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Mental Health Nursing

PERINATAL MENTAL HEALTH

SPECIAL ISSUE PART 2

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- PERINATAL CARE IN PRISONS
- BLACK, ASIAN AND MINORITY ETHNIC WOMEN'S ACCESS TO SERVICES
- USING PERSONAL EXPERIENCES TO TELL STORIES OF PERINATAL MENTAL IILL HEALTH

PRODUCED WITH SUPPORT FROM

Maternal Mental Health Alliance

NEWS: INTERIM MOTHER AND BABY UNIT OPENS IN WALES

INTRODUCTION

STORIES ARE A WINDOW INTO PERINATAL MENTAL HEALTH

Vanessa Gilmartin Garrity, mental health nurse and independent consultant

What strikes me about this second part of this special edition on perinatal mental health is the way in which the importance of stories is woven through the articles.

Stories provide us with an empathic window into another person's life and connect us with the humanity of a person's situation. Arguably, fewer things connect us more with our own humanity than the miracle of a new life beginning.

It is widely considered to be a sacred rite of passage for women; a transitional period, with pregnancy symbolising the hope and expectation of new life and with mothers being positioned as the carriers of the future generation.

However, motherhood isn't always idyllic. In the words of Jane Fisher (p8), navigating motherhood is difficult enough, but with the complexity of mental illness, it becomes an unbearable struggle.

Jane explains that as a mental health nurse she has supported many women in their role as a parent, but that it was only when she experienced her own mental health struggles did she understand the enormity of the challenge. Jane has channelled her lived experience into a book called 'The Sun will shine again'.

Similarly, film maker Iain Cunningham (p14) shares how what started as a memorial to his mum who died when he was three, evolved into a film of his search for her story. Irene had experienced postpartum psychosis and subsequent bipolar illness.

As Iain says, the stigma around mental health problems is slowly being eroded, but public perceptions are still coloured by the way in which history has framed mental illness.

Stories influence change. They also enable us to have a much deeper understanding of a person's life and how this is impacted upon by mental illness, rather than seeing things solely through an over simplified, reductionist clinical lens.

Perinatal mental illness impacts on the entire family and its effects can be wide reaching and long lasting.

It is crucial that all women and families are able to access perinatal mental health support and that marginalised groups such as mothers in prison receive the same standard of care and support as women in the community; that we eradicate inequalities in accessing services for women from Black, Asian and minority ethnic groups; and that women don't have to travel for miles in order to access help and support.

Having a baby is life changing and can be wonderful, but it can also bring many challenges. For women experiencing perinatal mental health difficulties, there is a pressing need for services to be responsive and accessible, so that outcomes can be improved for entire families.

It is by hearing the stories of families affected by perinatal mental health challenges that we understand this and feel compelled to help bring about those changes.

If you feel affected by any of the issues raised in this edition, support and resources can be found at https://maternalmentalhealthalliance.org/resources. ■

Manuel Alejandro Leon from Pixabay

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Interim mother and baby unit opens in Wales

Wales now has a mother and baby unit (MBU), after the Uned Gobaith ('Unit of Hope') service opened for referrals in Neath, south Wales.

The new interim unit will provide specialist inpatient care to new and expectant mothers who experience serious mental health problems.

Since a unit in Cardiff closed in November 2013, Wales has been without a MBU. Women in need of inpatient treatment for perinatal mental health problems have either been admitted to acute mental health wards without their babies or have had to travel many miles away from family and friends to a MBU in England. At present, the closest unit for women living in the south Wales area is in Bristol.

The new six-bed interim unit, based at Tonna Hospital, part of the Swansea Bay University Health Board, will finally grant women in Wales access to specialist care for themselves and their babies much closer to home.

It has six individual bedrooms for women and their babies. Mothers who are admitted will also have access to a shared living room and kitchen areas along with a playroom, quiet room and sensory room.

Uned Gobaith will also offer accommodation for family members travelling to visit their loved ones.

A multidisciplinary team will support mothers and their babies on-site, including mental health nurses, psychologists, nursery nurses and psychiatrists, as well as social workers, health visitors and midwives.

Though it is undoubtedly a positive development for women and families in Wales, the Maternal Mental Health Alliance (MMHA) has expressed some concerns.

First, women and babies in north Wales will still need to travel significant distances to access specialist inpatient support.

Second, Uned Gobaith has been described by the Welsh Government Minister for Health and Social Services Eluned Morgan as being "an interim solution". There is no clear plan for when or how permanent provision will be established.

She said: "further work is needed to ensure that provision is also made available for mothers who live in north Wales" and confirmed that "discussions are being held with NHS England to develop the option of a joint eight-bedded mother and baby unit" on the border.

She also added that the Welsh Government will be monitoring the transition to providing perinatal inpatient provision in south Wales to ensure that the unit provides the level of service demanded of it.

MMHA Everyone's Business coordinator for Wales, Sarah Witcombe-Hayes, said: "The Maternal Mental Health Alliance is delighted to welcome the opening of Uned Gobaith.

"Having a MBU in Wales will make a significant difference to the lives of women and their families experiencing serious mental health problems.

"While it has taken some time to get here, it is an important step forward in providing specialist perinatal mental health support that is needed by families in Wales.

"We must however make sure that the next Welsh Government prioritises making this vital provision permanent, and to ensure that MBU provision is also made available for mothers and families who live in north Wales."

Janet Williams, associate service director of mental health and learning disabilities at Swansea Bay University Health Board, said: "This important service will significantly enhance perinatal care services across Wales and we are very proud to be hosting it in Swansea Bay University Health Board.

"Its development has only been possible with support from a wide range of experts, teams and patients across the country."

Eluned Morgan said: "It is fantastic news that we have our own perinatal mother and baby unit in Wales to support those struggling with their mental health.

"This will make a significant difference to the experience of new mothers as they will be able to get the specialist support that they and their babies need closer to home.

"We all know that the pandemic restrictions have added to the challenges during this last year and so I welcome the addition of this facility which will complement our strengthened perinatal community offer."

Sharon Fernandez, national clinical lead for perinatal mental health, said: "The opening of Uned Gobaith is a huge step forward for the treatment of pregnant women and new mothers experiencing severe mental distress.

"Providing this kind of specialised mental and emotional support for women at one of the most vulnerable times in their life is essential, and the family-friendly environment Uned Gobaith offers means that partners and older children can be involved and get the support they need too.

"As a network, we were very pleased to play a role in the development of Uned Gobaith. Its opening is a tribute to the hard work and commitment of everyone involved, especially the many women who shared their own personal experiences of perinatal mental health difficulties in order to improve services for others."

Michal Jarmoluk from Pixabay

Maternal Mental Health Awareness Week puts issues in the spotlight

This year's Maternal Mental Health Awareness Week was held from Monday 3 May to Sunday 9 May.

The week-long campaign takes place every year, and is dedicated to talking about mental health problems during and after pregnancy.

It aims to raise public and professional awareness of perinatal mental health problems, advocating for women affected by it, changing attitudes and helping families access the information, care and support they need to recover.

The week was organised and led by MMHA member Perinatal Mental Health Partnership UK (PMHP UK), which launched the first-ever UK Maternal Mental Health Matters Awareness Week in 2014.

PMHP UK is a small group of individuals, including women with lived experience, who came together to raise awareness of maternal mental health.

This year's theme was 'Journeys to Recovery', in response to the impact of the COVID-19 pandemic. This has dramatically changed the way services are delivered, so the aim was to highlight how mothers and families can seek support, alongside detailing the individual routes to recovery.

PMHP UK provided a supportive platform for families and signposted them to vital resources and safe support. The focus was on ensuring parents feel well informed and supported at a time when anxiety is heightened for so many.

