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Perinatal Mental Health: Listening to Women and Shaping the Road Ahead

Summary Report of an Exploratory Roundtable on Perinatal Mental Health in Ireland

National Women's Council

Contents

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Special appreciation goes to the chair of the roundtable; Dr Margo Wrigley, National Clinical Lead for the HSE Adult ADHD National Clinical Programme and the esteemed speakers; Dr Colm Cooney, National Clinical Lead of HSE National Programme for Specialist Perinatal Mental Health Services; Dr Déirdre Daly and Dr Susan Hannon from the MAMMI Study at Trinity College Dublin (TCD); and Dr Veronica O'Keane, author and former Professor of Psychiatry in TCD.

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- Cairde
- HSE
- Irish Nurses & Midwives Organisation (INMO)
- Mental Health Reform
- HSE National Woman and Infant Health Programme
- Pavee Point Traveller & Roma Centre
- Rotunda Hospital Dublin
- See Change

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List of Abbreviations

ADHD	Attention Deficit Hyperactivity Disorder
CAD	Comorbid Anxiety and Depression
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CPD	Continuous Professional Development
DSGBV	Domestic, Sexual & Gender Based Violence
EEM	Ethnic Equality Monitoring
EU	European Union
GP	General Practitioner
HG	Hospital Groups
HSE	Health Service Executive
INMO	Irish Nurses & Midwives Organisation
MAMMI Study	Maternal Health and Maternal Morbidity in Ireland Study
MBU	Mother & Baby Unit
NWC	National Women's Council
PHN	Public Health Nurse
PMH	Perinatal Mental Health
SPMHS	Specialist Perinatal Mental Health Services
TCD	Trinity College Dublin
UK	United Kingdom
WCC	Women Centred Care
WHO	World Health Organisation
WTE	Whole Time Equivalent

Note: When the report mentions "women," it is intended in the most inclusive sense of the word, encompassing all individuals who identify as women.

Executive Summary

This report provides an analysis of an exploratory roundtable the National Women's Council (NWC) convened on November 8, 2023, to discuss perinatal mental health in Ireland. It summarises a discussion between stakeholders and experts, and includes a literature review, key recommendations, and conclusion which address the current challenges and opportunities in perinatal mental health care.

Ireland's first *National Maternity Strategy* in 2016 led to the development of the *Specialist Perinatal Mental Health Services: Model of Care for Ireland* in 2017. These publications prioritised holistic care for mothers and babies, emphasising their interconnected journey. The Model of Care led to the development of a specialist perinatal mental health infrastructure, with a hub-and-spoke model being rolled out to include multi-disciplinary teams in six hubs and perinatal mental health midwives in all 19 maternity services, striving for integrated and stigma-free care.

Inviting a diverse range of speakers and participants to this roundtable, including – HSE colleagues from relevant sections, academics, an individual with lived experience of mental health difficulties, representatives of mental health services, advocacy groups; including those supporting migrant women and Traveller women – provided an opportunity to discuss these positive developments and the ongoing challenges for women. There was a particular focus on the experiences of marginalised women, including migrant women, Traveller women, and Roma women, who face specific structural inequalities when accessing care and supports. Furthermore, gaps in the implementation of the Model of Care concerning the increasing demand on services and the awaited establishment of a Mother & Baby Unit (MBU), were also key areas of focus at the event.

Literature Review:

The literature review for the report is broadly divided into three key areas concerning perinatal mental health: **Prevalence & Impact**, noting that up to 20% of women experience mental health difficulties during the perinatal period, often exacerbated by stigma, fragmented and underdeveloped services, impacting maternal and infant well-being; **Women Centred Approaches to Service Provision**, indicating disparities faced by marginalised groups of women in Ireland's hospital-led and obstetrics-centric maternity services, despite initiatives like the *National Maternity Strategy*, highlighting the need for women-centred-care and an MBU; and **Research & Data Collection**, emphasising the lack of resources and training for healthcare providers and the significant data gap in understanding diverse perinatal mental health experiences, especially among marginalised groups of women.

Discussion:

The discussion highlighted three key areas for improving perinatal mental health services including **Research, Data & Inclusivity**, emphasising the need for equality data collection, a mental health information system, and the adoption of Ethnic Equality Monitoring principles. **Opportunities for Early Intervention & Support**, stressing the importance of early intervention, tailored care, and better supports for mental health professionals and services at all levels. **Gender-Sensitive & Trauma-Informed Care**, advocating for gender-sensitive and trauma-informed policies and services, emphasising the need to integrate bereavement supports, and addressing gaps in maternity services for trauma-related experiences including pregnancy loss.

Recommendations:

Ten key recommendations emerged from the roundtable discussion:

1. Ensure secure and sustainable investment in perinatal mental health, to implement the updated Specialist Perinatal Mental Health Model of Care.
2. Increase HSE capacity to respond to those with perinatal mental health difficulties by resourcing Specialist Perinatal Mental Health Services based on 1 full time consultant led Multi-Disciplinary Team per 4,000 live births.
3. Establish a Mother & Baby Unit at St. Vincent's University Hospital, Dublin.
4. Further integrate perinatal mental health services with maternity care, primary care, and other mental health services.
5. Perinatal mental health policies and services should be informed by gender-sensitive approaches and trauma-informed practices, in line with *Sharing the Vision*.
6. Strengthen supports at primary care, by increasing the number of PHNs, enhancing primary care psychology, and providing additional resources/training to primary care professionals.
7. Primary and specialist services should be complemented by supports available in community settings.
8. Data collection should include appropriate equality data, including the collection of ethnic data to ensure the experiences and outcomes of marginalised groups of women can be identified and addressed.
9. Improve perinatal bereavement and trauma services, including perinatal palliative care services.
10. Extend 6-week postpartum care to at least 3 months.

