost always’ using Whooley, compared with just 33 per cent of respondents in another. However, the difference in the use of the Whooley Questions by Trust is not statistically significant and may simply reflect the occupational make-up of responses at Trust level.

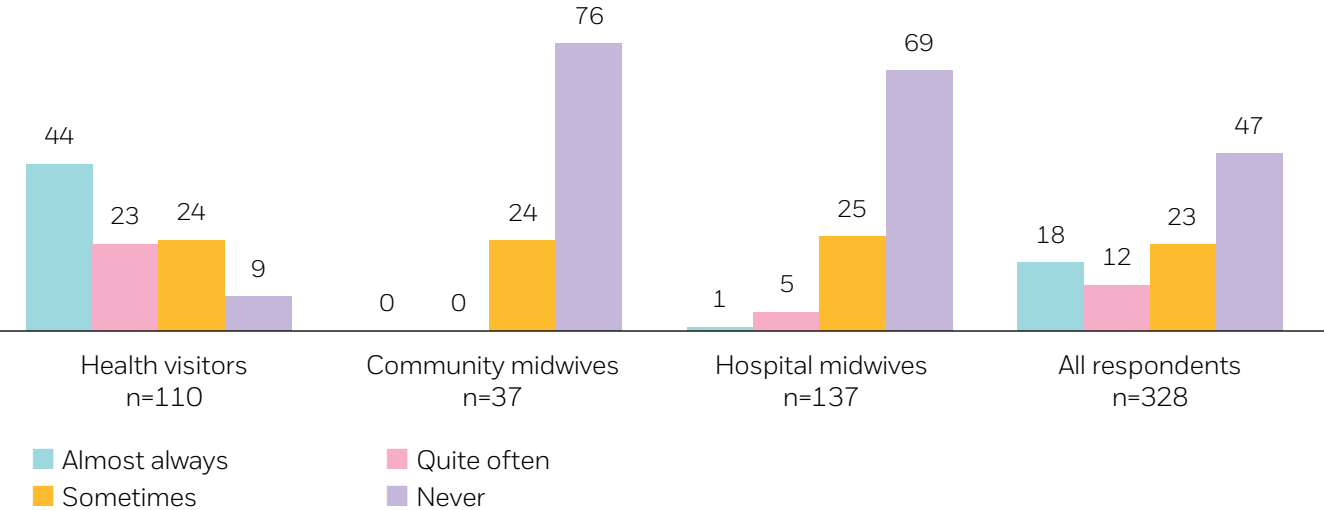
Edinburgh Postnatal Depression Scale

The EPDS is used within health visiting, but not midwifery. The regional care pathway (PHA, 2012; p. 13; PHA, 2017) states health visitors should consider using the EPDS ante- and post-natally when carrying out further assessment of women who have answered “yes” to one or both “Whooley Questions”.

The majority of health visitors (67 per cent, n=73) say they use the EPDS ‘almost always’ or ‘quite often’. However, almost a quarter of health visitors say they only ‘sometimes’ use the EPDS, while around one in ten ‘never’ use it (n=10).

Some variation is therefore apparent in policy and practice in the use of screening tools between Trusts and, in some cases, a divergence from the regional perinatal care pathway. The small number of health visitors who report ‘never’ using the EPDS (n=10) explain that it is no longer standard practice or is not widely used in their Trust. This conflicts with reports by other health visitors from the same Trusts, who report using the EPDS ‘sometimes’ or ‘quite often’. There is a difference in how often practitioners from the five Health and Social Care Trusts use the EPDS to help identify psychological problems. When the analysis is repeated only for health visitors, there

Figure 11: How often would you use the EPDS to help you identify psychological problems in your caseload?



is a difference between Trusts in their frequency of use of the EPDS. Follow-up tests show that health visitors from two of the Trusts use the EPDS significantly less than health visitors in other Trusts. No other differences between health visitors from different Trusts reached statistical significance.

Most useful screening tool

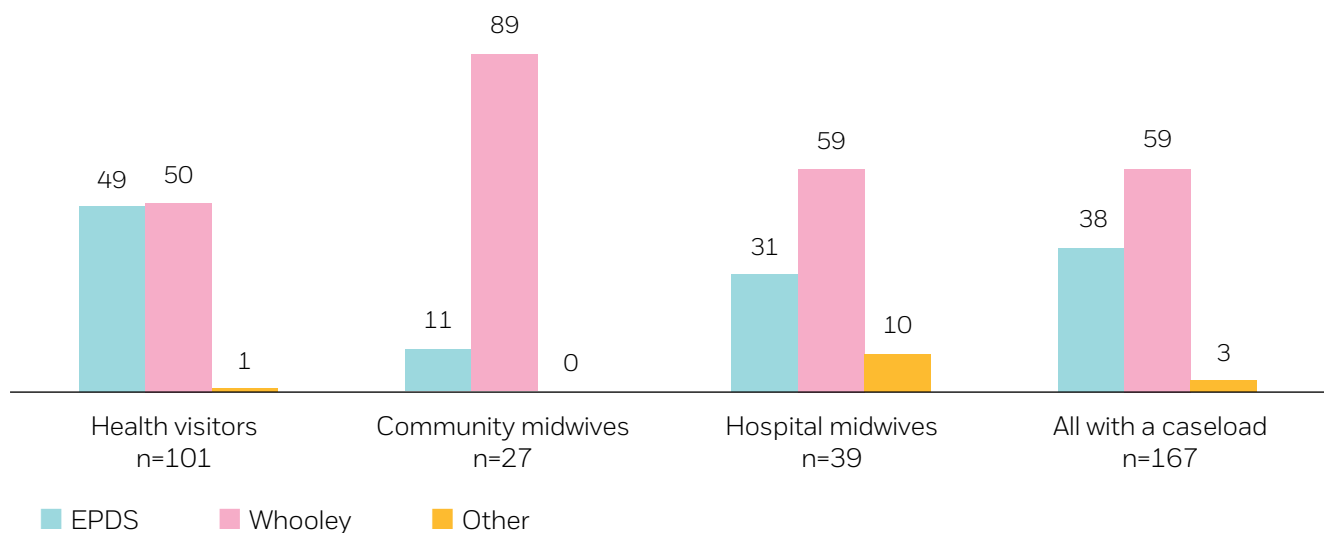
Professionals were asked which screening tool they find most useful to help them identify psychological problems within their caseload. Figure 12 presents findings only *for respondents who carry a personal caseload* (n=167)¹⁷.

Health visitors' preferences divide equally between the two screening tools, with a number stating that they find both useful. Both hospital and community midwives favour the Whooley

Questions. Given the EPDS is not used within midwifery, it is interesting that a small number of midwives find the EPDS most useful. A handful of respondents chose neither screening tool and cited 'Other' things, specifically conversing with women and deploying their professional experience, as most helpful for identifying psychological problems.

The most common alternative suggestions offered by respondents (n=59) are: conversation and listening to women, asking women directly about their mood, feelings and anxieties or asking about their eating, sleeping and general routine to gain a holistic view, combined with observation of non-verbal signs. Some professionals indicated that this might be additional to the use of a screening tool, others suggested these as a more helpful alternative to screening tools.

Figure 12: Which screening tool do you find most useful? Respondents with a personal caseload only (n=167)



17 This includes those hospital midwives who say they have a personal case load (n=39).

Most useful for identification

The survey explored what professionals find most useful overall to help identify a woman experiencing PNMI, asking respondents to rank a range of items in order of usefulness.