PMHP UK organised a busy schedule of online activities, including Facebook Lives and Twitter chats, and promoted the hashtags #journeystorecovery and #maternalmhmatters on social media.

More information on activities plus useful links can be viewed at: https://perinatalmhpartnership.com/2021/05/11/the-2021-uk-maternal-mental-health-awareness-week-overview/.

Majority of people with mental illness say discrimination is rife

The need to tackle stigma and discrimination experienced by people severely affected by mental illness has been laid bare in a new survey by the charity Rethink Mental Illness.

The survey, completed by more than 500 people severely affected by mental illness, including diagnoses of schizophrenia, bipolar disorder and borderline personality disorder, revealed:

- Three in four people (74%) felt that levels of stigma towards people severely affected by mental illness have not improved in the last decade.
- Eight in ten people (86%) reported that the fear of being stigmatised or discriminated against stopped them from doing things they wanted to do, including seeking help for a mental health problem (61%), disclosing their mental health condition to friends or family (69%) or applying for a job or promotion at work (61%).
- An overwhelming majority of 88% agreed that discrimination towards people severely affected by mental illness is widespread in England.

More positively, 67% of people agreed that levels of stigma towards more common health problems, which can be managed with the right treatment and support, had improved in the last ten years.

However, this had not extended to people severely affected by mental illness, whose condition impacts aspects of their daily life, such as the ability to build and maintain relationships or undertake work and recreational activities.

The conversation around mental health has evolved significantly in the last ten years, with high profile figures sharing their experiences of mental illness, increased take-up of training in the workplace and the coronavirus pandemic opening conversations around mental health and wellbeing.

Yet despite this, people severely affected by mental illness report stigma and discrimination continue to have a direct impact on their lives.

The charity is calling on the government to put anti-stigma and discrimination work at the heart of its public mental health programmes, with a focus on the experiences of people from black, Asian and minority ethnic communities and those living with less well understood mental health problems.

To achieve this, the charity argues it is vital that the government commits to continue its Attitude to Mental Illness research, to guarantee an up-to-date picture of changing public views.

Rethink Mental Illness also placed a renewed focus on tackling stigma and discrimination during Mental Health Awareness Week, which ran from 10 to 16 May, when it highlighted different conditions to help develop understanding.

Mark Winstanley, chief executive of the charity, said: "We still have a long way to go in our efforts to reduce stigma and discrimination experienced by people severely affected by mental illness.

"The damaging words and behaviour that people face can have a devastating impact on their lives. We must all commit to calling out stigma and discrimination when we see it.

"While it is positive to see improved perceptions of more common health conditions, we must ensure no one is left out in the national conversation about mental health."

Antonio, 23, who lives with a diagnosis of schizophrenia and borderline personality disorder, said: "I've experienced stigma and discrimination many times in my life, and I'm only 23. People are so quick to judge me based on a diagnosis – who I am as a person, and what I can achieve.

"It's been exhausting, confusing and distressing trying to deal with people's perceptions of me and it makes life harder. But if we pretend it doesn't exist, things will never get better."

New resources produced for perinatal care

New resources have been made available in England to help healthcare professionals providing perinatal mental health care.

NHS England has published 'Involving and supporting partners and other family members in specialist perinatal mental health services: good practice guide'.

This guidance, which focused on involving and supporting partners and significant others, is for staff working in specialist perinatal mental health services and commissioners.

It relates to the families of mothers receiving care from inpatient and community specialist perinatal mental health teams.

This includes partners, grandparents of the baby, siblings of the baby, and any significant others identified by the mother. It covers how to support and involve these family members.

The guide describes underpinning principles and key ideas for what services can do to involve and support partners and other family members, and why this is needed as a result of the impact on the whole family.

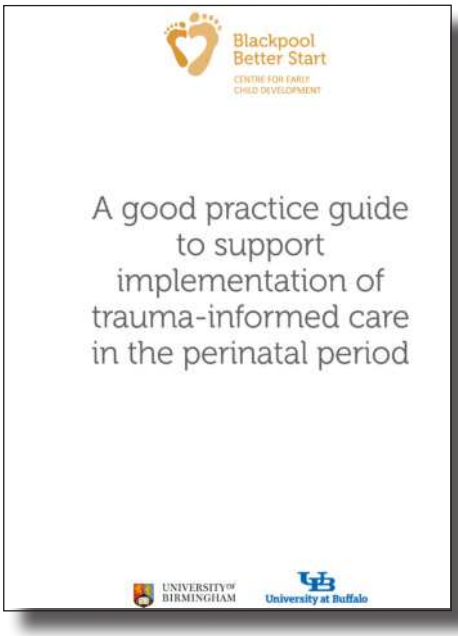
The good practice guide can be found at: https://www.england.nhs.uk/wp-content/uploads/2021/03/Good-practice-guide-March-2021.pdf.

Meanwhile, NHS England has also published 'A good practice guide to support implementation of trauma-informed care in the perinatal period'.

This guide applies to all staff (clinical and non-clinical) working with perinatal women in maternity and mental health services, although it may be more pertinent to certain roles.

It was produced by the Centre for Early Child Development in Blackpool, with support from the University of Birmingham and the University at Buffalo in the US.

The guide presents a combination of primary research (the voices of over 50 parents with lived experience of trauma and more than 470 staff, some of whom have also experienced trauma) and review of a broad range of evidence and information on what works well.



It recognises that all staff can play a part in ensuring women and their families feel safe and secure in the care setting. The guide is also for parents to help them understand what good trauma-informed practice might look like.

The guide can be found at: https://www.england.nhs.uk/wp-content/uploads/2021/02/A-good-practice-guide-to-support-implementation-of-trauma-informed-care-in-the-perinatal-period-February-2021.pdf.

NI fund to provide vital support to mental health charities

Northern Ireland's health minister Robin Swann has given further details of a £10m mental health fund providing support to mental health charities.

The grant scheme, entitled the Mental Health Support Fund, will be administered and managed by Community Foundation NI, and will be open to community and voluntary sector organisations with charitable purposes offering services for people with mental ill health throughout Northern Ireland.

Mental health charities and groups will be invited to submit proposals on key themes, all which are linked to improving the mental health and emotional wellbeing of the population.

These include talking therapies, interventions aimed at reducing pressures on mental health acute inpatient facilities for adults and children, advocacy and peer support work, and capacity building and sustainability in the delivery of mental health interventions and projects.

These interventions are key supports to tackling mental ill health as a result of the COVID-19 pandemic and will strengthen the person-centred care approach set out in the new 10 year mental health strategy.

Robin Swann said: "Our local charity sector provides important and vital mental health support services to many in our communities. It is important that those services are maintained, particularly during these challenging times.

"The new Mental Health Support Fund will equip and enable these charities in providing a wide range of support services for people with mental ill health and help to ensure that those who need to can continue to access mental health support services in the community."

MHN lead professional officer update

Dave Munday, Unite in Health @davidamunday

My last update was written a day after the second step of England's lockdown roadmap had been reached.

I sit at my kitchen table writing this one a few days after the announcement that step 4 will be delayed from the previously planned 21 June to the now hoped for 19 July.

The Delta variant has put added pressure on us all, including in the rush to get even more vaccinations done.

Compulsory vaccinations

While I would encourage everyone to get both doses of a COVID-19 vaccination if you haven't already, it was dispiriting to hear that the government appears to be poised to force social care staff to have it, and possibly health staff next.

Gail Cartmail, Unite's assistant general secretary, summarised Unite's position on this well when she highlighted our opposition and repeated the advice from the World Health Organization that 'encouragement, not compulsion' should be the way to go, for the very good reason that such an approach has been shown to work.