Conclusion:

Perinatal mental health impacts on mother and infant well-being. Despite progress in Ireland's Model of Care, challenges remain, such as the need for further integration of Specialist Perinatal Mental Health Services (SPMHS) with general maternity and mental health services, the absence of a dedicated Mother and Baby Unit (MBU), workforce constraints, resource shortages, and limited data on marginalised women's experiences.

This report urges sustained commitment, investment, and collaboration to enhance perinatal mental health services, ensuring optimal outcomes for women – in all their diversity – and their families.

Introduction

In 2016, the Health Service Executive (HSE) published Ireland's first *National Maternity Strategy*. This led to the development and publication of the *Specialist Perinatal Mental Health Services: Model of Care for Ireland* in 2017, emphasising a comprehensive approach centred on the mother, baby, and their interdependent relationship during pregnancy, childbirth, and early mother-infant bonding. A key turning point in identifying the pressing need for such strategies and specialist services was the investigation into the safety, quality, and standards of care provided to women in the maternity services following the death of Savita Halappanavar in 2012. Savita's death underscored the urgent need for a new model of care which recognises women as central decision-makers, understanding that their experiences and outcomes have public health consequences for their children, their families, and society.

Specialist Perinatal Mental Health Services (SPMHS) consist of consultant led, multi-disciplinary specialist teams in six hubs located in the maternity hospitals with the highest birth rates, addressing moderate to severe mental health difficulties. Additionally, perinatal mental health midwives provide care in all 19 maternity services. These primary and specialist teams collaborate to offer comprehensive care and support for a range of mental health difficulties, integrated into maternity services to reduce stigma. The hub-and-spoke model ensures coordinated care, with ongoing reviews to address the increasing demand for these services. A key focus of the upcoming model refresh is incorporating additional perinatal psychiatrists with dedicated resources for each spoke[1] likely through allocated appointments. For example, the Coombe hospital's consultant includes 3 appointments (1.5 days) dedicated to Portlaoise Hospital (see figure 1 of hub and spoke map).

On November 8, 2023, the National Women's Council (NWC) convened a roundtable discussion, bringing together key stakeholders to explore the current landscape of perinatal mental health research and service provision in Ireland. Perinatal mental health difficulties include various issues like anxiety, mild to severe depression, stress, and adjustment difficulties. These can develop during pregnancy or after childbirth, affecting many women differently.[2] These conditions pose significant risks to both maternal and infant well-being, impacting mother-infant bonding and family dynamics.[3] Early recognition and appropriate supports to address mild, moderate and severe mental health difficulties are crucial to ensure the wellbeing and mental health of both mother and child.

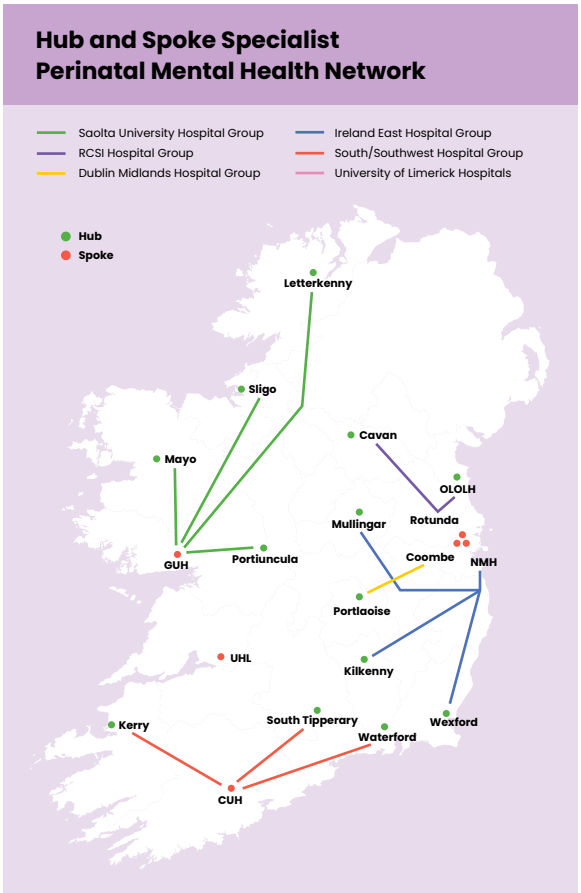

Figure 1

The purpose of the event was to identify progress to date in implementing this Specialist Perinatal Mental Health Model of Care, and to understand ongoing challenges and opportunities to improve perinatal mental health services and supports, and in effect the experiences and outcomes of women. The chairperson for the roundtable was Dr Margo Wrigley, National Clinical Lead for the HSE Adult ADHD National Clinical Programme, and former HSE Lead for the National Programme for Specialist Perinatal Mental Health Services.

1 In this context, "spokes" are smaller maternity units that are connected to and supported by larger hub hospitals within each Hospital Group (HG).

