WORLD MATERNAL MENTAL HEALTH DAY, May 4th 2016

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On Wednesday 4th May, 2016, a truly incredible event is taking place - the first World Maternal Mental Health day. This exciting initiative aims to drive social change by connecting people across the globe in raising awareness and reducing the stigma of maternal mental health problems. By using various social media platforms, professionals with specialist expertise together with women with personal lived experience, will be sharing their own events and discussing why maternal mental health matters. To get involved, look for #MaternalMHmatters as a hashtag across Twitter and join in this unique collaboration - whether commenting, contributing or just observing; all are welcome.

**So why does Maternal Mental Health matter?**

#MaternalMHmatters because having a baby and becoming a parent is a life changing process that is the hardest thing many of us will ever do in our lives but mental health problems during this time make it even harder. Although society has instilled deep expectation that women will make a seamless transition to motherhood, there is much potential for ill health, both physical and psychological. The concept of a pregnant women battling dark depression or a first time new mum unable to enjoy time with her baby due to debilitating anxiety are cultural contradictions that many find difficult to accept either consciously or subconsciously. However, mental health problems in the perinatal period (pregnancy and the first year postnatally) are common, with 1 in 5 women having symptoms severe enough to warrant a diagnosis (1). Postnatal depression is the condition most think of when considering perinatal mental health illness but there are many other diagnoses that women may experience during this time. As well as conditions specific to the perinatal period such as postpartum psychosis, PTSD related to a traumatic birth and tokophobia which is an extreme fear of childbirth, women may suffer any condition from the full psychiatric spectrum they are susceptible to at any other time of life such as anxiety disorders including OCD, schizoaffective disorders and eating disorders amongst others. Further training is needed for professionals of all disciplines to better understand the spectrum of mental illness a woman may experience during this crucial time in their lives. An excellent place to update with some CPD is the 5 module e-learning series on perinatal mental health available on the e-lfh platform, produced in conjunction with RCGP and HEE, available on line free of charge for all NHS employees: http://www.e-lfh.org.uk/programmes/perinatal-mental-health

#MaternalMHmatters because unfortunately, many women slip through the net – 50 % of women with problems are not picked up by healthcare professionals and therefore many women do not receive appropriate help (ref- 2). There are many reasons for this including women not recognising their own symptoms as being abnormal or significant and so not seeking help from their GP or other healthcare professional. There may be a reluctance to report their feelings to a GP for sense of failure, fear of judgement as a bad parent, stigma and concern that disclosure may lead to social services becoming involved and separation from their baby (ref-2). GPs may not ask about symptoms due to time pressures or competing priorities (i.e. the postnatal check may focus almost exclusively on the infant). GPs may inadvertently be dismissive – normalising those feelings of being totally overwhelmed, physically and emotionally exhausted as being “normal for a new mum”, without further compassionate questioning to look for a diagnosis of postnatal depression. A useful tip for GPs is to “listen for the pause” when asking how a woman is even if the answer is “I’m ok” – any hesitation may be indicative of a woman’s apprehension about disclosing their true feelings and so warrant further discussion.
because the problems of under reporting and under diagnosis are compounded by under treatment with only 50% of women receive the appropriate level of support they need, despite there being national evidence based guidance (ref-3). Lack of access to specialist perinatal trained teams is a significant reason for this with huge variability across the UK with almost half the country not having access to specialist psych teams (ref-2). For some conditions Psychological Therapy is recommended and the target time for treatment is within 6 weeks of referral for women who are in the perinatal time but this is challenging for many areas due to a lack of specialist perinatal training (ref 4). Medication is an area where there is much myth and misunderstanding as although no antidepressant is licensed for use in pregnancy and breastfeeding, the risks of some SSRIs such as sertraline and citalopram are small and when compared to the significant risks of untreated illness may well be a reasonable option for treatment acceptable to most women. However the decision must be made on an individual basis taking account of a woman’s past history, past response to treatment, stage of pregnancy and above all, a woman’s preference – what is considered an acceptable risk for one woman, may not be for another. There are some excellent sources of advice including the UKTIS website, professionals facing: http://www.uktis.org/ and BUMPS website, public facing – www.medicinesinpregnancy.org

If in any doubt, GPs can liaise with their local psychiatry services particularly about medication advice.

because the short and long term consequences of undertreated illness are significant for the woman, her partner and their child if there is a lack of the right help at the right time. Short term consequences include relationship strain, higher risk of paternal mental health problems as well as bonding problems and infant mental health concerns. Later effects may include relationship breakdown, child behavioural problems and educational challenges leading to problems and higher risk of mental health problems for the child in later life. However, early detection, and prompt treatment together with the absence of other determinants of ill health such as social adversity – domestic violence, substance misuse, lack of stable housing may mitigate the negative impact of maternal mental health. Women present to healthcare professionals frequently throughout their perinatal journey and each contact must be seen as a window of opportunity to improve their lives as well as the lives of their whole family through better detection and prompt treatment which will lead to better outcomes.

For more information see the Perinatal Mental Health pages of the RCGP website and look out for the Perinatal Mental Health Toolkit which is under construction and due for completion this summer.

References


2. Khan L. Falling through the gaps: perinatal mental health and general practice. 2015; London: Royal College of General Practitioners and Centre for Mental Health.