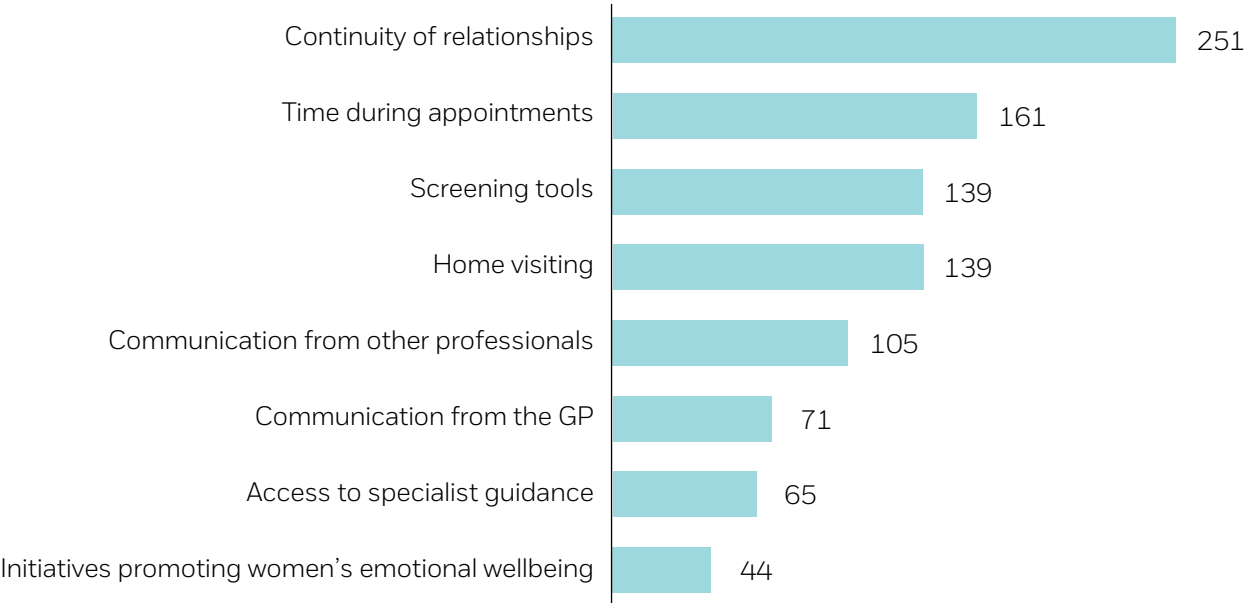
Figure 13 shows the range of options presented, with the results for all respondents. Across the board, continuity of relationships is ranked the most useful way to help identify women experiencing PNMI, followed by time during appointments, and then (jointly) screening tools and home visiting.

The things ranked *least highly* overall for usefulness are initiatives promoting emotional health and wellbeing amongst women, access to specialist guidance, and communication from the GP.

The views of respondents with an individual caseload (n=167) are presented in Figure 14, ‘Spotting perinatal mental illness’ (page 36). The top three ranking options for health visitors and community midwives are presented along with those of hospital midwives and all respondents, for comparison:

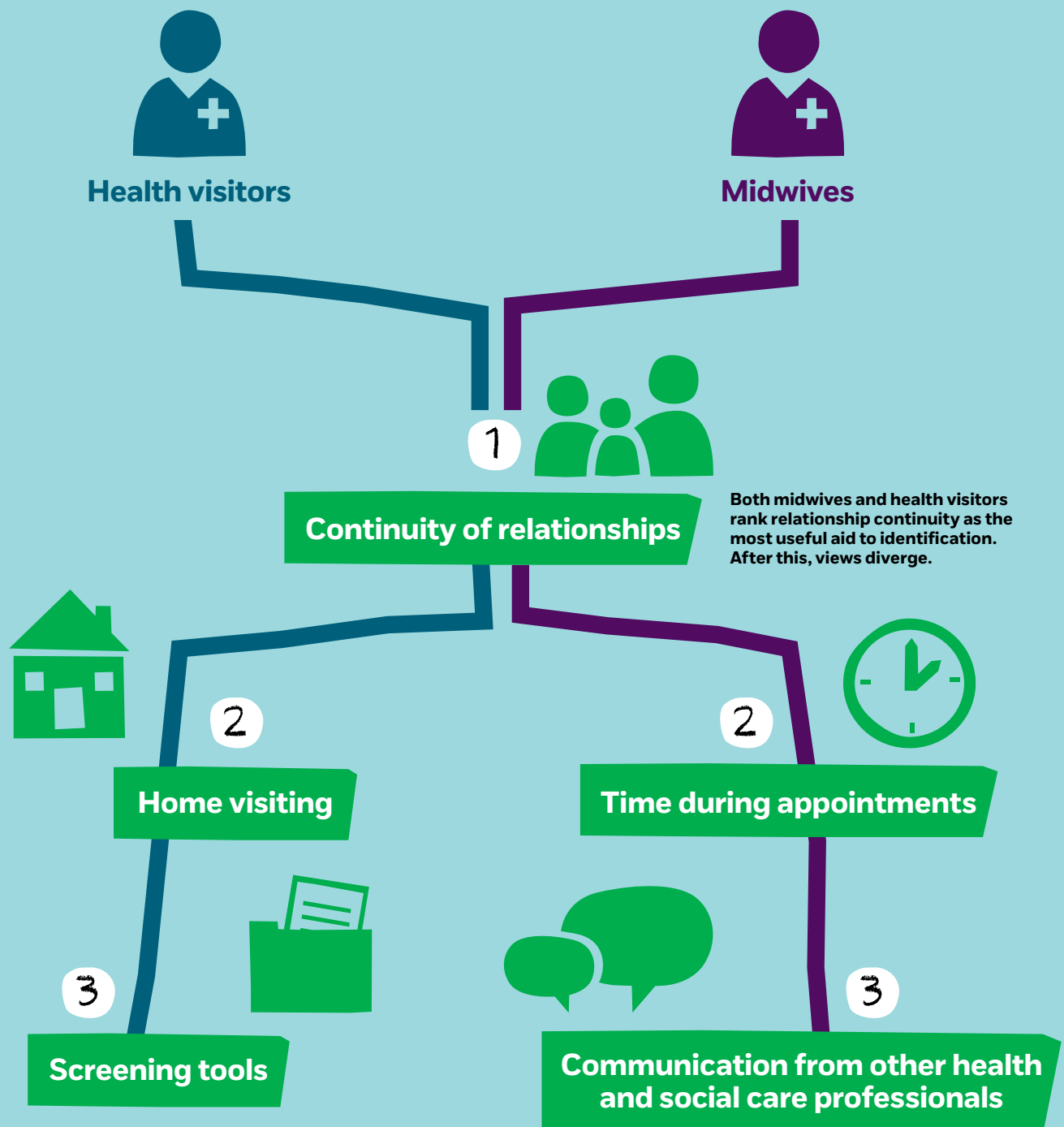
- Highest ranked is continuity of relationships, judged most useful by all.
- Home visiting is ranked second by health visitors, while midwives select time during appointments.
- For health visitors screening tools ranks third, while for midwives, communication from other health & social care professionals is third.

Figure 13: What do you find most useful for identifying PNMI? (Frequencies)



Spotting perinatal mental illness

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



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.