2 HSE (2017) Specialist Perinatal Mental Health Services- Model of Care for Ireland https://www.hse.ie/eng/services/list/4/mental-health-services/specialist-perinatal-mental-health/specialist-perinatal-mental-health-services-model-of-care-2017.pdf

3 Ibid.

Speakers for the event included Dr Colm Cooney, who now leads the HSE National Programme for Specialist Perinatal Mental Health Services. Also featured were Dr Déirdre Daly and Dr Susan Hannon from Trinity College Dublin (TCD), representing the Maternal Health and Maternal Morbidity in Ireland (MAMMI) study. Finally, Dr Veronica O'Keane, a distinguished author, and former Professor of Psychiatry at TCD, provided her insights as well. The roundtable drew additional participants from diverse backgrounds, including representatives from mental health services, advocacy groups, an individual with lived experience, in addition to civil society groups representing specific groups of women, including migrant women and Traveller women. This amalgamation of expertise and perspectives enhanced the depth and inclusivity of discussions, fostering a holistic approach to address the complex challenges in perinatal mental health.

This summary report provides a brief literature review, a thematic overview of the discussion from the event, as well as key recommendations and conclusion.

> Early recognition and appropriate supports to address mild, moderate, and severe mental health difficulties are crucial to ensure the wellbeing and mental health of both mother and child.

Literature Review

i. Prevalence & Impact

Pregnancy, childbirth, and the initial year with an infant represent transformative experiences for women, involving a spectrum of emotional and psychological states, both positive and negative.[4] It encompasses new experiences, physical changes, and can introduce stressors that impact on a woman's identity, mental health, and economic circumstances.[5] The perinatal period is defined as the time from when a woman becomes pregnant and up to one year after giving birth, any mental health difficulties experienced during this phase relate to perinatal mental health. These difficulties can include new onset and a relapse or reoccurrence of pre-existing conditions. This experience is not uncommon, with up to 20% of women reporting challenges in the form of perinatal mental health difficulties.[6] The prevalence of mental health difficulties experienced by women during pregnancy and the postnatal period underscores the significance of addressing perinatal mental health as a public health concern.

With 1 in 5 women encountering a mental health difficulty during the perinatal period, research emphasises the need for effective and accessible support.

With 1 in 5 women encountering a mental health difficulty during the perinatal period, research emphasises the need for effective and accessible support.[7] Unfortunately, despite the prevalence of the issue, most women globally do not receive the care and support they need.[8] This is often due to mental health concerns not being identified, stigmatisation of mental health, a lack of care and support options particularly in early intervention, a limited number of specialists, an absence of integrated care, and a lack of training on mental health amongst health care providers. Notably, marginalised groups of women, including Traveller women, Roma women, and migrant women, face additional structural barriers when accessing services.

Research demonstrates that the decline of a woman's mental health in the perinatal phase can detrimentally impact the individual, the infant, and the family. Poor mental health correlates with elevated risks of obstetric complications, suicide, and reduced attendance at antenatal and postnatal appointments.[9] Furthermore, unaddressed mental health issues may result in adverse birth outcomes, including low infant weight, heightened risks of physical illnesses, and childhood emotional and behavioural challenges.[10] For women with pre-existing mental health difficulties, the perinatal period may exacerbate their symptoms, while others may encounter mental health challenges for the first time.

4 Midwifery (2022) Perinatal mental health in Ireland: A scoping review https://www.sciencedirect.com/science/article/pii/S0266613820301352
5 WHO (2022)Guide for integration of perinatal mental health in maternal and child health services https://iris.who.int/bitstream/handle/10665/362880/9789240057142-eng.pdf?sequence=1
6 Midwifery (2018) Women's views and experiences of having their mental health needs considered in the perinatal period https://pubmed.ncbi.nlm.nih.gov/30149202/
7 Ibid.
8 WHO (2022) Guide for integration of perinatal mental health in maternal and child health services https://iris.who.int/bitstream/handle/10665/362880/9789240057142-eng.pdf?sequence=1
9 Ibid.
10 Ibid.

For women who do experience perinatal mental health difficulties, most presentations will be mild to moderate, while a smaller subset, approximately 2 to 4 per 1,000, will experience severe or complex mental health difficulties. A smaller proportion again may need hospital admission, typically to a specialised Mother and Baby Unit (MBU).[11] An MBU is a specialised in-patient unit which caters to women facing severe or complex mental health difficulties following the birth of their baby.[12]

These units ensure admission for both the mother and baby, allowing them to stay together to foster bonding and attachment.[13] While services like MBUs are a crucial component for specialist care, the World Health Organisation guidance on maternal health emphasises that most women will benefit from high-quality community-based services that are integrated, cost-effective, and uphold human rights principles.[14]

ii. Women Centred Approaches to Service Provision

Maternity services in Ireland have historically been hospital-centred and led by obstetricians, with midwifery playing a less prominent and underdeveloped role.[15] There have been efforts in recent years to give midwives a more central role, including the appointment of Directors of Midwifery in all 19 maternity units. Furthermore, the *National Maternity Strategy* (2016) aimed to increase options for maternity care models, however, a key obstacle has been a lack of clarity among stakeholders as to the ethos and correct implementation of Women-Centred Care (WCC).[16] Women-centred care is defined as care which prioritises women's unique needs, as defined by the woman herself, providing decision-making control to the woman.[17]

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11 HSE (2019) What is a Mother & Baby Unit (MBU)? https://www.hse.ie/eng/services/publications/mentalhealth/what-is-a-mother-and-baby-unit-mbu.pdf

12 In exceptional cases a woman with severe mental difficulties who is near term may be admitted to an MBU and readmitted there following delivery together with her baby.