This argument should also not deflect the rightful criticism aimed at the government on its actions and its record in terms of care homes.

Workload pressures

It was both interesting and depressing to hear Dominic Cummings's reflections on his period in Downing Street and his thoughts on the actions and competence of the Secretary of State for Health and Social Care, Matt Hancock MP.

But let's turn our attention to another (past) Secretary of State for Health and Social Care, Jeremy Hunt MP. As chair of the Health and Social Care Select Committee, he recently published a report on its 'workforce burnout and resilience in the NHS and social care' enquiry (see https://committees.parliament.uk/work/494/workforce-burnout-and-resilience-in-the-nhs-and-social-care/).

Even before the pandemic we knew that staff in healthcare were under immense pressure. This has certainly got worse with COVID-19.

Supporting mental health nursing

In terms of my recent work on related issues, I was pleased to hear that the All-England Plan for Mental Health Nursing finally got a new date for its next meeting with the newly installed chair, Baroness Watkin, although the group has now been transformed with a different name, the 'Mental Health Nursing Sub-group'.

This has been described as a sub-group of the '50,000 Nursing Domestic Supply Board'. Interestingly only two branches of nursing have such sub-groups: mental health and learning disability.

I have asked for reassurances that this won't negatively impact on the time spent on your profession in the main board. Work also continues on the NHS England oversight group on nurse suicide.

Again, related to this wider issue, on 1 June a new helpline launched that is the 'first national free peer-led listening service for all nurses and midwives', 'Nurse Lifeline'. You can find out more via the website www.nurselifeline.org.uk or call the helpline between 7pm and 11pm Monday-Friday on 0808 801 0455.

In a previous update I mentioned our support of accelerating the implementation of Steve Reed MP's Mental Health Units (Use of Force) Act 2018.

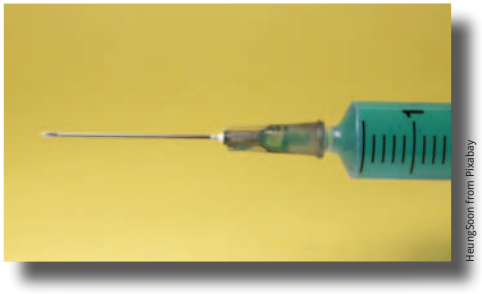
We had joined with him to express our concerns about the delay in setting out a timetable. A consultation has now been launched on the statutory guidance (see https://www.gov.uk/government/consultations/mental-health-units-use-of-force-act-2018-statutory-guidance).

Keeping connected

As always, the quickest way to hear about the work that I do on your behalf is to follow me on Twitter.

For example, followers will have seen tweets about the recent All-Party Parliamentary Group on Smoking and Health round table where a new report, with recommendations, was launched on the Tobacco Control Plan 2021.

You will also have had an account of the recent Nursing in Practice virtual conference that I chaired. ■



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How I used my perinatal mental illness experience to create a resource for families

Jane Fisher @Jane_Fisher2

I was a community psychiatric nurse on maternity leave when my life changed beyond all recognition.

Following the birth of my third child, I unexpectedly developed perinatal mental health problems. In a traumatic and sudden turn of events, I went from being a mental health nurse to being a mental health patient.

This was the start of my own personal journey and sometimes harrowing journey through mental illness and recovery.

Perinatal illness impact

Perinatal mental illness impacts all aspects of women's lives. It has a ripple effect on the entire family. Given the uniqueness of the life stage, it is the woman's identity and role as a mother that is tested and challenged.

Navigating motherhood is difficult enough, but with the complexity of mental illness it becomes an almost unbearable struggle.

Am I good enough? Am I damaging my children? These were frequent thoughts that would keep me awake at night.

Understanding the challenge

As a mental health nurse I have supported many women in their role as a parent.

I have witnessed great bravery and courage when women face their own struggles while remaining dedicated to their children's needs.

However, not until I became the mum with a mental illness did I truly realise the enormity and pressures of this challenge.

As a healthcare professional I had always advocated open, honest and age-appropriate conversations with children about maternal mental health. Now I had to put this into practice with my own daughter.

However, the acute and prolonged nature of my illness combined with the lack of specialist services at the time, made this incredibly difficult. I had no words to describe what was happening to me.

Creating the book

Two years later I had some clarity and ability to reflect. I thought about all the other families who must struggle for those words.

From this reflection came 'The sun will shine again', an illustrated children's book I have created that explores maternal mental health.

Experiencing the harrowing complexity of motherhood with mental illness led to this heart-warming story about a little girl called Faith, and her mummy who has a poorly mind.

The book is wonderfully illustrated by Amy Dignam, another woman with personal experience of perinatal mental illness.

Amy's illustrations depict the struggles of motherhood and maternal mental distress, while portraying the important messages of hope, recovery, and the power of a mother's love.

The book can be used by parents, other family members, schools and health professionals to start conversations and education around maternal mental health challenges.

Hope for the future

The message of hope is woven throughout the story. It is a message to both children and adults, that if we wait patiently, the sun will always shine again.

The book is for me as much as anyone else. I read it regularly with my

own children to help us make sense of the fact that sometimes mummy's mind is poorly.

My children are aware that minds can get poorly just like our bodies. And in my house, we talk just as much about looking after our minds as we do our bodies.

It is my hope that 'The sun will shine again' will challenge some of the stigma that is still attached to perinatal mental illness.

The idea of motherhood as being blissful and idyllic is long outdated, but there remains a degree of fear and shame in disclosing the gritty reality of experiencing motherhood with mental illness. I firmly believe there is a power in sharing our stories.

Perinatal mental health services that have lived experience and peer support embedded in the fabric of the services they provide, can impact families profoundly.

In simple terms, services that are planned and delivered carefully have the ability to reassure mothers that they are not alone, and that recovery will happen.

Supporting staff and parents

The human cost of perinatal mental illness can be devastating. For perinatal mental health care to be truly holistic, children in the family must be considered. Their needs should be acknowledged and assessed.

> "I hope the book will challenge some of the stigma that is attached to perinatal mental illness"

Health professionals need to have a wide range of appropriate resources to equip them in supporting children and families.

It is my hope that 'The sun will shine again' can be one of these tools, and help make a difference for women and families who are struggling to comprehend what is happening.

My personal mental health struggles have fuelled my passion for mental health nursing and education. If I can help another family, then something good and lasting will have come out of my greatest battle.

When I read the book to my own children, my hope is that they know perinatal mental illness will never change how much I love them.

They were and are the reason I am still here today. ■

Jane Fisher is a mental health nurse and nurse lecturer at the University of Central Lancashire.

You can purchase a copy of 'The sun will shine again' at www.thesunwillshineagain.co.uk. Bulk order discounts for health and social care are available.

Developing an interprofessional approach to undergraduate perinatal mental health education

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Abstract
This paper outlines how an interprofessional team collaborated to design and deliver a perinatal mental health workshop facilitated by practice partners. The process of design and delivery is explained, alongside evaluation comments with a view to sharing good practice and the experiences of delivering a complex topic to an interprofessional group of undergraduate nursing and midwifery students.

Key words
Perinatal mental health, education, interprofessional, undergraduate, postnatal depression, PND, PTSD

Introduction

Maternal mental health disorders are estimated to affect one in five mothers during pregnancy or in the first postnatal year (Royal College of Obstetricians and Gynaecologists, 2017).

A key recommendation from NHS England's Implementing the Five Year Forward for Mental Health (NHS England, 2016a) was to increase awareness, develop skills and improve the confidence of professionals who work with families in the perinatal period. It has been noted that mental disorders experienced by women during pregnancy and in the postnatal period are frequently "unrecognised, undiagnosed and untreated" (Centre for Mental Health and London School of Economics, 2014: 3).

