Appendix B: Maternal Mental Health Survey

Introduction

Suicide is a leading cause of maternal death in New Zealand (PMMRC 2011) as in the UK (CMACE 2011b). Mental health problems are common during pregnancy and the postnatal period. At least one in 10 women experience depression during pregnancy, and a similar number are depressed following the birth of a child (O'Hara 1984; Bennett 2004; O'Hara and Swain 1996). Psychosis (a serious illness) complicates the early postnatal period after two in 1000 pregnancies, and women with some pre-existing mental health conditions such as bipolar disorder are at high risk of relapse (50–70%) even if they have been previously well (Weick 1991; Robertson 2005). Anxiety disorders are also common (Ross and McLean 2006), and there are some that are specific to the perinatal period such as tokophobia (Hofberg 2000). The Fifth Annual Report of the Perinatal and Maternal Mortality Review Committee (PMMRC) recommended that lead maternity carers (LMCs) ask about current mental health, past mental health and family history of mental health problems at the booking visit (PMMRC 2011). It is recommended that a woman's mental health history be shared between general practitioners (GPs) and LMCs when the LMC is other than the GP. It is suggested that women with a history of serious mental illness should be referred to mental health services for monitoring and support during pregnancy, until three months postnatal. These guidelines are supported by the New Zealand Guidelines Group and the NICE guidelines (New Zealand Guidelines Group 2008; National Institute for Health and Clinical Excellence 2007).

These guidelines require that LMCs enquire about a pregnant woman's mental health as part of her general history. LMCs need to feel comfortable in doing this and, if necessary, need to know where to seek further advice or where to refer women if required. This involves information sharing, and the interfaces between LMCs, GPs, maternal mental health services and generic mental health services are important. We set out to investigate whether, in fact, LMCs were routinely enquiring about mental health history, how comfortable they were in doing this and whether clear pathways for referral existed if needed. In addition, we asked about existing mental health services and whether there were difficulties in accessing services or problems in LMCs accessing support when deciding what management plan may be optimal for a particular woman. Questions were also asked about inpatient mental health facilities, as there is no mother and baby unit in the North Island to which mentally ill women can be admitted with their infants. In contrast, the South Island has such a unit in Christchurch. Maternal mental health services are configured differently throughout the 20 DHBs in New Zealand for a variety of reasons, and the aim was to understand any problems encountered by LMCs in daily practice.

Design

The Maternal Mental Health Services Survey was opened on Survey Monkey on 20 October 2010 and closed on 4 February 2011. Respondents were asked if they routinely asked women about their personal and family history of mental illness. They were asked if there was a specific referral pathway if a problem was identified and about access to services.

Questions asked were:

- Which DHB do you primarily work at?
- Which professional group do you identify with?
- Are there specific questions about the woman's personal and family history of mental illness included on the clinical notes that you routinely use when assessing a woman presenting for maternity care?
- Is there a specific referral pathway for women identified as having an existing mental health problem or being at high risk of developing mental health problems during pregnancy or postpartum?
- If past mental health history is identified, to which service(s) is a referral made?
- Describe the process for an acute mental health admission.
- If the mother is admitted, do the inpatient facilities allow her to be admitted with her baby?
- If the mother is admitted, is she admitted with the baby or separated?

- Do you have a specialised maternal mental health team?
- Can you refer a woman directly to this service?
- Do you have access to general psychiatric services?
- What other psychiatric/mental health services do you have available for high-risk women? Please describe.
- What psychiatric/maternal mental health services does your area lack?
- What is your level of comfort in asking a woman about her personal mental health history?
- Did you receive any training to ask questions about personal mental health history?
- Do you think you would benefit from more training?
- Do you have any further comments?

Results

The survey was conducted via Survey Monkey. It reached approximately 1000 LMCs and generated 398 responses in all. The respondents were midwives (89.6%), obstetricians (9.3%) and paediatricians (1.1%), and local PMMRC coordinators were also represented. LMCs from all DHBs were represented, but Canterbury participation was the highest at 17.7 percent of the total, which was disproportionately high for that DHB.

The majority of LMCs (74.2%) routinely ask specific questions about mental health history, but a significant 25.8 percent do not. Only 60.1 percent identified a specific referral pathway if a woman is identified as having an existing mental health problem or being at high risk.

4. Are there specific questions about the woman's personal and family history of mental illness included on the clinical notes that you routinely use when assessing a woman pressenting for maternity care?

	Response Percent	Response Count
Yes	73.9	266
No	22.8	82
Don't know	3.3	12
	answered question	360
	skipped question	10

5. Is there a specific referral pathway for women idetified as having an existing mental health problem or being at risk of developing mental health problems during prednancy or post-partum?

	Response Percent	Response Count
Yes	60.6	194
No	25.3	81
Don't know	14.1	45
	answered question	320
	skipped question	50

With respect to comfort in asking about mental health history, 44.8 percent reported that they were completely comfortable in enquiring about mental health history. However, 16.1 percent felt uncomfortable to some degree. Most LMCs (83.3%) felt they would benefit from more training to enquire about mental health history, and over half (55.6%) said they had never received any training in this area.