13 Ibid.

14 WHO (n.d.) Maternal mental health https://www.who.int/teams/mental-health-and-substance-use/promotion-prevention/maternal-mental-health

15 Midwifery (2020) Perinatal mental health in Ireland: A scoping review https://www.sciencedirect.com/science/article/pii/S0266613820301352

16 BMC pregnancy and childbirth (2017). Woman-centred care during pregnancy and birth in Ireland: thematic analysis of women's and clinicians' experiences. https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-017-1521-3

17 Woman-centered care 2.0: Bringing the concept into focus: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7846029/

Ireland's maternity healthcare system measures the quality of care provided by its mortality and morbidity outcomes, which are globally commendable. However, this approach overlooks the experiences, preferences, outcomes, and diverse needs of women.[18] Researchers have noted that the health services' rigidity limits the potential for WCC, as busy maternity hospitals in urban areas are responsible for thousands of births every year, and therefore prioritise practices which support the efficiency of hospital operations. This results in a focus on streamlined and standardised birthing processes, often neglecting the individuality of women's experiences.[19] The challenges within the Irish maternity system are further exacerbated for marginalised groups, including asylum-seeking women, women of colour, Roma women, and Traveller women. Internal racism, notably against Travellers and migrant groups, has been documented, with gaps in their physical and mental health outcomes stark when compared to women from the majority population.[20]

Sharing the Vision, Ireland's national 10-year mental health strategy, focuses on developing a broad-based mental health policy for the entire population, recognising the need for specialist perinatal supports. The implementation plan for 2022-2024 included phased implementation and evaluation of the Model of Care for specialist perinatal mental health services. Another key supporting strategy is the Department of Health's *Women's Health Action Plan 2022-2023* – and the successor Plan for 2024-2025 – which aim to prioritise women's health needs. Targeted investment in women's mental health has supported the establishment of postnatal hubs, as well as the current 6 multidisciplinary perinatal mental health teams and perinatal midwifes in the remaining 13 maternity hospitals.

One component in the Model of Care, was the establishment of a Mother and Baby Unit by 2023, which remains outstanding. This is significant, as international research indicates that specialist in-patient units like Mother and Baby Units (MBUs) are also increasingly being preferred over general inpatient units primarily because of the co-admission of mothers and babies, creating a child-friendly environment with perinatal expertise. In England, MBUs are established, and it is recommended that women with serious perinatal mental health difficulties should have access to a specialised community perinatal mental health team, consisting of perinatal psychiatrists, mental health nurses, and other specialists, providing comprehensive assessment, interventions, and support throughout pregnancy and postnatally.[21]

In Northern Ireland, all five health trusts are now equipped with community perinatal mental health teams. These teams provide crucial support and interventions to women throughout their perinatal period. However, staffing is limited; for example, the Belfast Trust Team has just 3 staff members, compared to 8-10 full-time staff per team in the Republic of Ireland. In 2023, Belfast City Hospital was chosen as the site for a new regional Mother and Baby Unit, marking a substantial step for perinatal mental health.[22] There is also now a cross-border group in place to advance the development of MBUs in both jurisdictions. This includes consideration for co-operation, including if women in Donegal should have access to the MBU in Northern Ireland.

18 Midwifery (2022) Perinatal mental health in Ireland: A scoping review https://www.sciencedirect.com/science/article/pii/S0266613820301352
19 Ibid.
20 Ibid.
21 Journal of Mental Health (2020) A qualitative investigation of models of community mental health care for women with perinatal mental health problems https://www.tandfonline.com/doi/abs/10.1080/09638237.2020.1714006
22 Department of Health (2023) Update on community perinatal mental health services https://www.health-ni.gov.uk/news/update-community-perinatal-mental-health-services

While the literature demonstrates MBUs are an essential part of robust women-centred-care, barriers can persist. These barriers include the limited number of beds and the distant location, resulting in women from rural areas having to travel to access an MBU.[23] Additionally, post-discharge, many women face challenges accessing essential support, contributing to difficult transition, feelings of isolation and reduced confidence in their ability to cope.[24]

Key observations of the MAMMI study to date have centred on Ireland's short post-natal care period, which concludes at 6 weeks postpartum, designed with the assumption that physical health concerns resolve by then.

iii. Research & Data Collection:

Trinity College Dublin's, the Maternal Health and Maternal Morbidity in Ireland (MAMMI) study offers the only longitudinal Irish data examining the prevalence and risk factors of a range of morbidities, including mental health, for women in Ireland. The MAMMI study examines sociodemographic influences on postpartum mental health, identifying heightened odds of depression, anxiety, and stress symptoms among younger mothers and those born outside the European Union (EU). Along with socioeconomic factors such as lack of partner cohabitation, absence of post-graduate education, unemployment during pregnancy and relationship problems or fear of a partner were also linked to increased vulnerability.[25]