Improving the care of women experiencing mental health problems perinatally was called for in the 2018 Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries across the UK (MBRRACE) report (MBRRACE, 2018).

Including fathers

There is a growing interest in the perinatal mental health of new fathers. However, there continues to be a dearth of contemporary research exploring the experiences of new fathers, and there also appears to be a challenge in applying the current evidence into practice and engaging fathers better (Bateson et al, 2017).

New fathers continue to report being ignored and excluded from perinatal health services overall (Baldwin et al, 2019; Darwin et al, 2017), ranging from being ignored during antenatal appointments to disempowerment during labour, birth and early parenting (Finnbogadottir, 2003; Hodgson et al, 2021).

It has been acknowledged for some time that fathers can experience postnatal depression (PND) at rates of around 8.4% (Cameron et al, 2016), and increasing research indicates that fathers can also experience post-traumatic stress disorder (PTSD) related to birth trauma (Alexander et al, 2019; Daniels et al, 2020; White, 2007).

Since men of childbearing age continue to be over-represented in suicide statistics (Office for National Statistics, 2020), a greater acknowledgement of their perinatal mental health needs is required in order to support them, and therefore mitigate the impact on whole families.

Identifying the education needs of undergraduates

It was identified through speaking with students and lecturers at Sheffield Hallam University that perinatal mental health was a key area of undergraduate education in need of development.

With a broad range of health

programmes offered at the university, there was a unique opportunity to develop an interprofessional workshop to investigate innovative and creative approaches to pre-registration perinatal mental health education.

Since much of the current funding for perinatal mental health training is aimed at qualified practitioners, equipping our undergraduate students with the knowledge, skills and confidence in perinatal mental health has the potential to improve their efficacy in working with families perinatally.

Research has noted that some midwives have limited understanding of mental health disorders. Furthermore, student midwives have been found to possess both limited knowledge of and confidence in working with women with mental health problems perinatally (Jarrett, 2015). Moreover, they lack awareness of referral pathways to appropriate resources or services. However, there has been some progress more recently (RCM, 2021).

Raising awareness and developing the skills and confidence of practitioners working with women and families experiencing mental health problems in the perinatal period is a key recommendation in NHS England's implementing the Five Year Forward for Mental Health (NHS England, 2016a).

Anecdotally, student midwives have suggested that they needed more taught content relating to perinatal mental health. A report by the Royal College of Midwives (2014) highlighted a lack of confidence in student midwives being able to recognise serious mental disorders.

Mental health nurses have also been found to lack confidence in working with women and families in the perinatal period (McConochie and Whitford, 2009).

This workshop aimed to support integrated care and collaborative working in order to reduce the siloed working in perinatal mental health services and promote holistic approaches to care (Bayrampour et al, 2018).

Tumisu from Pixabay

Interprofessional education

Serious case reviews and external reviews following serious incidents continue to highlight a failure in communication and effective collaboration between different professions as a contributing factor to deaths or serious injuries (Laming, 2003; 2009; Francis, 2013).

Interprofessional education theory suggests that bringing students together from different professional backgrounds has a facilitative effect on their understanding of professional roles and responsibilities, which has the potential to significantly improve care (Centre for the Advancement of Interprofessional Education, 2002; World Health Organization, 2010).

Sharing this experience at undergraduate level sets the tone for future practice and contributes to reducing professional protectionism.

Collaborative practice is fast becoming the new norm, embedded in the standards for nurse education (Nursing and Midwifery Council, 2018).

The National Maternity Review (NHS England 2016b) indicated that interprofessional learning should be at the core of pre-registration healthcare education as, because of enhanced teamwork and collaborative practice, it significantly improves patient outcomes (Davies et al, 2016).

This is supported by the National Maternity Review, which recommended that multiprofessional learning should become a central component in pre-registration education (NHS England, 2016b).

Our university is well placed to provide interprofessional education due to the broad range of health programmes offered.

This presented a clear opportunity for both lecturers and students to learn with, from and about each other (Barr and Low, 2013) in the context of perinatal mental health.

By improving the effectiveness of collaborative practice during the perinatal period, the safety of more mothers, babies and families will be ensured (Cornthwaite et al, 2015).

> "Mental illness in pregnant women often goes unrecognised, undiagnosed and untreated"

Box 1. Learning outcomes

- Identify common mental health conditions related to perinatal mental health.
- Examine the professional roles and responsibilities in relation to perinatal mental health.
- Explore the provision of voluntary organisations within perinatal mental health.
- Explore mothers' and fathers' experiences of perinatal mental health problems and identify how we can support their holistic needs.

The team

Our team consisted of interprofessional lecturers and practitioners (Barr and Low, 2013); a midwifery lecturer, a mental health nursing lecturer and a children's nursing lecturer/doctoral researcher, researching the transition to fatherhood.

In addition to the lecturing team, a practice partner from the local perinatal mental health service was involved to add both a practitioner's and expert by experience perspective.

A local perinatal mental health charity contributed to the workshop to offer a third sector organisation perspective.

The workshop

A number of learning outcomes were devised for the workshop. These are shown in box 1. The workshop ran for three hours and was interactive, using a variety of media to support learning (Grover et al, 2016).

Initially a series of icebreaker and fun activities took place to provide an opportunity for these two groups of students to become familiar with one another (Kirkham, 2021), and acknowledging the sensitive topics they would be discussing throughout the workshop.

The rest of the session was then framed around a case study, which was drip-fed to the participants.

This encouraged debate and discussion in between presentations from service providers, charitable organisations and the lecturing team (see box 2 for the topics covered).

It is important to acknowledge that the workshop addressed both mothers' and fathers' perinatal mental health needs, with the aim that a whole family approach would become normalised for these future practitioners.

Evaluation

One of the key outcomes from this training was the opportunity for the students to share knowledge and skills with other disciplines and to debate and challenge practice in a safe and encouraging environment.

The inclusion of paternal mental health and the challenges faced by new fathers was well received and a novel area of education for these soon-to-be practitioners.

Since this was a new approach to perinatal mental health education, the process of evaluation was fundamental to ensuring that the students' learning needs were met. Ethical approval to survey the students was gained from Sheffield Hallam University Research Ethics Department (Ethic Review ID: ER10418612).

Some of the qualitative feedback received is shown in box 3 to give an essence of the students' perceived benefits of this session.

Next steps

As a result of lecturer reflection, discussion with practice partners and evaluation comments from the students, there are several aspects that we would like to develop further.

- Complexity: feedback from students has shown that they would like more support in managing complex cases.

Box 2. Topics covered

1. Paternal mental health; Paternal perinatal depression, anxiety and PTSD
2. Supporting family relationships
3. Professional roles and responsibilities
4. Case study based group work to identify signs and symptoms of perinatal mental health problems
5. Addressing the challenges of assessment and identification in antenatal period
6. Anxiety and stress
7. Perinatal depression
8. Post-partum psychosis
9. Obstetric consequences of perinatal mental health conditions
10. Awareness of and communication with voluntary sector services
11. Traumatic birth, stillbirth and miscarriage
12. PTSD
13. Obsessive compulsive disorder

- Low mood: Having the confidence and skills to recognise low mood and how to support new parents with this, such as facilitated self-help and psychosocial interventions.
- Early stages of psychosis: skills in identifying the early stages of psychosis and referral pathways.

