Maternal Mental Health in Northern Ireland: a summary briefing August 2014

Of the 25,273 births in Northern Ireland in 2011, 2,527 women developed antenatal depression, 3,790 women developed postnatal depression, 50 mothers developed puerperal psychosis and 50 were admitted as a result of relapsing (DHSSPS, 2013). A recent 32 week study found that 75 pregnant women who were admitted to an acute psychiatric ward could have instead have benefited from being treated in a mother and baby unit (Royal College of Psychiatrists, 2013). A woman may have a pre-existing mental health condition, or mental ill-health can arise during pregnancy (DHSSPS, 2013). Some women with pre-existing mental illness diagnosis may not become pregnant because they have been (incorrectly) advised by health professionals that women with a psychiatric illness should de facto not have a family.

This briefing has been produced by the Northern Ireland Maternal Mental Health Alliance whose membership includes: professional bodies, clinicians, voluntary and community organisations, and women and their families who have been directly impacted by these issues. We are part of the UK Maternal Mental Health Campaign “Everyone’s Business” (funded by Comic Relief until September 2016). “Everyone’s Business” aims to: raise awareness of perinatal mental illness among health and social care providers, stop the postcode lottery of perinatal mental health provision and highlight best practise in health and social care (www.everyonesbusiness.org.uk). Perinatal mental health is concerned with the pregnancy and first year of a child’s life.

Northern Ireland has committed to implement the NICE Guidelines on Antenatal and Postnatal Depression and produced the Integrated Perinatal Mental Health Care Pathway (Public Health Agency 2012). However, due to inadequate investment in public, community and voluntary sector services, women and their families face the stark and unacceptable situation of a postcode lottery in provision. We have no mother and baby unit in Northern Ireland, and only one specialist psychiatric perinatal health service in the Belfast HSCT (Murray and Hamilton, 2005); education and support programmes by voluntary and community organisations are limited; and there is an inconsistent and inadequate approach within professional training.

In Northern Ireland we are campaigning for best practise services using the stepped care approach consistently provided across all HSCTs and the full implementation of policy commitments by May 2016. We are seeking the following.

1. Health professionals to focus on early intervention and act quickly in order to prevent adverse outcomes.
2. Mental health integrated within ante-natal classes in order to improve awareness about potential challenges and available support.
3. Having the same midwife/health professional throughout a woman’s pregnancy in order to provide fully informed care, and build rapport/trust so that the woman feels that she can be open about her feelings.
4. Health professionals, especially midwives, trained on maternal mental health in order to recognise vulnerability, offer appropriate help; and reduce stigma.
5. A care plan implemented throughout a pregnancy including an emphasis on maternal mental health and a question about mental health at first contact in order to ensure help at any stage of the pregnancy.
6. A mother and baby unit to allow the mother to receive specialist help and also bond with her child in the same facility.

Positive maternal mental health is vital not only for the mother’s health and wellbeing but also those of her baby, her partner and wider family. A child’s development is mediated through its attachment to his or her mother. Poor maternal mental health can impact a child’s development; and, conversely, intervention and secure attachments improve the child’s emotional and educational...
outcomes as they grow older (Martin, 2012) and enhance the child’s long term cognitive, behavioural and emotional outcomes. Early intervention can help *strengthen* family relationships especially with their partner; *support* continued social contact with friends, and *develop* a closer mother-baby bond. Early intervention reduces the likelihood of financial pressures because the mother’s return to work is less disrupted, and family members do not need to become carers (Robson and Waugh, 2013). Investment in early intervention makes economic sense. Post natal depression can cost UK healthcare £35.7 million every year; and this figure rises when we take into account the long term health, education and employment costs for mother and child (NICE guidelines, 2007).


In Northern Ireland, the mental health sector is underfunded proportionate to need; and there is no parity between mental health and physical health funding. In 2011 spending on mental health was just 7% of the whole health budget and 10-30% lower than English spending on this sector. This is despite our need being 44% greater compared to England. Only 3.7% was spent on maternity and child health (Appleby, 2011). Maternal mental health provision is often regarded as having little priority for the NHS (Moorhead, 2013). Women who are pregnant in Northern Ireland have higher rates of depression compared to their UK counterparts. However this isn’t reflected in current expenditure levels for the mental health sector (Children and Youth Programme, 2011).

Access to services varies both within Northern Ireland and across the UK. There are 19 mother and baby units across the UK (2 in Scotland, 17 in England and none in Wales and Northern Ireland). Specialist perinatal mental health provision varies considerably between regions. The majority of Wales or Northern Ireland has no provision in place. There is only adequate provision in the middle and South of England. Scotland is varied with the most provision in the middle of the country. (Maternal Mental Health Alliance, 2014)