Key observations of the MAMMI study to date have centred on Ireland's short post-natal care period, which concludes at 6 weeks postpartum, designed with the assumption that physical health concerns resolve by then. However, MAMMI findings demonstrate stress, anxiety, depression, Comorbid Anxiety and Depression (CAD) and other complex 'Mental Health Disorders' (MHDs) increase 3 months after birth and were the highest at 6 months postpartum. Furthermore, while depression and stress dropped slightly at 9 months, another increase is seen again at 1 year postpartum.[26] These findings make a strong case for a more comprehensive perinatal care system, extending beyond the conventional period, that would allow women to address both physical and mental health concerns, fostering optimal well-being throughout the first year of motherhood.[27]

23 BMC Psychiatry (2019) A qualitative comparison of experiences of specialist mother and baby units versus general psychiatric wards https://link.springer.com/article/10.1186/s12888-019-2389-8
24 Ibid.
25 Archives of Women's Mental Health (2022) Maternal mental health in the first year postpartum in a large Irish population cohort: the MAMMI study https://link.springer.com/article/10.1007/s00737-022-01231-x
26 Maternal mental health in the first year postpartum in a large Irish population cohort: the MAMMI study: https://rdcu.be/dvxyr
27 Journal of Affective Disorders (2023) Physical health and comorbid anxiety and depression across the first year postpartum in Ireland (MAMMI study): A longitudinal population-based study https://www.sciencedirect.com/science/article/pii/S0165032723002161

GPs, midwives, Public Health Nurses and other members of multidisciplinary health teams face constraints due to limited, under-resourced, fragmented, and uncoordinated service and referral options.[28] Consequently, GP and Public Health Nurses, who have unrivalled access to women during the postnatal period, often prioritise the infant's development during visits to new mothers, offering limited support for the woman's transition to motherhood.[29] Research has found that GPs require additional support, including access to Continuous Professional Development (CPD) opportunities, specialised Perinatal Mental Health (PMH), and psychological services to meet the diverse needs of the population.[30] This ensures competence and adherence to the scope of practice, as also highlighted in the Specialist Perinatal Mental Health Model of Care.

Qualitative studies on the experiences of women during the perinatal period have highlighted apprehension about potential judgment and feelings of stigma and shame when discussing or disclosing perinatal mental health difficulties.[31] Participants of such studies conveyed a sense of being 'labelled' or defined solely by their mental health history.[32] Similarly, the MAMMI study also noted how women reported worrying about how they would be perceived by their family and wider community after disclosing they were experiencing poor perinatal mental health.[33] These feelings of stigma are reinforced by society's limited and often unhelpful framing of pregnancy and motherhood as purely joyous. This results in some women being concerned that their ability as a mother would be questioned if they did discuss their mental health and that it is not 'normal' to be feeling anxiety or symptoms of depression during or after their pregnancy.

28 BMC (2018) Irish general practitioners' view of perinatal mental health in general practice: a qualitative study https://researchrepository.ul.ie/articles/journal_contribution/Irish_general_practitioners_view_of_perinatal_mental_health_in_general_practice_a_qualitative_study/19823953

29 Midwifery (2022) Perinatal mental health in Ireland: A scoping review https://www.sciencedirect.com/science/article/pii/S0266613820301352

30 HSE (2017) Mind mother project https://healthservice.hse.ie/filelibrary/mind-mothers-project.pdf

31 Midwifery (2018) Women's views and experiences of having their mental health needs considered in the perinatal period https://pubmed.ncbi.nlm.nih.gov/30149202/

32 Ibid.

33 Archives of Women's Mental Health (2022) Maternal mental health in the first year postpartum in a large Irish population cohort: the MAMMI study https://link.springer.com/article/10.1007/s00737-022-01231-x

Research on perinatal mental health emphasises three key points: a substantial number of women experience these issues, with varying reported prevalence rates; risk factors include a history of mental health difficulties and insufficient social support; and current health service provision inadequately address these concerns.

Within the Irish context, there is a notable scarcity of data crucial for shaping policies and practices addressing a diverse array of mental health difficulties that unfold across the trajectory of motherhood. Addressing this gap is imperative for informed decision-making and effective support systems for women as they navigate through the phases of motherhood. Research on perinatal mental health emphasises three key points: a substantial number of women experience these issues, with varying reported prevalence rates; risk factors include a history of mental health difficulties and insufficient social support; and current health service provision inadequately address these concerns.[34] Additionally, there is an observed deficit in women-centred research, particularly regarding the perspectives and experiences of marginalised women in Ireland.[35]

To advance the vision of women-centred maternity care, imperative steps involve conducting research that places women's subjective experiences of perinatal mental health and well-being at the forefront. This encompasses the voices of marginalised women in Ireland's diverse society, ensuring the outcome is a comprehensive understanding of the range of unique perspectives within the field of perinatal mental health.[36]

34 Midwifery (2020) Perinatal mental health in Ireland: A scoping review https://www.sciencedirect.com/science/article/pii/S0266613820301352
35 Ibid.
36 Midwifery (2020) Perinatal mental health in Ireland: A scoping review https://www.sciencedirect.com/science/article/pii/S0266613820301352

Discussion

The roundtable discussion opened with an acknowledgement of the contribution of the speakers, whose presentations provided an excellent grounding into how pregnancy, birth and the first year with a new baby constitute life-changing physical and cognitive experiences for many women. Several themes emerged during the discussion, including i). Research, data and inclusivity of perinatal mental health supports and services ii). Early intervention and support, and iii). Gender-sensitive and trauma-informed approaches to care for women.