Barriers to disclosure

Respondents were asked what they feel is the greatest barrier to disclosure of mental health difficulties, with the facility to rank up to three options¹⁸. The results are illustrated in Figure 15. Based on 325 valid responses, the top three barriers to disclosure identified by professionals are fear of consequence of disclosure (194 responses, 60 per cent); lack of continuity of health professional (n=165, 51 per cent) and lack of relationship between professional and patient (n=142, 44 per cent). The overwhelming barrier, in the eyes of professionals, is the stigma surrounding mental illness and women's fears about social work involvement with their babies, identified by six in ten respondents. The second major issue is the quality of the relationship between women and the professionals caring for them. Factors which undermine this relationship, such as lack of continuity of care and time

constraints are therefore considered significant barriers to disclosure.

Figure 16, 'What barriers are women facing?' (page 38), presents health visitors', community midwives' and hospital midwives' respective views about the three greatest barriers to disclosure for women in Northern Ireland. While there is broad consensus about the main barriers across occupations, there are also some differences:

- Lack of continuity of health professional is ranked highly by midwives, but not health visitors.
- Lack of time in appointments is ranked more highly by community midwives than health visitors.
- Health visitors and hospital midwives rank the lack of relationship between professional and patient as the third greatest barrier.

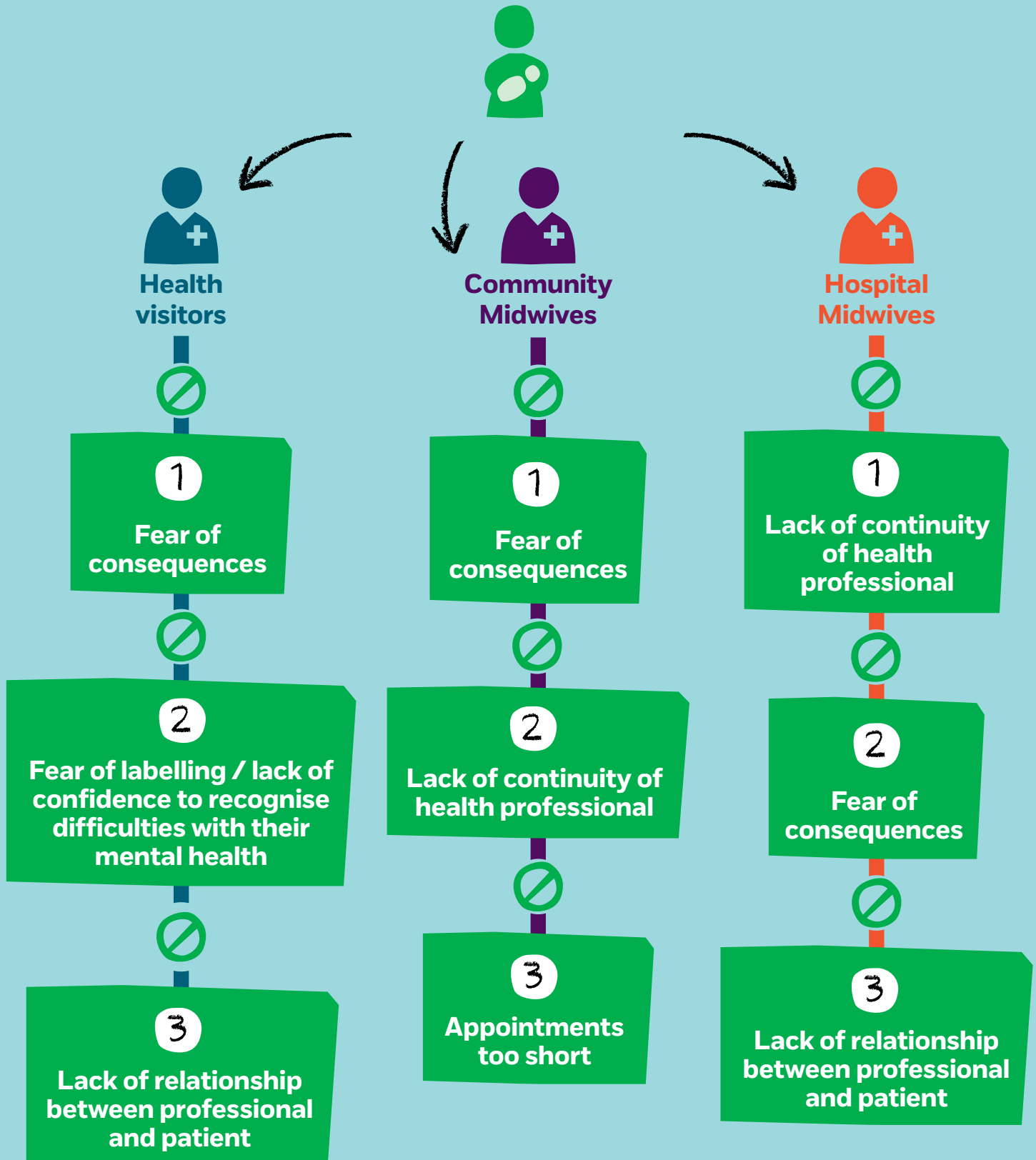
Figure 15: Perceptions of the greatest barriers to disclosure by women (n=325) (Frequencies)



18 The aggregated scores for each type of barrier were calculated, based on all three options.

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



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.

