



Spotlight on maternal mental health: a prepandemic and postpandemic priority

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Annually in May, there is a spotlight on maternal mental health (MMH) globally. In the UK, MMH awareness week is coordinated by the perinatal mental health partnership (@PMHPUK) (3 May 2021 to 9 May 2021)¹; while in the USA, 'The Blue Dot Project'² uses a blue dot as a symbol for unity and awareness for those living with mental health (MH) conditions.² This annual focus enables professionals, stakeholders and individuals to raise awareness and influence policy on this critical issue. Evidenced based nursing will be supporting MMH Awareness week by publishing a series of blogs representing a range of views during May 2021.

Perinatal mental health (PMH) encompasses any MH condition affecting people during pregnancy and in the first year after having a baby.³ This includes conditions ranging from mild depression and anxiety to psychosis; pre-existing MH and MH recurrence during pregnancy.³ PMH conditions can be pregnancy specific such as tokophobia (fear of childbirth), or postpartum traumatic stress disorder; or be more generalised, and range in the degree to which they can impact on quality of life. In general, PMH conditions affect 10–20% of pregnancies, although reported prevalence rates differ by classification and severity of disease.⁴

Those with mild to moderate PMH conditions may self-manage using strategies such as journaling⁵ and mindfulness.⁶ Techniques to prepare for labour, such as hypnobirthing may have an impact on anxiety fear.⁷ Medical treatment must be considered in parallel with individual medical history and decision-making should happen in partnership with a PMH specialist.³ Access to specialist services is essential; in 2015 a task force highlighted gaps in service provision across the UK.⁸ Following investment, services improved supported by an ongoing campaign to 'turn the map green'.⁹ Many PMH teams are multidisciplinary, with psychiatrists, MH nurses, social workers and nursery nurses,¹⁰ however, little evidence exists on the most effective model of community and inpatient care and access to services varies globally.¹⁰ Acceptance and stigma are also barriers to care for MH conditions, which the campaign for awareness hopes to address.¹¹

Identification and opportunity for disclosure of MH concerns should remain a priority for healthcare professionals with use of mandatory inquiry and screening tools common practice.¹² Additionally, opportunities for active listening are required to facilitate disclosure, following which a sensitive and effective response is needed, underpinned by healthcare staff awareness and training.

Stressful life events are associated factors in the development of PMH issues³ and the last 12–18 months have been stressful for families everywhere. On 12 January 2020, the WHO confirmed a novel coronavirus, later to be named SARS-CoV-2 or COVID-19. The Royal

College of Obstetricians and Gynaecologists and Royal College of Midwives rapidly produced clinical guidance for doctors, midwives prioritising the reduction of transmission of COVID-19 to pregnant women and the provision of safe care to women with suspected/confirmed COVID-19.¹³ Many pregnancies would be impacted globally.¹⁴ The priority was to reduce social contact reducing the number of antenatal and postnatal contacts in the UK¹⁵ and elsewhere. Many hospital services were reconfigured due to the unprecedented demands, with more than a fifth of birthing centres and a third of homebirth services closed due to midwifery shortages.¹⁶ There were calls for the focus of healthcare professionals to be on social support for mothers during lockdown¹⁸; recognising that sources of support help mothers to maintain their own MH and their capacity to cope with the demands of being a mother.¹⁸ Survey respondents (n=1451) identified potential barriers including 'not wanting to bother anyone', 'lack of wider support from allied healthcare workers' and concerns such as acceptability of virtual antenatal clinics, the presence of birthing partners and rapidly changing communication methods.¹⁹ Several recently published papers report similar results of online surveys undertaken during the lockdown in various countries.^{20–22}

There is a need for extra vigilance as we remain in and recover from the pandemic. Maternal suicide remains the leading cause of direct deaths occurring in the year after the end of pregnancy,²³ with psychiatric illness (including drugs and alcohol related deaths) being the fourth overall cause of death after cardiac, thrombosis and neurological causes.²³ Sadly, a recent UK report²⁴ identified that four women died by suicide during March to May 2020, echoing concerns raised in previous mortality reports.²³ Data from Australia²⁵ and the USA indicate a similar trend, with organisations such as *2020mom* campaigning for the USA to begin tracking maternal suicide rates.²⁶ A review of perinatal suicides in Canada over 15 years,²⁷ found that mood or anxiety disorders (rather than psychotic disorders) were common, and more lethal means (hanging or jumping) were used than in non-perinatal suicides indicating suicidal intent.²⁷

Healthcare professionals should not underestimate the potential consequences of declining PMH and should be vigilant to screen, enquire and refer. COVID-19 has resulted in changes to service provision, face to face contacts as well as significant depletion in the MH of the National Health Service workforce.²⁸ Now more than ever, campaigning on MMH needs to focus on awareness, action and policy, to support those in need of support and those required to provide it. Join us with #maternalMHmatters (w/c 843).

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