i. Research, Data & Inclusivity of Services:

Presenters and attendees representing migrant and Traveller communities raised concerns about the inclusivity of the mental health services for ethnic minority groups. Traveller Primary Health Care Workers from Pavee Point Traveller & Roma Centre noted the lack of representation from marginalised groups of women in research underpinning mental health strategies in Ireland. The prevalence of mental health difficulties is already higher within these groups, for example, the suicide rate for Traveller women is 6 times higher than non-Traveller women in Ireland.[37] Therefore, perinatal mental health services and policies should be particularly responsive to ethnic minority groups, as research shows those with pre-existing mental health difficulties are at an increased risk of experiencing poor mental health outcomes during the perinatal period.

> The suicide rate for Traveller women is 6 times higher than non-Traveller women in Ireland.

Social determinant of health, like education, accommodation, and experiences of racism were also discussed, along with additional practical barriers marginalised women may face when accessing perinatal mental health supports, including literacy, language, a lack of medical cards for some Roma and migrant women, as well as unreliable access to transport to attend appointments. While there is limited research in Ireland, research in the UK has found a higher burden of perinatal mental health difficulties among ethnic minority groups, citing increased likelihood of exposure to psychological triggers, social isolation, inequity in health care access, and culturally insensitive and dismissive mental health providers.[38]

The limited research in Ireland to capture the diversity of experiences of services with respect to ethnicity, socioeconomic status, and education, was discussed, noting that despite the absence of conclusive national data, the burden of perinatal mental health difficulties in Ireland is likely much higher among marginalised groups. Attendees acknowledged how critical continuity of care, anti-racism training for health care professionals, and policies addressing the social determinants of health are to tackling these significant perinatal mental health inequalities. The screening questions used by doctors, midwives, and public health nurses need to be carefully considered, especially when cultural and language barriers are present. Community midwives discussed how delivering culturally appropriate care can be a challenge, as there may be significant differences in maternal expectations and practices. One midwife spoke about how they determine early whether an interpreter is required, thus facilitating and ultimately ensuring that the women's needs are being met.

37 Department of Health (2010) All Ireland Traveller Health Study https://www.gov.ie/pdf/?file=https://assets.gov.ie/18859/d5237d611916463189ecc1f9ea83279d.pdf#page=null

38 Plos One (2019) A systematic review of ethnic minority women's experiences of perinatal mental health conditions and services in Europe: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0210587

This call for reliable data across the health services is not a new one, as advocacy groups working with marginalised cohorts of women have already supported the development of Ethnic Equality Monitoring (EEM) principles with HSE Social Inclusion.[39] EEM ensures the collection of ethnic data to demonstrate the uptake of various ethnic minority groups engaging in health services. This data helps to identify whether discrimination, direct or structural, is impacting on service delivery and service user outcomes. EEM also recommends that marginalised groups are included in the design and implementation of services, ensuring that barriers like language or literacy, are addressed. The collection of this information about ethnic groups, combined with clinical data, can provide an evidence base for the effectiveness of specific services and supports across the range of maternal health services, including primary, community and specialist perinatal mental health services.

Additionally, listening to women's lived experiences and recognising them as experts in their own care is crucial in tailoring services to their needs, necessitating a cultural shift within services.

An integral component of data collection is effective data monitoring and storage. However, the current absence of a national mental health information system means there is no standardised and electronic mechanism to capture equality data if it is collected. This need for a mental health information system is referenced in *Sharing the Vision* (Recommendation 86), stating that it will avoid the frustration of service-users often having to repeat details of their circumstances "from scratch" with each professional they encounter. An information system would also facilitate interworking between different services, contributing to better organisation within the health care system and better outcomes for women.

ii. Opportunities for Early Intervention & Support:

While pregnancy and motherhood are times of increased risk of mental health difficulties, they are also periods with unparalleled contact with health service providers. Attendees discussed how this should provide an opportunity to identify women who may be at risk and in turn ensure early intervention and support. Additionally, listening to women's lived experiences and recognising them as experts in their own care is crucial in tailoring services to their needs, necessitating a cultural shift within services. This is critical, as timely and effective care plans can improve maternal and infant health outcomes. The range of potential difficulties and their severity also means that there is no 'one size fits all' approach to delivering care and support. A range of services are required to appropriately respond, meaning there is a need to do so in an integrated manner so that primary, community, and specialist services are linked to effectively meet the diverse needs of all women and improve outcomes. Offering a choice of therapies and supports is also vital, as facilitating flexibility and personalised care options leads to better outcomes and alignment with the principles of *Sharing the Vision.*

39 Policy & Practice in Ethnic Data Collection & Monitoring: https://www.paveepoint.ie/wp-content/uploads/2016/04/Counting-Us-In-A4_WEB.pdf

Relevant services involved in an overall perinatal mental health response including the specialist component (in bold font) are listed below:

- Voluntary and self-help organisations
- General Practitioners, public health nurses and the extended primary care team
- Health and social care organisations, children's centres
- Psychological and talking therapies at primary care
- Psychology services linked to maternity services
- Maternity services
- Parent-infant maternal health services
- Child and adolescent mental health services
- Intellectual disability services
- Alcohol and drug misuse services
- Adult mental health services
- **Maternity liaison psychiatry services**
- **Specialist perinatal mental health teams**
- **Specialist inpatient mother and baby units**