Support services most frequently offered by midwives and health visitors

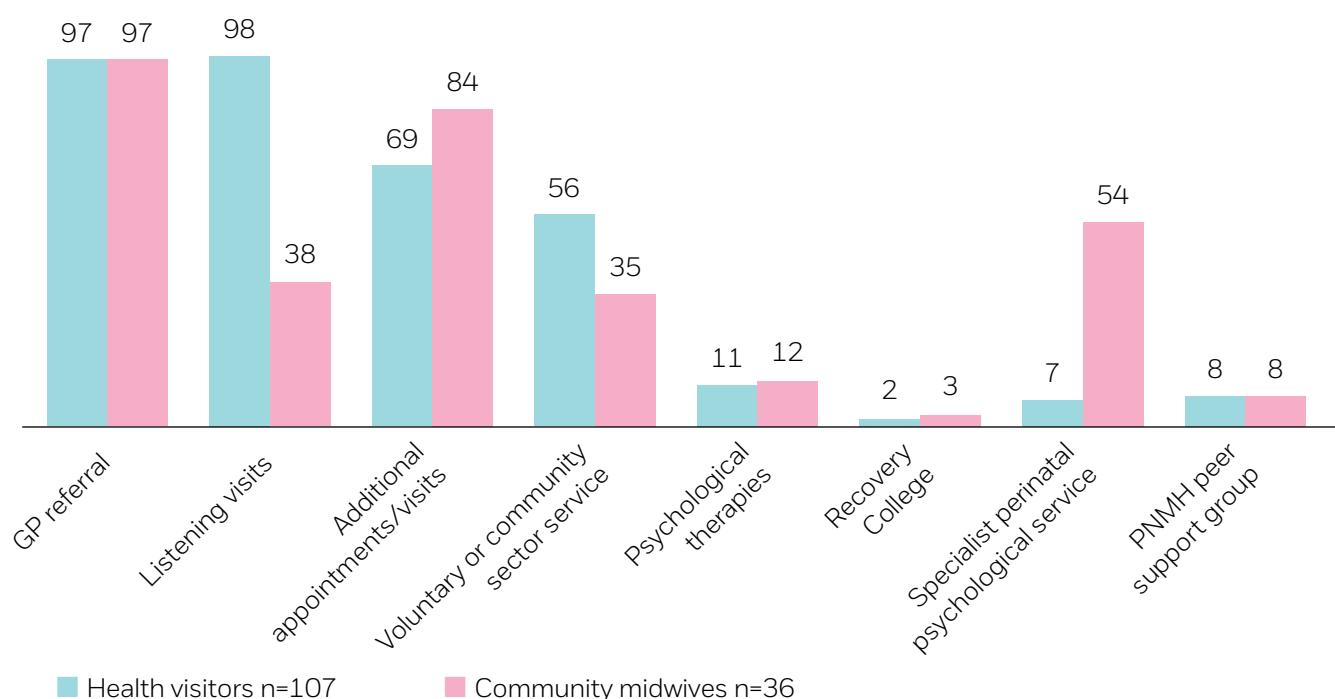
Key findings

- Referring a woman to her GP is the most frequent form of support that health visitors and midwives offer women, followed by additional appointments or visits from a community midwife or health visitor.
- Psychological therapies are amongst the services least likely to be offered, as in most Trusts access to these is through the GP.
- Just a few professionals said they would offer a perinatal mental health peer support group, although voluntary or community sector services are commonly offered, particularly by health visitors.

The support services most frequently offered to women experiencing a perinatal mental illness reflect the Regional Perinatal Mental Health Care Pathway and professionals' different roles and inputs in supporting women. The responses, illustrated in Figure 17, are also indicative of the availability of local sources of support for women and of professionals' awareness of this support. Findings are reported for community midwives and health visitors only, as these occupations have closest contact with women in the perinatal period¹⁹.

- Ninety seven percent of community midwives (n=36) and health visitors respectively (n=107) say they refer a woman who is experiencing a PNMI to their GP.
- Eighty four percent of community midwives (n=31) and 69 per cent of health visitors (n=76) offer additional appointments or visits, while 98 per cent of health visitors (n=108) and 38 per cent of community midwives offer listening visits (n=14).

Figure 17: Support services offered to women by respondents.



¹⁹ In comparison to most midwives working in hospital settings, they carry an individual caseload and are most involved in offering support.

It is important to note that these services are not mutually exclusive, for example, a PNMH peer support group could be offered by a voluntary or community sector service.

More than a third of community midwives (35 per cent, n=13) and over half of health visitors (56 per cent, n=62) frequently refer women to a voluntary or community sector service. This indicates that there are sources of voluntary or community support available in some local areas. A limitation is we do not know what these consist of; which voluntary sector community-based services exist across Trust areas, what they offer, and their capacity or quality.

More than half of community midwives (54 per cent, n=20) but less than one in ten health visitors (7 per cent, n=8) suggest a specialist perinatal psychological service²⁰. Only one HSC Trust (Belfast) has a funded service of this type, which takes referrals from maternity staff. Other trusts may have some informal arrangement with clinical psychology within generic adult mental health or infant mental health, with referrals being made through the GP and not by maternity staff.

Psychological therapies are among the services least likely to be offered and this may be because in most Trusts it is the GP who makes referrals to

these services; one in ten community midwives (n=4, 11 per cent) and fewer than one in five health visitors (n=19, 17 per cent) say they offer these.

A perinatal mental health support group and the Recovery College, are the services offered least, with just a handful of community midwives and health visitors suggesting these²¹.

Additional support services suggested

Some respondents (n=21) mentioned other frequently offered additional types of support services²². Additional services mentioned by midwives include: South Eastern HSC Trust's Births Afterthoughts Service which has a midwife specialising in trauma therapy, a consultant midwife with an interest in PNMH, South Eastern Trust's hospital PNMH team, Belfast HSC Trust's PNMH service and Northern HSC Trust's Rapid Assessment Interface and Discharge (RAID) team. One community midwife commented that only a woman's GP can refer for other therapies as per the regional perinatal care pathway.

Additional services mentioned by health visitors include cognitive behavioural therapy (offered by two CBT trained health visitors), the community mental health team and extended family support.

20 When analysed by trust, the responses from community midwives suggest some confusion or conflation of these two i.e. between a specialist perinatal psychology service and the more general psychological therapies services which are available in all trusts as part of generic adult mental health teams.

21 Eight per cent of each occupation offer a peer support group (n=3 MW and n=9 HV). In total, just three respondents offer the Recovery College (MW & HV combined).

22 These include eight health visitors and 13 midwives, 11 of whom are hospital midwives.

Opportunities and challenges

Key points

- The availability of specialist perinatal referral pathways and access to guidance from a PNMH specialist are what professionals think would be most useful for helping to identify and respond to perinatal mental illness.
- The greatest challenges for their profession in improving perinatal mental health care are systemic, according to practitioners, including lack of time, capacity and funding.
- The next greatest challenge cited is the lack of specialist services and specialist support for perinatal mental health.
- Access to specialist training in perinatal mental health was identified as a challenge by midwives.

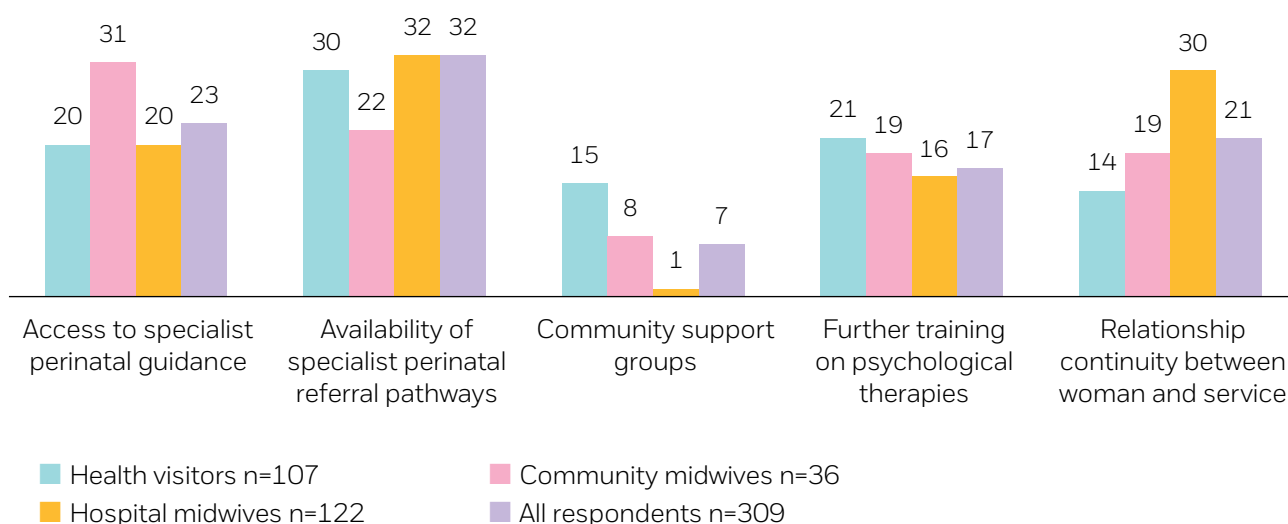
Presented with the choice of five options to help identify and respond to a woman experiencing PNMI, respondents (n=309) had mixed views about what would be most useful:

- Thirty-two per cent (n=98) selected specialist perinatal referral pathways;
- Twenty-three per cent (n=71) said professionals having access to specialist perinatal mental health guidance;
- Twenty-one per cent (n=64) chose relationship continuity between woman and service;
- Seventeen per cent (n=53) selected further training on psychological therapies; and only
- Seven per cent (n=23) said community support groups.