"Students had the opportunity to share knowledge and skills with other disciplines"

• Pre-existing mental health problems: collaborative working with services already involved to support families.
• The 'big conversation': having difficult conversations, how to approach mental health, providing reassurance that mental health problems do not mean bad parenting.
• Theory to confidence: how to apply the learning done in the classroom to real life practice; being realistic and understanding roles and responsibilities more.
• Increasing emphasis on new fathers' wellbeing: this is gaining momentum and must be fundamental to all perinatal mental health services in order to provide a whole family approach and improve outcomes for children.
• Including specialist community public health nursing (SCPHN) and children's nursing students: since midwives will hand over care of families to health visitors at 2-4 weeks post-birth, it is essential that health visitor students are able to feel confident in perinatal mental health. In addition, children's nurses will be caring for families in the community and in hospitals when there is an acute period of ill health or when there are additional physical or developmental needs for the child. Health visitors are a key stakeholder in perinatal mental health, working collaboratively with midwives and mental health nurses during the perinatal period.

Box 3. Quotes from students

"The best bit about the session is the facilitators joining the groups, informal interaction encouraged open discussions"

"The best bits about this session was the activity and interacting with other professionals"

"The best bit about the session was the presentation about the impact of traumatic experiences on fathers, this has made me consider my own practice"

"The scenarios were good for thinking about what actions we would take into practice"

"Meeting students from midwifery and asking questions'

"The best bit about this session was gaining different perspectives on perinatal mental health"

"The best bit about the session was using different teaching methods – group work, Padlet, videos and different presentations"

Summary

Interprofessional perinatal mental health during undergraduate training has been shown to be helpful in improving both midwifery and mental health nursing students' confidence in working with service users in this area.

Students appreciated a balance between academic, service provider and researcher delivery, and benefited most from being able to discuss case studies and practice with people from other disciplines. ■

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‘Irene’s Ghost’: telling the untold story of my mother’s postpartum psychosis

Iain Cunningham @_iaincunningham

Introduction

There’s often a pressure that comes with making something personal public. As a filmmaker who has tackled a personal story, I have sometimes been asked, “why did you make a film about it?” or “why did you choose to expose this story?”

The implication is occasionally that maybe this stuff is better kept personal, and not shared at all.

Why do we tell any personal stories about mental health and make them public? I think for me it started as a memorial.

My mother, Irene, passed away when I was nearly three years old. My Dad remarried, the lines started to blur, and it was never really spoken about again.

As a result, I grew up without knowing anything about Irene, or what had happened to her. I had no real memories of her, but I could still remember how it felt to lose her.

Like any child, my imagination was pretty powerful, and the images of my childhood are still very strong. I’d see a thistle seed blowing past and think it was her, or see her in a bright full moon. I also had very vivid nightmares.

When I was 18 I was given a box of her things, including the first photographs I’d seen of her and of me as a baby. I learned a bit about her then, but it still felt like a taboo subject.

It was only years later, when I had my own child, that I fully realised the enormity of losing my Mum at that age and the impact on me of the silence around her.

By that age I’d had some issues with mental health myself, with anxiety. Watching my daughter grow made me think back to my babyhood, and about Irene.

I was desperate to find out more about her. My Dad had always found it very difficult to talk about, so we’d avoided the subject, and her family had disappeared from our lives soon after her death.

Making the film

I decided to try and find other people who knew her and to try and get to know her through what they could tell me. I filmed what I was doing, and eventually it grew into a documentary film called Irene’s Ghost, which was broadcast on TV last year.

At the beginning I just wanted to get to know her and feel a connection

> "We enjoyed at least a year together with her partially recovered and looking after me"

to her. I put an advert out, and found estranged family members and friends, including her best friend Lynn, who told me about their joy-filled teenage holidays in Margate.

A picture slowly formed of a shy but fun loving young woman, with a big smile like mine.

I started to retrace some of her steps, visiting the ballroom she danced in, the tights factory she worked in, and the woods she played in as a child.

I grew up around all these places, not knowing the connection with my Mum, and they all held a bit of her in them.

The film uses animation in places to express that mix between the real and the imagined, memory and reality.

In part, the film is a love letter to a lost mother, and in other ways a sort of emotional detective story.

People described what happened to Irene in so many different ways. No one could really say exactly what her illness had been, and that was very confusing to me. It was a blood clot, or a stroke, or a heart attack, but none of her friends mentioned mental illness. The family story had been that she had been in a coma and then died.

Discovering the truth

Through a long process piecing together records and differing accounts, it eventually became clear that she had suffered from postpartum psychosis, with a subsequent bipolar illness.

She'd had a very severe initial illness, involving catatonia and deep delusions. After spending nearly a year in hospital, she and I enjoyed at least a year together with her partially recovered and looking after me.

She passed away from heart complications on a psychiatric ward following a relapse. It was a lot to take in, and very painful to read and to hear.

I had never heard of postpartum psychosis, and started to try and learn what I could about perinatal mental health from health professionals and people with lived experience.

It's much easier now to access information and find out about it, but it's still not very widely known.

Personal stories from women with lived experience have added greatly to that resource, to help families understand what is happening.

I had great help from a charity called Action on Postpartum Psychosis, who introduced me to mothers who could tell me about their experience.

At the time, I don't think even my Dad really understood what was happening, as his wife and the mother of his newly born child shrank and changed and eventually disappeared from his life.

It seemed like a confusing and utterly terrifying thing for both of them to experience.

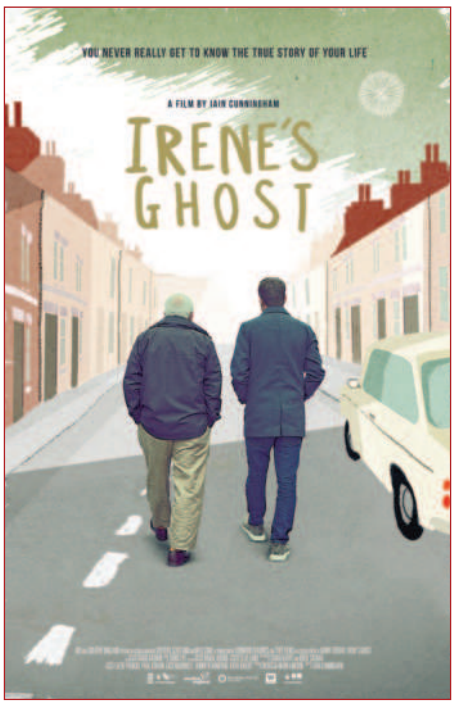
Talking and healing

It was a shock to me to discover how devastating her illness had been, and it made me think about the impact it must have made on my Dad.

There wasn't much family support at the time, and the general advice was to "be strong and carry on" and to protect me as a child by not talking about it.

This idea of stoic silence is embedded in the male psyche, but can sometimes be quite damaging. The heart of the film is the relationship between my Dad and I as we started to understand each other a bit more deeply and gradually began to talk.

We had never really spoken about the loss we had both shared before, and maybe could have helped each other earlier if we'd found a way to talk about it. That process was very healing for both of us, and has continued after the filming stopped.



One thing that often comes up in question and answer sessions with audiences after film showings is that so many families have similar stories of things they find difficult to talk about. Sometimes it takes a personal story, a film or an article to draw that out into the open.

Screenings of the film have been quite cathartic. Often men would come up to me afterwards and talk to me about a struggle to talk about mental health within their own family, or about their desire to talk to their dads.

In a dark room after a communal emotional experience it can be easier to share. I've missed being a part of that in locked down, closed cinema times.

In the last few years, there is far more public awareness and a much more receptive climate to this kind of conversation.

Telling our stories

Sharing personal stories has become the currency of public health campaigns and mental health is increasingly more visible.

The idea that mental health problems are something to be ashamed about and hide away is slowly being eroded, but I'm sure that history still partly colours our view of mental health.