GPs and Public Health Nurses are the most common point of contact for post-natal women, particularly after the official end of the formal postpartum care at 6-weeks. There is a pressing need to better resource GPs and other primary care professionals, including Public Health Nurses and primary care psychologists, to ensure comprehensive and accessible support for women during the crucial postpartum period. Other health care professionals like physiotherapists or urogynaecology consultants will regularly meet with women in the weeks and months following birth. Therefore, education and training in identifying mental health difficulties in women must be provided for all health care professionals. Similarly, community groups working with women, particularly marginalised women, should be funded and supported to make referrals to primary or more specialist care if required. Additionally, investment in community services is crucial as they play a key role in supporting women, promoting mental health and well-being, ultimately improving outcomes for a large cohort of women.

In its inception, the specialist perinatal Model of Care recommended 1 Whole Time Equivalent (WTE) consultant-led multidisciplinary team for every 10,000 births. Clinical leads in the HSE acknowledged that this needs to be revised, and a more appropriate ratio would be 1 WTE consultant-led team to every 4,000 births.

For women who require referral to specialist services, it is vital that these are adequately resourced. In its inception, the specialist perinatal Model of Care recommended 1 Whole Time Equivalent (WTE) consultant-led multi-disciplinary team for every 10,000 births. Clinical leads in the HSE acknowledged that this needs to be revised, and a more appropriate ratio would be 1 WTE consultant-led team to every 4,000 births. In recent years, there has been an increased demand for specialist services, evidenced by a doubling in the numbers of referrals and attendees. Consequently, a refreshed Model of Care is imperative, accompanied by sustainable investment and development of services to meet these evolving needs effectively.

> Participants, particularly those with lived experience noted that bereavement supports, and mental health services, were not well integrated and often do not recognise the unique gender-sensitive or trauma components impacting on perinatal mental health difficulties.

Integral to the provision of specialist services, is the establishment of a Mother and Baby Unit (MBU). MBUs allow for joint admission for both mothers and babies and are designed to facilitate women to receive care, following a risk assessment, and for the infant to continue to be cared for. As Ireland's Specialist Perinatal Mental Health Service (SPMHS) does not currently have an MBU, women with severe or complex perinatal mental health difficulties are admitted to general adult inpatient units without their baby, adversely impacting mother-infant bond and attachment, despite evidence advocating for their co-location. The current site selected for Ireland's first MBU is St Vincent's Hospital in Dublin, which would be inconvenient for many women and their families living outside of Dublin. The need for one unit was based on bed requirements in the UK, which has a network of MBUs. Therefore, a 10-bed unit was recommended, with plans to monitor usage and consider a second unit in Limerick if necessary. The provision of specialist teams now means a greater number of women with severe perinatal mental health difficulties can be supported within the community which may be preferred by many mothers and their families. However, this does not diminish the critical need for an MBU, which provides specialised, inpatient care that cannot be fully replicated through community support alone.

iii. Gender-Sensitive & Trauma-Informed Care:

The roundtable participants discussed how policies and services must be gender-sensitive and trauma informed. This need for gender-sensitivity and trauma-informed care is underpinned by Ireland's national mental health policy, *Sharing the Vision*. Such service practices are crucial for comprehending how gender and trauma experiences shape the mental health needs and support systems for individuals, families, and communities. *Sharing the Vision*, outlines that for these principles to be adopted, "language, behaviour, and policies" need to be carefully considered.[40]

40 Sharing the Vision: A Mental Health Policy for Everyone (2020-2030), page 7.

Roundtable attendees shared this sentiment, discussing how maternity services, primary care, and specialist perinatal mental health services need to consider how their operations impact women and families who have experienced trauma in the context of pregnancy and pregnancy loss. The Specialist Perinatal Mental Health Model of Care does acknowledge that birth trauma and physical clinical events (e.g., death of a baby, a child born with significant health problems, a previous obstetric loss, etc.) should inform the delivery of specialist perinatal mental health services. However, participants, particularly those with lived experience noted that bereavement supports, and mental health services, were not well integrated and often do not recognise the unique gendered or trauma components impacting on perinatal mental health difficulties.

The framework by which health services respond to loss and bereavement is informed by *The National Standards for Bereavement Care* and accompanying Implementation Plan. This resulted in Bereavement Teams being established in each maternity service, with the appointment of a bereavement midwife to provide emotional and practical support to parents. The standards apply to all pregnancy loss situations, including from early pregnancy loss to perinatal death, and the end of a pregnancy in situations where a fatal foetal anomaly is detected. While this Plan aims to provide consistent care to all women and families, qualitative research in this area has found that many families experience issues with respect to communication and lack of available time of staff. This lack of individualised and respectful support was shown to increase feelings of upset and anger. A positive transition from hospital stay to community or outpatient support was found to be an important factor in reporting positive experiences following loss and trauma.