15. What is your level of comfort in asking a woman her personal mental health history?

	Response Percent	Response Count
Completely uncomfortable	7.1	22
Somewhat uncomfortable	8.4	26
Neither comfortable nor uncomfortable	12.6	39
Somewhat comfortable	25.8	80
Completely comfortable	46.1	143
	answered question	310
	skipped question	60

16. Did you receive any training to ask questions about personal mental health history?

	Response Percent	Response Count
Yes	42.1	131
No	55.0	171
Don't know	2.9	9
	answered question	311
	skipped question	59

17. Do you think you would benefit from more training?

	Response Percent	Response Count
Yes	83.5	258
No	8.7	27
Don't know	7.8	24
	answered question	309
	skipped question	61

Maternal mental health teams were available to 64.4 percent of respondents, and 75.6 percent said could refer directly to that service. A similar number (62.5%) had access to general psychiatric services. There are a number of different services to which women are referred if a significant mental health problem is identified. These include referrals most commonly to the general practitioner (28.3%), maternal mental health (33.8%), and mental health, including crisis or liaison services (23.4%). Referrals are less commonly made to social work (7.1%) or obstetricians (2.2%) and also referral to the mother-baby service (6.1%) for those in Canterbury. There were comments in the free text responses that LMCs were at times confused and felt unable to access what they needed or were unclear of the pathway, depending upon the severity of the issue identified.

The process by which an acute admission was dealt with was generally clear, most replies indicating that LMCs had access to acute mental health services in some form in their area. However, 8.3 percent had 'no idea' what the process was, 4.9 percent had experienced difficulties in the past and 1.7 percent had no prior experience and would be unsure what to do.

The question concerning what services are felt to be lacking was answered by 207 LMCs, of whom 50 (24.1%) felt that their area lacked a mother-baby unit. Access to services was also commonly felt to be a problem. Crisis situations were more easily dealt with than less acute problems for which expert advice or help was needed. A total of 32.3 percent of respondents felt that maternal mental health services were overwhelmed, poorly coordinated or insufficient. There were 14 percent who felt that there were problems with access to services. There were some comments (10) that a very good service existed.

Conclusions

Although the survey reached 1000 LMCs, there were 396 replies and considerably fewer for many of the qualitative responses. It was, however, an attempt to ask the providers of maternity care something about their experiences of dealing with women with mental health issues. Shortcomings were that we did not ask more specifically about the interface between LMCs and GPs. In addition, there were no questions about alcohol or drug use, although some of the responders were concerned about this issue. There were no specific questions about Māori, although in the replies, specific Māori services were highlighted as valued resources in some districts.

The data did not allow us to make comparisons between DHBs directly, but it did appear that those in Canterbury (who participated at the highest rate) were also both better trained (some had postgraduate qualifications in perinatal mental health) and more satisfied with services in that district.

It seems clear from this survey that the area of mental health is often not one where LMCs feel confident. Over half had never received any training to ask about mental health issues, and 83.3 percent felt they would benefit from more training. A minority (16.1%) said they were uncomfortable enquiring about mental health issues.

The survey did not specifically establish how much information about mental health history is shared by GPs at booking. However, it does seem clear that, when a mental health problem exists, there is a lack of clarification about whether a referral to another service is necessary, and if it is, what is the appropriate pathway. When a crisis occurs, there is clear support from GPs and acute mental health services. What is less clear is, when women have a significant history of a mental health problem or a current problem of moderate severity, what support should be offered and from which service. Many LMCs felt unsure about this, and also frustrated at being unable to access services themselves (referral is via the GP) when the problem was not a crisis.

There were many comments about the interface with general practice, and GPs were one of the most frequent services to which referrals were made if a mental health problem was identified, including in a crisis. A significant minority of LMCs (39.9 percent) did not know of the referral pathway when a woman was identified as either having a mental health disorder or being at high risk of developing one during pregnancy.

The lack of a mother and baby unit where women could be admitted with their infants in the postnatal period was identified as the main area where maternal mental health services were actually deficient. There were many comments that services were excellent but tended to be overwhelmed and were therefore difficult to access and had long waiting lists. A dedicated liaison maternal mental health clinician was identified as valuable when available, whereas 9.6 percent felt that their service lacked such a resource.

Recommendations

In order that the recommendations of the PMMRC can be implemented throughout New Zealand, it is important to understand whether LMCs feel that they can competently ask about a woman's mental health and are able to identify if any ongoing management is required from other services and seek an appropriate referral pathway where necessary.

The 20 DHBs in New Zealand are differently configured, so the referral pathway will look slightly different in each one. However, more training in mental health issues would be welcomed by most LMCs and clarity around the referral pathway when a woman is identified as requiring support from either primary care or mental health services. A specific liaison person may be an integral part of the pathway for many districts, as discussion about how to proceed is valuable and provides support to LMCs. Improved integration between maternity services, mental health services and primary care is recommended. This will ensure mental health problems are highlighted and managed appropriately in pregnancy and postpartum.

The lack of a facility where women who are acutely mentally unwell can be admitted with their babies was seen as a major gap in services. The PMMRC recommends that there be a mother and baby unit in the North Island.