I live now near an old asylum that's been turned into flats, and in the meadows around it there are 3,000 former patients who are buried in unmarked graves.

There's a simple memorial to mark it which was erected recently. It reads "Remember me when I am gone away", from a poem by Christina Rossetti.

In the final scene of the film my daughter is riding around the meadows on her bike, and we're talking about the importance of memory, and keeping memories alive.

Telling personal stories, sharing about the experience of mental ill health, and the ripples it makes in the lives of families and communities, all act as markers that say that these lives are important.

They mean something. They stop lives from being erased, as they were in the not too distant past.

So why do we tell personal stories? Sometimes it's part of a therapeutic process. Sometimes it's an act of claiming space for something or giving a voice to something that has been largely silent.

It can be a window into an experience we might not fully understand. It can help other people, or even help you to reach out to people who can help you.

It can build communities, or even rebuild communities. Sometimes it's just because we want to tell the story, and feel like it's ours to tell. ■

Iain Cunningham is a film-maker.

The DVD of Irene's Ghost was released in May 2021 to coincide with Maternal Mental Health Awareness Week.

Irene's Ghost is available on demand on Sky TV, and some Now TV and Virgin TV packages. It's also available to rent or buy on Amazon Prime, Youtube, iTunes and Rakuten TV. For more information see www.irenesghost.com

Speak up: prison is not the place for pregnant women

Vanessa Gilmartin Garrity @VanessaRNMH

Imagine that you've just been sentenced to prison for a non-violent crime. You stole some food from the local supermarket and some toys for your daughter's birthday.

You did this because you're poor. You've suffered with depression and anxiety for most of your life and you use drugs and alcohol to self-medicate, though you haven't since you realised you were expecting another baby. It wasn't a planned pregnancy, but that doesn't mean it's not a wanted one. You're good at being a mum and you're determined to do things right by the baby, but life is a constant struggle.

There is no mother and baby unit in the prison where you are on remand. Should you ask for a transfer to another prison, where you can keep your baby with you but your older children won't be able to visit because of the distance? If you don't apply your baby will probably end up in foster care, alongside your other children. You don't have any family to call upon and you're no longer with the baby's father.

You decide to apply. It takes a couple of weeks before you are brought in front of the panel that determines your fate. In the meantime, you're in a cell on a regular prison block. You share your cell with another woman. You've asked a few times for an extra pillow to support your bump, but it hasn't arrived. You don't want to make a nuisance of yourself because the sound of constant alarms reminds you that there are other priorities on the wing and it's always short staffed. You've been told that getting a place on a mother and baby unit is a privilege so you don't want to rock the boat.

It is easy to 'other' people in the prison system, to take a collective view that women in prison are all mad, bad, and dangerous. The more we remove people in prison from our day-to-day consciousness, the more that our perceptions are shaped by the stories that we read about in the tabloids. If we believe that everyone in prison is there because they have committed a heinous crime, it is easy to dehumanise and then ignore the complex social inequalities that blight many of these women's lives and separate our stories from theirs.

Having worked in prisons as a perinatal mental health nurse, I can confidently say that none of the women I supported were there because they were dangerous, scary or bad. They were all women who were in prison because of the unlucky cards that they had been dealt in life. Poverty, trauma and mental health difficulties cast a long shadow over their day-to-day lives.

These women were mothers like many of us, who would do anything for their children. In desperation, this might include stealing or sex work, as a means of survival. It's not surprising that they might also use substances to numb the pain of a bleak existence.

In this country there are only a handful of mother and baby units in prison. In making a decision about who to award a place to, the best interests of the child is paramount. The length of sentence is taken into account because these units are only able to accommodate babies up to the age of 18 months. After that, it is considered detrimental to a child's development. The mother has to demonstrate that she would be able to assume parental responsibility for her child and that there is no evidence of behaviours and attitudes that are detrimental to the care of other residents.

In short, the panel must make complex, highly emotive and life-changing decisions about whether a mother is able to remain with her baby or whether there will be an enforced separation. Sadly, not all women are successful in securing a place.

Mother and baby units in prisons are not mental health units, nor are they commissioned to support women who are acutely mentally unwell. Mental health practitioners are not based on the units and resources only allow for support to be offered on a sessional basis. Women who need more intensive support during the perinatal period are generally referred to secure mental health services. However, there are no secure perinatal mental health beds where a mother and baby can stay together, so generally in these situations a mother remains on the unit during pregnancy and then babies are separated from their mothers after birth, simply because there is a lack of provision that enables them to stay together.

Recently, progress has been made to improve access to specialist perinatal mental health support. However, the debate continues about whether prison is the right place for pregnant women generally – and particularly where an alternative community facility could be offered.

Prison is most certainly not the right place for women experiencing serious mental health difficulties during the perinatal period. There is clearly an urgent need to address inequalities in the system that exclude our most vulnerable families. ■

Vanessa Gilmartin Garrity is a mental health nurse and independent consultant

Connection in a disconnected environment: Can pregnant women in prison truly connect with their babies?

Tânia Rodrigues @TRClinPsych

Our brains are wired to connect from the moment we are born. It is through interactions with a sensitive and attuned care-giver's brain that the infant develops the capacity to attune and empathise, enabling them to mentalise and develop sophisticated social skills.

These sophisticated social skills allow us humans to cooperate in large groups which is in essence the reason for our survival as a species.

When we're not focused on a task, the brain's default position is to make sense of our relationship with others.

Infants are in this permanent default position and their need to attach to a parent/care-giver is the foundation on which latter attachments are built.

The lack of an attuned and emotionally responsive carer can be a source of emotional distress to a young infant.

Over prolonged periods of time, exposure to such distressing experiences negatively impacts on cognitive and emotional neurodevelopment as infants fail to experience co-regulation with another, thus hindering their ability to develop emotional regulation and self-soothing skills.

ErikaWittlieb from Pixabay

This lack of attunement significantly limits infant's ability to develop secure enough attachments to others and to develop a sense of 'feeling felt' that emerges in close relationships (Siegel and Hartzell, 2003).

When this fails to happen it significantly impacts infant's ability to develop self-esteem and self-confidence to allow them to explore the world and take measured risks.

Social pain hurts like physical pain. Our identity, our most private sense of who we are, is intimately linked to the important people and groups in our lives and how they accept and interact with us. When humans experience loss or rejection, the brain responds in the same way it does to physical pain.

The current pandemic context has for most of us highlighted the importance and role of relationships in our lives. We have collectively, though to varying degrees, experienced a sense of disconnect not only from our daily life routines but also from our usual roles within our families and friendship networks.

The imposed restrictions, even if, within the context of keeping us safe were experienced as impositions that forced us into compliance, losing choice and control over our lives.

The impact of such restrictions on our daily lives and sense of disconnect is perhaps a good window into understanding the circumstances of mothers in prison and how this affects the next generation of babies born in prison or children growing up with incarcerated parents.

According to Felliti et al's (1998) research into adverse childhood experiences (ACEs), there is a strong relationship between exposure to abuse and household dysfunction during childhood and mental health difficulties in adulthood.

ACEs are defined as childhood abuse (psychological, physical and sexual abuse) and household dysfunction which includes substance misuse, mental illness, domestic violence, incarceration of a parent.

However, it is important to keep a critical appraisal of this research in mind, as its focus on the biomedical moves us away from socioeconomic factors and its social justice underpinnings (Taylor-Robinson et al, 2018).

It is well known that women, and particularly pregnant women in prison, are among the most vulnerable and in most need of extra care.

It is also well known that a substantial number of women in prison have been victims of crime and many have multiple complex needs and traumatic

experiences including having violent partners, having suffered childhood sexual abuse and rape, struggling with addiction, trafficking and mental health difficulties (Abott, 2018).