It is interesting to note that there is a relationship between responses to this and professional role (n=309), as illustrated in Figure 18.

There was no relationship between these responses and having or not having received PNMH training.

Figure 18: View of the most useful options for identifying & responding to PNMI, by role (n=309)



Contrasting these responses with those given to an earlier question, which asked what professionals found most useful within their current practice, relationship continuity was considered by far the most useful within current practice, while just 21 per cent selected it here. Access to specialist perinatal guidance ranks second here, but was ranked much lower when asked about in current practice. It may be that presented with the possibility of additional types of support for their role, professionals prioritised the option of receiving types of specialist assistance such as specialist training, guidance and referral routes to services.

A very small number of respondents (n=11) provided additional comments or context to their response, including the need for specialist staff such as a specialist PNMH midwife within their Trust. Most comments identified challenges linked to resources and capacity including the absence of a Mother and Baby Unit, poor provision of community support groups, and difficulties in building relationships with women due to time constraints and discontinuity of care (n=5). One commented on policy, stating that the Healthy Child, Healthy Future visiting schedule 'does not facilitate building a trusting relationship with a mum'.

Future challenges

Respondents were asked the following open question: "Looking to the future, in your opinion what is the greatest challenge(s) faced by your profession in seeking to improve the early identification of *and response to* women with perinatal mental illness in Northern Ireland?" Professionals were given the freedom to voice their personal opinions, unprompted and in confidence, naming as many issues as they wished.

Across the occupational groupings, there is remarkable consistency both in the emergent themes and their prioritisation. The sole area of divergence is training, with more midwife respondents highlighting the training needs within their service than health visitors.

Overwhelmingly, the greatest challenges identified relate to the systems in which professionals work, namely lack of time to deliver woman-centred care, lack of capacity in the face of growing demands, and lack of funding for their service.

These responses are consistent with professionals' views, reported earlier, about what is most useful in helping with identification of PNMI, namely continuity of relationships and

Table 2: Greatest challenge(s) faced in improving identification of and response to PNMI in Northern Ireland

	Community Midwives n=36	Health Visitors (including HV Managers) n=127	Hospital Midwives n=129
Systemic issues: time constraints, capacity and funding	21 (58%)	87 (69%)	82 (64%)
Lack of specialist resources/ service provision	7 (19%)	32 (25%)	29 (22%)
Specialist training	7 (19%)	5 (4%)	25 (19%)
Care pathways	2 (6%)	8 (6%)	6 (5%)
Stigma/fear of disclosure	3 (8%)	12 (9%)	7 (5%)

Note: respondents may cite more than one type of challenge. Percentages do not sum 100.

time during appointments, and also views about barriers, in which continuity of care and lack of a relationship also rank highly. They also match the findings of recent surveys exploring the experiences of women as service users, reported in chapter 2.

The question of stigma, and women's fears about disclosing mental health difficulties provides an interesting point of difference. As reported earlier in this chapter, professionals regard this as the greatest overall barrier to disclosure (identified by 60 per cent of respondents). However, when asked for their opinion on how early identification of PNMI can be improved, *within the context of challenges faced by their profession*, stigma and fear of disclosure features little (reported by five to nine per cent of respondents) and the response is overwhelmingly concerned with constraints within the working environment. This may be explained in terms of professionals being focused on *what is required to tackle the barrier of women's fears about disclosure*,

that is, the *conditions* needed to build safe, trusting relationships.

While there is broad consistency across the professions, more detailed analysis reveals a degree of distinctiveness in the responses received by occupational grouping.

The overriding challenges reported by community midwives are systemic (n=21) but chief amongst these is time, specifically the lack of time to spend with women (n=18), allied with challenges related to a lack of specialist training and of services and specialist resources available.

"Time to give these women help to improve their mental health in pregnancy and to follow up and to provide help for these women to bond with their pregnancy" (community midwife respondent)

"Lack of time at antenatal appointment and pressure on resources when wanting to refer therefore long waiting time" (community midwife respondent)



In comparison, the systemic challenges reported by health visitors break down into three broad inter-related issues: time constraints (n=26), continuity of care (n=33), and workload pressures (n=32). Frequent references are made to health visitor shortages, sickness absence and retention difficulties leading to health visitors absorbing/ providing cover for 'vacant' caseloads. This appears to have two main impacts: it results in frequent changes to caseload, and subsequently to a lack of continuity of care provided to women. It also adds to excessive caseload weight or size, which not only constrains the time available for each contact, but also affects the quality of that time, and of relationships with women, particularly when caseloads contain high numbers of women with additional vulnerabilities and needs.

"Huge caseload and not enough time" (health visitor respondent)

"More time to build the professional client relationship, so mother feels safe to disclose and availability of support" (health visitor respondent)

"Lack of professional resilience skills leading to being 'too busy' and stressed, professionals have learnt behaviour of being full up, the woman is therefore not seen, heard or understood. greatest challenge is enabling practitioners to be mindful and reflective with an openness to change" (health visitor respondent)

Some health visitors highlighted the specific impact of this on early recognition and intervention in the ante-natal period:

"Sufficient health visitors and time available to carry out antenatal contacts as these visits are crucial in providing a past history which can inform future input" (health visitor respondent)

"Being able to prioritise time for antenatal visits" (health visitor respondent)

The view was also expressed that the introduction of 'skill mix' is a factor undermining continuity of care.

"Lack of continuity in care, caseloads changing too frequently, lack of training and lack of time for appointments. Also, management leaning towards H/V appointments being delegated to CHAs or PHSNs [public sexual health nurses]" (health visitor respondent)

The second greatest challenge reported by health visitors (n=32) is the lack of specialist PNMH services and ongoing community support available to women and their families affected by PNMI. While the overriding issue is the gap in services, others include lengthy waits to receive help from mental health services, and the specific problems of provision in rural areas.

"I do not feel identification is the problem but that there is a lack of support from mental health services when a woman does disclose that she is suffering with her perinatal mental health" (health visitor respondent)

Hospital midwives also located the greatest challenges to identifying and responding to PNMI within their working environment (n=82). By far the greatest among these is time to spend with patients (n=47). Time constraints received double the number of mentions than the next most commonly reported concern.

"Developing a relationship in a busy clinical setting where women are happy to open up about mental health issues" (hospital midwife respondent)

"Staff just don't have time anymore to sit down and talk with mothers, too busy trying to deal with increasing workload and paperwork" (hospital midwife respondent)

"Time constraints of the service reducing ability to build trust and rapport – sticking to structured tick boxes as so much to achieve in allotted time – miss the full picture" (hospital midwife respondent)

The second most commonly reported systemic issues, viewed as challenges by hospital midwives, are continuity of care (n=23) and funding (n=21). Responses frequently mentioned time and continuity of care in tandem, with references to staff shortages sometimes also made.

“Women have little time with their midwife and may find at each appointment they meet a different professional. Continuity... ensures referrals are followed up and any deterioration in mood are picked up quickly” (hospital midwife respondent)

“Lack of time in comparison to work load and also lack of continuity of care. Hospital midwives might only ever see the woman once at booking if consultant led care” (hospital midwife respondent)

Lack of funding was often linked to staffing levels, time off for hospital staff to attend training, and to resources available for mental health services.