These findings are reinforced by the HSE's first *National Maternity Bereavement Survey* in 2022. In which women and their partners were asked about the bereavement care that they received in an Irish maternity hospital or unit following a pregnancy loss or perinatal death. The aim of the survey was to learn from the experiences of bereaved parents to improve the standard and quality of maternity bereavement care in Ireland. More than a quarter (26%) rated their care as "fair to poor", identifying the need to make improvements in relation to information and support regarding grieving, physical recovery, and mental health after leaving hospital. Participants expressed a desire for dedicated spaces in hospitals for grieving parents; more consistent communication across services involved in their care; additional support for physical and mental health; and more support for partners. Bereavement Teams being in place in all the maternity services provides a mechanism for this valuable feedback from bereaved parents/guardians to be adopted.

In conclusion, alongside the points outlined in the discussion section, it is imperative to mention additional key points raised during the roundtable discussion. These include the need for more research with greater investment in longitudinal studies to comprehensively track perinatal mental health in Ireland; particularly focusing on under-researched and marginalised women. The need to prioritise education and training programmes for healthcare professionals is essential to ensure timely detection, intervention, and support for women facing perinatal mental health difficulties. Participants also noted there needs to be an increased focus on the specific needs of neurodiverse women, including women with ADHD. Lastly, enhancing public awareness to mitigate stigma and promoting timely access to care and support, thereby fostering improved outcomes for mothers and infant is necessary.

Recommendations

1. Ensure secure and sustainable investment in perinatal mental health, to fully resource and implement the updated Specialist Perinatal Mental Health Model of Care.
2. Increase HSE capacity to respond to those with perinatal mental health difficulties by resourcing Specialist Perinatal Mental Health Services based on 1 full time consultant led Multi-Disciplinary Team per 4,000 live births. This would help to address the need for equity of access and equivalence of service across hub and spoke sites.
3. Establish a Mother & Baby Unit at St. Vincent's University Hospital, Dublin.
4. Further integrate SPMHS with the maternity services, as well as with primary, community-based, and specialist services, (such as General Adult, Liaison and CAMHS and mental health clinical programmes).
5. The development and delivery of perinatal mental health policies and services should be informed by gender-sensitive approaches and trauma-informed practices, in line with *Sharing the Vision.*
6. Strengthen supports at primary care, by increasing the number of PHNs, resourcing primary care psychology, and providing additional resources and training (including CPD training) for primary care professionals.
7. Primary and specialist services should be complemented by supports available in community settings. Increased investment and awareness raising of existing services would provide a robust framework for women to access peer-support, or other community-based parenting and mental health supports.
8. A greater emphasis on data collection and research in perinatal mental health, including the establishment of an education, training, and research centre. Data collection should include appropriate equality data, including the collection of ethnic data to ensure the experiences and outcomes of marginalised groups of women can be identified and addressed. Data collection tools and a mental health information system would also facilitate better research opportunities.
9. Improve perinatal bereavement and trauma services, including perinatal palliative care services. These supports should be specialist and community based.
10. Extension of current model of 6-week postpartum care in Ireland to at least 3 months to detect and provide adequate support for women's mental health needs.

Conclusion

In conclusion, previous perinatal mental health research on which the Model of Care in Ireland is based highlights the wider impact of perinatal mental health difficulties. The effects of such difficulties extend beyond the mental health of the mother to significantly include the social, emotional, behavioural, and cognitive well-being of their children who may potentially experience enduring challenges throughout their life.[41]

While significant strides have been made in advancing perinatal mental health services in Ireland, including the establishment of a Model of Care, several key challenges persist. Improvements are needed in areas such as, further and enhanced integration of Specialist Perinatal Mental Health Services (SPMHS) with general maternity primary care and mental health services, the absence of a dedicated Mother and Baby Unit (MBU), workforce capacity constraints, lack of resources within primary, community and specialist settings, limited data collection and research on the experiences of marginalised cohorts of women, and gaps in perinatal bereavement and trauma supports. In particular, the continued absence of the MBU, as the remaining critical component of the Model of Care, is an egregious failure by the State. In addressing these gaps, the recommendations outlined in this summary report will collectively ensure a more comprehensive and inclusive approach to perinatal mental health in Ireland.

Many traditional mental health supports, like Cognitive Behavioural Therapy (CBT) have been recognised as effective and appropriate options to address mild to moderate perinatal mental health difficulties. However, as discussed, many barriers impact women's access to such supports.[42] Therefore, services and practitioners need to prioritise person-centred, gender-sensitive, and trauma-informed approaches that acknowledge the uniqueness of each woman's intimate relationships, values, past experiences, and worldviews.[43] Perinatal mental health services should cultivate an inclusive culture that embraces women in all their diversity.

Lastly, this report concludes with a call to Government and other key stakeholders for sustained commitment, investment, and collaborative efforts to ensure that perinatal mental health services in Ireland evolve to meet the dynamic needs of diverse women and families. A comprehensive, woman-centred, and inclusive approach is essential for fostering optimal mental health outcomes during the perinatal period and beyond.

41 HSE (2017) specialist perinatal mental health- Model of care. https://www.hse.ie/eng/services/list/4/mental-health-services/specialist-perinatal-mental-health/specialist-perinatal-mental-health-services-model-of-care-2017.pdf

42 BMC (2018) Irish general practitioners' view of perinatal mental health in general practice: a qualitative study https://researchrepository.ul.ie/articles/journal_contribution/Irish_general_practitioners_view_of_perinatal_mental_health_in_general_practice_a_qualitative_study/19823953

43 HSE (2017) Mind mother project https://healthservice.hse.ie/filelibrary/mind-mothers-project.pdf

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