Hence women – and pregnant women in particular – accessing the criminal justice system are often a marginalised group of individuals who have endured significant traumatic experiences and social disadvantage.

It is estimated that in England each year around 600 pregnant women enter prisons and approximately 100 babies are born in prison (Center for Women's Justice, Mothers in Prison, 2020).

Other pregnant women are held under immigration rules, having committed no crime (Shamsie, 2020).

The Farmer Report (2019) said: 'Healthy, supportive relationships are not just "nice to have" for every woman in the criminal justice system. They are utterly indispensable if she is to turn away from criminality and contribute positively to society: relationships she can rely on are a 'must-have' for her rehabilitation.'

With this context in mind, when thinking about mothers and pregnant women in prison the focus should be on fostering connection between mother and baby and mother, children and family to ensure that we can minimise the impact of intergenerational trauma into the next generation.

The complexities of 'mothering' from prison are vast and can impact negatively on both mothers and children experiencing separation from not only the mother but in many cases from the family due to being taken into care.

As a clinical psychologist working within a female prison service with a mother and baby unit, it has been my experience that despite much effort being placed on improving the life of mothers – and pregnant women specifically – in prison, the challenges remain significantly high.

Prisons are overwhelmingly male environments. Within the female prison I am based at, despite the main governor being female, the majority of the senior team from governors, custodial managers and senior officers are male.

> "Officers who are more nurturing in approach may be perceived as being too soft"

This male/female balance is important when dealing with issues around motherhood and pregnancy, as this will have an impact on the expectations and perceptions of women by staff.

One of the most significant challenges I have encountered while supporting pregnant women both located in the main wing as well as in the mother and baby unit is the loss of identity as mothers.

Pregnant women or new mothers are still first seen as 'offenders' and as such the expectation is that they will continue to engage with the prison regime despite the significant physical and emotional changes they experience.

Despite allowances being made for women returning from hospital after giving birth this is still often seen as a privilege rather than a right.

The issue of risk management vs opportunities for mother and baby bonding remains an area that is difficult to manage and will continue to be so until there is an acceptance and understanding of the crucial role of bonding and attachment for emotional and psychological wellbeing of both mothers and babies.

This lack of clarity regarding women's identities as mothers vs offenders within mother and baby units creates another challenge, as the restrictions applied to the mothers have a direct impact on the choices available for babies.

Issues such as choice to parent a child based on cultural practices is also limited and this starts right from the inability to choose a birthing plan, a birthing partner and the appropriate family support, which is such an important part of the mothering experience as a rite of passage in so many cultures.

The prison culture is not nurturing and this often adds pressure to prison officers working with pregnant women and within the mother and baby unit, as their 'custodial' role can often clash with the 'carer' role when in a nurturing environment.

Officers who are more nurturing in their approach can also find themselves struggling to navigate through the rigid procedures applied to mothers in prison, while also being targeted by colleagues who may perceive them as being 'too soft'.

Appropriate training for prison officers, healthcare professionals, nursery staff or any other relevant professionals on the impact of trauma on neurodevelopment, attachment and social justice is crucial in minimising intergenerational trauma for babies born in prison.

Embedding a trauma informed approach offers support for both staff and prisoners in moving away from a custodial and medical model to a model of connection and attunement. ■

Tânia Rodrigues is the national lead consultant psychologist and trauma informed clinical lead for a mental health service within HM Prison Service

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Black, Asian and minority ethnic women and access to perinatal mental health services

Elaine Amoah

Before the COVID-19 pandemic, I completed a study on Black, Asian and minority ethnic women and access to perinatal mental health services for low mood and depression.

The research highlighted inequalities in accessing services for Black, Asian and minority ethnic women, which is ongoing and urgently needs addressing.

This is especially important with the current circumstances of the pandemic as evidenced by the recent report 'Maternal mental health during a pandemic', which was commissioned by the Maternal Mental Health Alliance and conducted by the Centre for Mental Health, and the Parent-Infant Foundation's 'Babies in Lockdown' report.

It is paramount that the mental health needs of women from Black, Asian and minority ethnic communities are recognised and that they receive adequate treatment supporting their journey to recovery in the perinatal period.

Key research findings

My research revealed:

- 98% of women surveyed were willing to receive treatment for their mental health, but around one-third (32%) had not received treatment including talking therapies such as cognitive behaviour therapy and counselling.
- Around one-fifth (20%) of women reported that they did not visit healthcare professionals to talk about their low mood and depression.
- One of the major barriers to accessing perinatal mental health services was 'Wanting to solve the problem on my own'.
- Internalised stigma, perceived public (social stigma), and treatment stigma impact Black, Asian and minority ethnic women and act as barriers to receiving treatment.
- Internalised stigma (having stigmatising beliefs about oneself) was found to be a significant predictor of perinatal depression. Around 1 in 8 of the women surveyed were identified as having experienced alienation and social withdrawal (13% and 12% respectively).
- Around one-third (30%) of the women surveyed felt 'Receiving treatment for emotional or mental problems carries social stigma'.
- The major treatment stigma-related barriers to accessing services were found to be 'Concern that I might be seen as a bad parent', 'Not wanting a mental health problem to be on my medical records', 'Concern that my children may be taken into care or that I may lose access or custody without my agreement', and 'Concern that I might be seen as weak for having a mental health problem'. This is significant as Black and Brown women may feel that they have to uphold the narrative of being a 'Strong Black Woman' or meet expectations to 'deal with it'.

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Recommendations from the research

My research highlighted several recommendations to improve the situation.

Group-based intervention

A group-based intervention for Black, Asian and minority ethnic women may allow a safe space for opportunities and expressions of emotion regarding mental health and provide a space for a network of women with shared experiences to feel less alone.

Internalised stigma was found to play a significant role in relation to perinatal depression and internalised, perceived public, and treatment stigma were found to have an association with one another.

Preventing the impacts of internalised stigma such as alienation and social withdrawal is more important than ever before with COVID-19.

Support network

Services need to ensure that any of the support networks (including possibly a partner and/or family) of Black, Asian and minority ethnic women are included throughout care and treatment so that they have the support needed to recover and do not feel that they need to walk the journey to recovery alone.

Partners and/or families can also play an important role in identifying symptoms of perinatal mental depression. In addition, families can be supported to better understand mental health and wellbeing as a possible benefit to reducing perceived public and treatment stigma.

Social networks can be used as a foundation of support, allowing women to talk about their issues and access service provision.

Meaningful clinical support

Services need to provide meaningful and helpful advice throughout the perinatal period.

When asked to rank healthcare professionals, the women surveyed were most willing to talk to their doctor about their low mood and depression as 'They will provide me with the most meaningful advice and treatment'.

Healthcare professionals (all ethnicities) also surveyed reported 'Initial response: initial advice and support given to women in the perinatal period' as the highest demand in terms of care pathways for women from Black, Asian and minority ethnic communities, followed by 'Initial response: initial advice and support given to health professionals (such as GPs or midwives)'.

There is an opportunity to use maternity services, voluntary organisations and available social networks and resources within the local community to improve awareness through social capital, social exchange, and community empowerment.

Services need to ensure early recognition of emotional difficulties and access to information and advice is provided as this is central to journeys to recovery and ensuring suitable interventions are in place.

Opening a conversation

Healthcare professionals, especially in primary care services, need to ensure that they bring up the topic of mood, for example 'upsetting feelings around birth'.

The women surveyed were found to be most comfortable answering questions about mood at home, then subsequently discussing their responses in their next visit with their health provider.

This suggests a safe space such as their home is preferable for expressing feelings as well as the opportunity to discuss responses.