“Lack of funding, lack of referral pathways - no joined up services - Addictions, Alcohol, Drugs, Social work, health visitor, clinical psychologists and overall co-ordinating midwife to ensure services available to all women who need support for mental health issues” (hospital midwife respondent)

“Lack of staffing and resources not allowing staff to go to enough training” (hospital midwife respondent)

One in five hospital midwives who responded identified a lack of specialist support services as a challenge for responding to PNMI (n=29). Ten of these specifically referred to the lack of specialist inpatient Mother and Baby Units, while

eight mentioned the lack of specialist perinatal mental health midwifery posts, and others the need for a regional PNMH team including dedicated psychological services.

Overlooked issues

As mentioned, relatively few respondents reported the tackling of stigma or anxieties about PNMI being classed as a child protection issue, as the greatest challenges faced by their profession. This is despite women's fears about the consequences for themselves and their babies being viewed as the greatest barrier to disclosure of PNMI (Figure 15). Indeed, issues surrounding the mother-baby relationship, and the impact of PNMI on infants were rarely referred to in the responses. This is despite the relatively high levels of infant mental health training reported (Figure 4). A few respondents talked about the need for a change in social attitudes towards both motherhood and mental illness, and the need to focus on the mother-infant relationship:

“Societal ignorance to perinatal mental illness and unrealistic perceptions of what a mother should be following the birth of a baby” (health visitor respondent)

“Mums reluctant to express how they are feeling for fear of people thinking they are failures” (health visitor respondent)

“Truthfully the lack of time given to build relationships. However I am involved in EITP [Early Intervention Transformation Programme] and Getting ready for Baby programme and feel Solihull approach is one of the ways forward in providing continuity and early discussions around feelings, containment and mental health” (midwifery manager)

Chapter 5: Discussion

The provision of specialist services for women with PNMI and their babies has been the focus of much recent research and policy-related activities in Northern Ireland. For the first time, this research explores the views and experiences of the health visitors and midwives who care for women in the perinatal period within primary care.

Overall, the findings confirm that health professionals in Northern Ireland experience similar types of challenges in identifying and responding to PNMI as their counterparts in the rest of the UK. The strong message from professionals is that when it comes to disclosure of PNMI, 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 PNMI is invested in.

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

The key findings are discussed as they relate to the main aims of the study.

Health visitors' and midwives' awareness of the importance of early identification of perinatal mental health problems

The results shed light on a number of aspects of awareness including the focus on the child, confidence in recognition, training needs and ways to improve identification.

Infant mental health

It is the potential impact on the child, as well as the mother, that makes the early detection of PNMI so important. Encouragingly, more than

three quarters of health visitors and over half of community midwives report having received training in infant mental health. A high proportion (70 per cent) of respondents said their PNMH training had included the impact of PNMI on the child, including nine out of ten health visitors and two thirds of community midwives. However, when professionals were asked, unprompted, about the greatest challenges for improving identification and response to women with a PNMI, concerns about infant mental health and the mother-infant relationship were barely mentioned. Professional confidence in detecting difficulties through observation of mother and baby is an important issue, and one which needs further investigation.

At the same time, midwives and health visitors have work to do to dispel the myth that PNMI is a child protection issue. However, where child protection concerns are an issue, there is a need for engagement with social services, and social work professionals need to be engaged in debates with the midwifery and health visiting professions.

Key points

- Greater emphasis is needed on the importance of face to face time with women and their babies for both identifying and responding to PNMI.
- There is a need to focus attention on the mother-infant relationship so that the infant mental health strategy and the regional perinatal care pathway are more closely linked via good multi-disciplinary working within maternity services. Health visitors, midwives, infant mental health practitioners, psychiatric nurses, GPs should all be part of the team.
- Midwives and health visitors need to work together to dispel worries that PNMI is a child protection issue.

Skills in early identification

The results suggest the majority of frontline professionals see a need to improve their skills in recognising PNMI, with a shift needed from being 'somewhat confident' to 'very confident'. The findings indicate that health visitors are more confident than midwives in their ability to recognise a woman with a PNMI.

In terms of the factors that help explain confidence in recognising PNMI, the results suggest an association not with training, but with length of service, a proxy for professional experience. Having seen so many more women, older, more experienced midwives and health visitors may be better able to recognise and respond to PNMI than those with less experience. It is also possible that having trained and begun their practice at a time when workloads were less onerous, they may have had more space and time to develop specialist knowledge around PNMI. It is interesting to note that, while professional experience/service is associated with confidence in *recognising* PNMI, it is not associated with confidence in referral, management or treatment of PNMI.

One reason may be that a Regional Perinatal Mental Health Care Pathway has only been in existence for five years, a relatively short time for practitioners to acquire familiarity and confidence, especially in the context of considerable variability in the structure of PNMH services and where learning opportunities for practitioners through direct referrals to mental health services or access to specialist PNMH posts are not available in most Trusts.

Training needs

Given the emphasis in the literature on the importance of training, the lack of association between training and recognition of PNMI seems counterintuitive. However, it could be that it is the content and quality of the training which makes a difference, rather than training in general.

While four out of five respondents (80 per cent) reported having received training in perinatal mental health at some point, a limitation of the study is that it did not collect information about the level, duration and accreditation status of this training, so preventing further exploration of this.

- Training may need to focus on more than just detection, recognition and referral and look at the need to provide staff with some skills such as brief interventions, motivational interviewing and pathways to self-help.

Of those in the sample who had received training in PNMI, there is a difference between health visitors and midwives in their levels of satisfaction with the training received, with health visitors reporting higher levels of satisfaction. Overall, midwives are less likely than health visitors to have received training in PNMH, are less likely to have received training recently, and their training is less likely to have covered the impact on the child. Satisfaction with training received was also lowest amongst midwives.

Managers in both midwifery and health visiting also appear less likely to have received recent training in PNMH and four in ten midwifery managers who responded have never received training in PNMH, a limitation for those who are involved in case supervision.

- There is a need to examine and target awareness training in PNMI for more senior managers

When asked about the greatest challenges for their profession in seeking to improve the identification and response to women with a PNMI, one in five midwives (hospital and community) cited the lack of specialist training. The training needs of midwives relate to the spectrum of PNMI but more detailed training

is especially important in relation to the more common forms of PNMI, particularly those related to the timeframe of midwifery care. Midwives tend to lack confidence in recognising the most severe forms of PNMI, which many do not see in the course of their careers. For this reason, to build sustained confidence and deliver change in practice, midwives require not one-off training but regular CPD through refresher training, as well as access to consultation with a mental health professional.

- It is important that there is no one-size-fits-all approach to training, particularly for midwives, where the variation in midwifery roles must be respected. Hospital midwives for example may have different training needs than community midwives and antenatal specialists.

Over half of health visitors and just under half of community midwives report having received training in PNMI *within the past two years*. Professionals with less than ten years' service last received training more recently than their longer serving colleagues. However, one in five respondents in this study have *never* received training in perinatal mental health, including 31 per cent of hospital midwives and 40 per cent of midwifery managers, but just 5 per cent of health visitors.

- This indicates that Trusts are not currently ensuring that all staff delivering care to women in the perinatal period have training in perinatal mental health, and that they receive regular updates and CPD.
- To help address this a standard should be developed for mandatory training on this topic for midwives and health visitors along with guidance on the frequency of mandatory updates.

While not part of the survey the issue of PNMI may be a very commonplace or relatable one for other professionals who encounter it, such as social workers. It may be helpful for other professions to examine how this issue is dealt with in pre-and post-qualified training.

Health visitors' and midwives' use of screening tools, skills and techniques to identify perinatal mental health needs

In keeping with research literature on the effectiveness of screening, professionals cite stigma, and women's fears about child protection consequences as the overwhelming barrier to disclosure of mental health difficulties. The quality of the relationship between women and the professionals caring for them is seen as the second greatest barrier to identification of PNMI, with time constraints and lack of continuity of care viewed as important factors which undermine this. Again, this reinforces the existing literature on screening. It is also compatible with the finding that professional experience/length of service is positively associated with confidence in recognition of PNMI as these factors constrain the ability of practitioners to develop and to exercise professional judgement.

Continuity of care is ranked by professionals as the most useful way to identify women experiencing PNMI, followed by more time during appointments. Screening tools rank less highly, but are identified as the third most useful way to identify PNMI. Almost one in ten respondents spoke about the importance of conversation, listening to women, and observation of non-verbal signs in addition to or as an alternative to the use of screening tools. The finding that confidence in recognising PNMI is associated with experience rather than training is pertinent here. It suggests an emphasis within training on advanced practice skills to enhance and develop *how* practitioners work with women may

be helpful for the future. The results suggest these are regarded as the most effective way to tackle the stigma and fear which, in the opinion of professionals, is the greatest overall barrier to disclosure by women.

In terms of strengthening continuity of care, the research suggests a number of areas of good practice including a need for interactions about PNMH to start strongly with the midwife; and for PNMH to be part of the handover between midwifery and health visiting.

- While screening tools are viewed as having a place, the time and continuity of care necessary to build rapport and trust with women is valued more highly by health visitors and midwives. Care needs to be taken to avoid an over-reliance on screening tools as a mechanism for identification and detection of PNMI.
- The reported usage of screening tools by health visitors and midwives suggests inconsistency in policy and practice at Trust level and, in some cases, a divergence from the Regional Perinatal Mental Health Care Pathway. In particular, there is a difference in how often health visitors from the five Trusts use the EPDS to help identify problems, with health visitors employed by two Trusts using the tool significantly less than health visitors in others.
- It may be helpful for the Public Health Agency to clarify the use of screening tools for the professional groups and examine any training needs.

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

Referring a woman to her GP is the most frequent form of support that health visitors and midwives offer women, as the GP is the pathway into generic adult mental health services, which are the most common form of mental health provision for women with PNMI in Northern Ireland. GPs therefore play a critical role in ensuring early intervention for women where PNMI has been detected. It is a concern that recent reports have found low levels of awareness and training in PNMI amongst GPs (Khan, 2015; RQIA, 2017). Indeed the 2017 RQIA review found that 80 per cent of GPs in one Trust were still unaware of the original Regional Perinatal Mental Health Care Pathway published in 2012. The awareness and training of PNMH amongst GPs deserves further exploration in Northern Ireland as does the principle of health visitors and midwives being able to directly refer women for specialist help.

The second most frequent support offered is additional appointments or visits from community midwife or health visitor. These findings reflect the regional care pathway, but are also indicative of the availability of local sources of support for women.

A voluntary or community sector service, for example, is frequently offered by more than half of health visitors, and over a third of community midwives, suggesting that these types of services are available in some areas, although what these consist of is unknown. In written comments to other survey questions the capacity of such services and existence of waiting lists were also mentioned.

In contrast, psychological therapies are amongst the services least likely to be offered by midwives and health visitors, but this may be because in all but one Trust these therapies are part of generic adult mental health services and it is the GP who makes referrals. Others least likely to be offered include a PNMH support group and the Recovery College, although the reason these are under-represented may be because they can be offered by voluntary and community sector services, which was a separate category.

It is salutary that health visitors and midwives have less confidence in the response to PNMI within their own service, than they have in their own ability to recognise a woman with PNMI. To some extent this reflects the fact that many respondents will have little experience of direct involvement in management and treatment of PNMI beyond referral to the GP. Nevertheless, only half of respondents are confident that women's illnesses will be managed appropriately, and less than half are confident that women will receive the treatment they need.

While clinical experience indicates early identification has increased significantly within maternity services, this has not been matched by improvements in services. Professionals cited a lack of specialist community PNMH services, inpatient Mother and Baby Unit, specialist midwifery posts, dedicated psychological services, and available community based support.

- A high proportion of health visitors and midwives express frustration about the lack of specialist resources and service provision and this was reported as the second greatest challenge for improving both identification and the response to PNMI.

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

Overwhelmingly, the greatest challenges cited by professionals relate to the systems in which they work, namely lack of time to deliver woman-centred care, lack of capacity in the face of growing demands, and lack of funding for their service. These resonate with the themes of research conducted with health professionals elsewhere in the UK.

These responses are also consistent with professionals' views, reported earlier, about what they find most useful to help with identification of PNMI, namely continuity of relationships and time during appointments, and also views about barriers, in which continuity of care and lack of a relationship also rank highly. The sole area of divergence is training, with relatively more midwife respondents highlighting specialist training needs within their service than health visitors.

- The findings reinforce the importance of professional face to face time both for identifying and helping to tackle PNMI.

Variation in views about early identification and response to perinatal mental health needs across professions, length of service and training

Differences in professional role, including the nature and duration of involvement in women's care, explain the majority of the variation in responses.

As highlighted, in comparison with health visitors, midwives are less likely to have received training in PNMI, their training is less likely to cover the impact on the child, and levels of satisfaction with training are lower. In contrast to health visitors, levels of confidence are lower in recognition, management and treatment of PNMI within their service. More midwives than health visitors identify a need for specialist PNMH training.

There are also remarkably similar themes across the occupations. Foremost is work intensification

and the shortage of time to spend with women. Within both midwifery and health visiting services, the main challenges for recognition and response are regarded overwhelmingly as systemic. Lack of relationship between professional and woman is seen as the second greatest barrier to disclosure. Qualitative analysis of the open responses suggests that the context in which screening activity is undertaken leads to a tension, in which screening can be perceived as a 'tick box' approach to identification of PNMI.