Approaches that enable women to describe their feelings to healthcare professionals will have an effect on whether mental health difficulties are detected, and the timeliness and nature of the support that is offered.

Co-production of services

Women from Black, Asian and minority ethnic communities can help with public health initiatives and NHS services to promote more helpful messages about mental health and seeking support.

This will allow the collaborative discovery of solutions to mental health difficulties using the power of lived experience to better build on cultural sensitivity, understanding and knowledge. ■

Elaine Amoah is an assistant psychologist at the South London and the Maudsley NHS Foundation NHS Trust

A version of this article first appeared on the Maternal Mental Health Alliance website, and it is reproduced with the kind permission of the MMHA

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Inside the mind of... Raja Gangopadhyay

Mental Health Nursing meets the lead consultant obstetrician in perinatal mental health at West Hertfordshire Hospitals NHS Trust, and founder of the International Forum for Wellbeing In Pregnancy charity @RajaGangopadhy3

What is the biggest challenge you are facing at the moment?

Perinatal mental health (PMH) illnesses are very common during pregnancy and within one year of childbirth, affecting up to 1 in 5 women. This is one of the leading causes of maternal death all across the UK and globally.

Without a doubt, the COVID-19 pandemic has added additional stress and challenges for mothers and their families, making them even more vulnerable and susceptible to develop PMH conditions. This is especially true for those with a pre-existing mental health illness.

It has undoubtedly been an emotionally challenging journey for me to see the devastating psychological impact of covid and hear the real-life experiences of the mothers in my clinics.

Many of them lost their livelihoods, with serious worries about their finances to meet the increasing expenditure after the childbirth. Due to the lockdown, school closure and other social distancing measures, mothers have often felt isolated and could not attend in-person antenatal classes or mother and baby groups to meet others to socialise and get peer support.

There have been restrictions on the partners visiting the wards, antenatal clinics and scan appointments. I have seen mothers breaking down in tears when they felt like having their partners by their sides at the time of making important decisions about their care and birth. Thankfully things are improving with the ease of lockdown measures.

> "Lockdown has meant mothers have felt isolated and unable to socialise"

There are growing concerns about the significant rise of domestic abuse in the UK during this pandemic. We know that domestic abuse can start or worsen during pregnancy and postpartum, and can have a devastating impact on the mental health, mother-child bonding, and sometimes maternal death. Mothers could find it difficult to seek help, especially when the consultations are taking place online and they are trapped in the home with an abusive partner with a lack of privacy.

On the other hand, we must not forget the couples with infertility. Many IVF treatments were cancelled or delayed in the early stages of the pandemic, adding to the misery in the traumatic journey of infertility.

It is still early days to know the exact impact of the pandemic on PMH illnesses and the mental health of partners. More research is required in this area.

What is the biggest opportunity?

The pandemic has certainly opened up new opportunities for patient care through effective use of virtual consultations. However, patient selection for virtual consultation is an important issue, based on the severity of illness, disabilities and access to the internet/ mobile device.

There have never been such wonderful opportunities of virtual learning and continuous professional development.

I have seen a real community spirit and togetherness, especially when I became very unwell last year with COVID-19. I received relentless support from neighbours and local volunteers, and will remain ever grateful to them.

What advice would you give to mental health nurses?

First of all, look after your own physical and mental health in spite of your heavy workload during the pandemic, and ensure adequate sleep, healthy food and regular exercise. This is important to prevent burnout. Many NHS trusts and private employers have employee assistance programmes, so contact them if required. If you are working from home, ensure regular breaks and good posture to prevent backache and other musculoskeletal injury.

While caring for mothers with PMH illnesses, there are some key things to remember.

PMH conditions can deteriorate very rapidly. If you do not have expertise, experience or training in managing PMH illnesses please escalate or seek help from the specialist PMH team without delay. Your prompt action can save a life.

PMH illnesses can cause pregnancy complications, such as pre-eclampsia, premature birth, fetal growth restriction (leading to low birth weight baby). They can affect bonding and attachment, infant mental health, and the future physical

and mental health of the unborn child. Therefore, timely diagnosis, care and support are vital.

Many women believe that this is a sign of failure of being a good mother, a sign of weakness or a lack of confidence in their parenting capacity. We must reassure them, as these are not true.

Many mothers suffer in silence – 7 out of 10 mothers do not either disclose their symptoms or underplay the severity of their illness. This is due to stigma and shame in our society, so our approach should be non-judgemental. Many also are scared that their child will be removed by social services, which is a myth.

Many psychiatric medications can be used safely during pregnancy and breastfeeding. Women should not be stopping their medications without medical advice when they discover they are pregnant. Ensure they are supported with evidence-based information.

PMH illness can happen for the first time during perinatal period, completely out of blue, and in the absence of any prior history of mental health illness.

Be aware of domestic violence and other challenges mothers are facing during the pandemic. Therefore, always think outside the box.

Remember that PMH illnesses can affect the mental health of the father too.

Consider pre-conception counselling (if available in your area) for women with severe mental health issues, or those who are on medications with potential teratogenic effects (such as lithium).

Finally, empathy, care, compassion and kindness are keys at every step of your care, keeping mothers and families at the centre of everything you do. Remember that you can make a huge difference in their lives, regardless of your job role.

What would you do if you were made PM?

My wish list is long! I would like to see mandatory health education on leading a healthy lifestyle in schools and universities, ensuring good diet, regular exercise, adequate sleep and stress management techniques.

These measures can prevent obesity, chronic conditions, and some cases of cancer and mental health illnesses.

I would invest in preconception care, encouraging mothers in optimising health even before pregnancy whenever possible.

A part of my health budget would go towards developing robust peer support in PMH with mothers with lived experience, care pathways for all women with birth trauma, and dedicated mental health support for the fathers/partners who are affected too.

What's the biggest professional decision you've had to make?

During a night shift in the early days of my training in obstetrics and gynaecology, I came across a mother who developed severe postpartum psychosis.

The course of my life changed when her husband asked me the following day what the obstetricians could have done differently during pregnancy to prevent this condition. I was speechless and did not know the answer.

That day I made a decision to work as an obstetrician with a special interest in PMH in the future.

After I completed my further training, I was fortunate to get a job as a consultant obstetrician and gynaecologist, and lead obstetrician in PMH.

I soon realised the importance of raising awareness of the importance of mental health and wellbeing during pregnancy. Since then, I have campaigned extensively for better PMH care within the maternity units.

To raise awareness, I organised community events locally, nationally and internationally. Notably among them were events at the House of Commons, which I organised annually for three consecutive years (2016 to 2018). People attended the events from all across the UK and abroad.

Throughout my career, I have seen the important role of the obstetricians and the midwives in developing robust care plans during pregnancy for early diagnosis and treatment of

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PMH conditions.

It may not be always possible to prevent such a condition developing in the first place, due to the very nature of the illness. But morbidity and mortality can definitely be reduced, and full recovery is certainly possible.

This is why I am dedicated to the training of the maternity staff to help them develop necessary skills in PMH.

I founded a registered charity, the International Forum for Wellbeing In Pregnancy (www.ifwip.org), with an aim of improving health and wellbeing during pregnancy through evidence-based information and setting up a global pregnancy wellbeing programme.

What is your ambition/ working goal?

As I developed long COVID symptoms following a severe infection last year, full recovery is my first priority.

Sadly, inequalities in PMH care still exist in our maternity units in many parts of the UK. Therefore, I would like to continue my advocacy and campaign for a more standardised care pathway at every maternity unit across the UK following NICE guidelines.

I would certainly like to get more involved in training in PMH and continue my work through my charity. ■

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