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.**

Appendix 1: The respondents

Respondents by role (n=332)

	Role	Frequency	Percent
Midwifery	Community midwife	37	11
	Hospital midwife	141	43
	Midwifery manager	20	6
	Sure Start midwife	4	1
Health visiting	Health visitor in practice	110	33
	Health visiting manager	20	6
All respondents		332	100

Respondents' role by caseload (n=328)

		Caseload (frequencies)		Total
		Does not have caseload	Has caseload	
Role	Community midwife	7	27	34
	Health visiting manager	19	1	20
	Health visitor	8	101	109
	Hospital midwife	102	39	141
	Midwifery manager	17	3	20
	Sure Start midwife	1	3	4
Total		154	174	328

Respondents by age (n=326)

	Frequency	Percent
Up to 30 years of age	28	9
31-40	94	29
41-50	101	31
51-60	94	29
More than 60 years of age	9	3
All respondents	326	100

Role by health and social care trust, frequencies (n=332)

	Role	Belfast	Northern	South Eastern	Southern	Western	Total
Midwifery	Community midwife	7	16	6	4	4	37
	Hospital midwife	50	35	17	27	12	141
	Midwifery manager	2	9	1	4	4	20
	Sure Start midwife	1	1	0	1	1	4
Health visiting	Health visitor in practice	7	40	26	22	15	110
	Health visiting manager	0	8	2	7	3	20
	Total	67	109	52	65	39	332

Respondents by role and number of years' service, percentages (n=332)

	Role	Up to 10 yrs	11-20yrs	21-30 yrs	30+ yrs	Total
Midwifery	Community midwife	8	32	43	16	99
	Hospital midwife	53	16	21	10	100
	Midwifery manager	0	30	50	20	100
	Sure Start midwife	0	0	25	75	100
Health visiting	Health visitors	55	29	11	6	101
	Health visiting manager	5	60	30	5	100
All respondents		42	26	22	10	100

Note: totals may not sum 100 due to rounding

Appendix 2: Statistical tests

Training and qualifications

Research Question	Page	Sample Size	Statistical Test	Test Statistic	Statistical Significance
Is there a difference between health visitors and midwives, in their levels of satisfaction with PNMH training?	3	N = 265 (140 Midwives; 125 Health Visitors)	Mann-Whitney U Test	$U = 6348.50$	$p < 0.001^*$
Is there a difference between professionals from different Trusts, in their levels of satisfaction with PNMH training?	3	N = 320 (62 Belfast; 106 Northern; 49 South Eastern; 65 Southern; 38 Western)	Kruskal Wallis	$\chi^2 = 6.84$	$p = 0.144$
Is there a difference between professionals with different lengths of service, in their levels of satisfaction with PNMH training?	3	N = 320 (132 ≤ 10 years; 84 ≤ 20 years; 71 ≤ 30 years; 33 > 30 years)	Kruskal Wallis	$\chi^2 = 3.41$	$p = 0.332$

*Statistically significant at the $p < 0.001$ level

Confidence in recognition, referral, management & treatment

Research Question	Page	Sample Size	Statistical Test	Test Statistic	Statistical Significance
Is there a difference between practitioners from the 5 HSC trusts in their levels of confidence in the recognition ¹ , referral ² , management ³ and treatment ⁴ of PNMI?	8	¹ N = 332 (67 Belfast; 109 Northern; 52 South Eastern; 65 Southern; 39 Western)	Kruskal Wallis	¹ $\chi^2 = 2.36$ ² $\chi^2 = 2.11$ ³ $\chi^2 = 6.83$ ⁴ $\chi^2 = 4.96$	¹ $p = 0.670$ ² $p = 0.715$ ³ $p = 0.145$ ⁴ $p = 2.92$
Is there a difference between health visitors and midwives in their levels of confidence in the recognition and referral of PNMI?		¹ N = 332 (202 Midwives; 130 Health Visitors)	Mann-Whitney U Test	¹ $U = 16,554$ ² $U = 18,775$ ³ $U = 11,926$ ⁴ $U = 12,134$	¹ $p < 0.001^*$ ² $p < 0.001^*$ ³ $p = 0.127$ ⁴ $p = 0.209$
Is there a difference between professionals who have and have not received training, in their levels of confidence in the recognition and referral of PNMI?		¹ N = 329 (39 Never Received; 265 Received)	Mann-Whitney U Test	¹ $U = 7984$ ² $U = 6296$ ³ $U = 8248.50$ ⁴ $U = 7425.50$	¹ $p = 0.376$ ² $p < 0.001^*$ ³ $p = 0.714$ ⁴ $p = 0.096$
Is there a difference between professionals with different lengths of service, in their levels of confidence in the recognition and referral of PNMI?		¹ N = 332 (139 ≤ 10 years; 85 ≤ 20 years; 74 ≤ 30 years; 34 > 30 years)	Kruskal Wallis Test	¹ $\chi^2 = 9.34$ ² $\chi^2 = 4.60$ ³ $\chi^2 = 6.30$ ⁴ $\chi^2 = 6.85$	¹ $p = 0.025^{**}$ ² $p = 0.204$ ³ $p = 0.098$ ⁴ $p = 0.077$

*Statistically significant at the $p < 0.001$ level

**Statistically significant at the $p < 0.05$ level

Screening tools

Research Question	Page	Sample Size	Statistical Test	Test Statistic	Statistical Significance
Is there a difference in the frequency of use of the Whooley Questionnaire at trust level?		N = 328 (64 Belfast; 108 Northern; 52 South Eastern; 65 Southern; 39 Western)	Kruskal Wallis	$\chi^2 = 53.84$	p<0.001*
Is there a difference for health visitors between Trusts in how often they use the EPDS?		N = 130 (7 Belfast; 48 Northern; 28 South Eastern; 29 Southern; 18 Western)	Kruskal Wallis	$\chi^2 = 53.84$	p<0.001*
Is there a difference for midwives ¹ and health visitors ² between Trusts in how often they use the EPDS?		N = 134	Chi-square test of association	$\chi^2 = 9.91$	p = 0.042**
		N = 65		$\chi^2 = 2.59$	p = 0.628

*Statistically significant at the p<0.001 level

**Following a Bonferroni correction for the number pairwise comparisons, the test is not statistically significant at the p<0.025 level

Opportunities and challenges

Research Question	Page	Sample Size	Statistical Test	Test Statistic	Statistical Significance
Is there an association between professional role and responses to Q29?	23	N = 309 (182 Midwives; 127 Health Visitors)	Chi-square test of association	$\chi^2 = 22.24$	p < 0.001*
Is there an association between having received PNMH training and responses to Q29?	23	N = 309	Chi-square test of association	$\chi^2 = 2.47$	p = 0.650

*Statistically significant at the p<0.001 level

**Statistically significant at the p<0.05 level

Appendix 3: Project advisors

A **Professional Advisory Group** supported the project at the following stages:

1. Supporting and advising on the development of the survey
2. Reviewing and commenting on the draft report.

The Advisory Group formally met on one occasion in January 2017. Subsequent contact was by email and telephone. The following external members were represented on the advisory group:

- Averil Bassett, Senior Education Manager, HSC Clinical Education Centre
- Dr Grainne Doran, Chair, Royal College of General Practitioners Northern Ireland
- Professor Gerry Leavey, Director, Bamford Centre for Mental Health and Wellbeing, Ulster University
- Dr Janine Lynch, Consultant Perinatal Psychiatrist
- Tom McEneaney, Head of Business Development, Aware Northern Ireland
- Dr Geraldine Scott-Heyes, Consultant Perinatal Clinical Psychologist

NSPCC NI, CPHVA and RCM were also represented on the Advisory Group by:

- Caroline Cunningham, Senior Policy Researcher, NSPCC NI
- Mary Duggan, CPHVA
- Louise Hales, Northern Ireland Chair, CPHVA
- Shona Hamilton, RCM
- Breedagh Hughes, former Director, RCM Northern Ireland
- Janet Taylor, UK Chair, CPHVA

Two **mothers with first-hand experience of perinatal mental illness**, Lindsay Robinson (Have you seen that girl? haveyouseenthathatgirl.com/) and Nuala Murphy (Moment Health, momenthealth.io/), also supported the project in parallel to the Professional Advisory Group. This process was facilitated by Aware Northern Ireland.

The authors and project advisors formally met on one occasion in February 2017 at Aware NI's Belfast office. Subsequent contact was by email.

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