Perinatal Mental Health Alliance of Newfoundland & Labrador

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POSITION STATEMENT TO ENHANCE THE WORK OF PUBLIC HEALTH NURSES (PHNs) RELATED TO PERINATAL MENTAL HEALTH IN NL

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Introduction

During the perinatal period, the time between pregnancy and the first year after delivery, up to 28% of Newfoundland and Labrador (NL) mothers may be affected by a range of mental health issues, including anxiety, depression, and postnatal psychotic disorders. This is higher than the Canadian average of 23% [1-2]. These mental health issues can stem from various factors such as physical, emotional, hormonal, and socio-environmental stressors. Recent local research confirmed that many of these women do not receive the support they need [3]. The risks of untreated perinatal mental health issues can include compromised prenatal care, obstetrical complications, self-medication or substance abuse, compromised mother-baby interactions, and compromised infant's emotional, cognitive, and physical development. In extreme cases of postnatal psychosis, maternal suicide and infanticide could be the fatal outcome [4].

Additionally, current research evidence argues that increasing rates of mental health issues among children, youth, and adults may be connected to environmental and mental health stressors before conception, during pregnancy, and in the first three years of life [4-6]. Consequently, identifying ways to enhance supports and services throughout the perinatal period is key in preventing more serious and costly negative outcomes in the future [7-9]. For that reason, perinatal mental health has been declared by the World Health Organization (WHO) a public health priority [10-11].

In most Canadian provinces, and other high-income countries, there are policies based on best practices, guidelines, toolkits, or frameworks to prevent, identify, and care for perinatal mental health issues [12].

In NL, this is still a work in progress. This position paper summarizes how perinatal mental health may impact parents, babies, and families, and the current public health approach to perinatal health in the province. Additionally, recommendations are provided for how public health service delivery could be optimized.

Perinatal mental health at stake

The most common maternal mental health disorders in the perinatal period are postpartum depression, and postpartum anxiety, with 15-20% of mothers exhibiting different symptoms of these disorders. Also, among these women, combined symptoms from both disorders may be present. Depression and/or anxiety can lead to a lack of interest in regular activities, sleep and appetite disturbances, feeling of numbness and being overwhelmed, among other experiences [13-14].

High levels of fear or worry are part of postpartum anxiety disorders and could manifest as generalized anxiety disorder (GAD), panic attacks, social anxiety, post-traumatic stress disorder (PTSD), and obsessive-compulsive disorder (OCD) [14].

Postnatal psychosis, traditionally known as *puerperal psychosis*, is a severe psychotic illness, and although not very common (0.2%), it constitutes a psychiatric emergency due to potential safety concerns for mother and baby [15-16].

History of mental health issues before pregnancy should highlight the need to provide follow up care to these women. This follow up care is especially important if they suffer serious mental illness, such as bipolar disorder or schizophrenia. In these cases, ongoing support is recommended, as these conditions are risk factors for developing postnatal psychosis [17].

Other risk factors to keep in mind are limited social support, and having experienced adverse life events [17-19], such as:

- Bereavement
- Poverty
- Family or domestic violence
- Trauma
- Substance misuse
- Complications with conception
- Complicated pregnancy
- Unplanned pregnancy
- Adverse birthing experience
- Unrealistic expectations of parenthood

However, there is evidence that any perinatal mental health issue, including postpartum psychosis, can occur without the mother having experienced any identifiable risk.

Evidence also suggests that paternal mood disorders may be under reported and undertreated, with negative consequences for the family well-being. Fathers may suffer mental health issues during this period with a prevalence of one in ten for paternal depression and one in six for anxiety [20-21]. Although these estimates are for fathers, irrespective of the partner's mental health, the incidence increases when the partner suffers perinatal depression.

Untreated perinatal mental health disorders may affect the nurturing interaction with the newborn, impairing parent-baby bonding process and secure attachment [4, 6, 17]. Bonding and secure attachment are the foundations of the infant's socio-emotional development or mental well-being. Mental well-being during the early years allows young children to grow confidence, learn self-regulation, get along with others, explore, solve problems and develop skills, supporting their overall cognitive development and future mental well-being [22].

Enhancing public health nursing service to the perinatal population

Public health nurses (PHNs) play a crucial role within the broad scope of public health, defined as, "the organized efforts of society to keep people healthy and prevent injury, illness and premature death. It is a combination of programs, services and policies that protect and promote the health of all Canadians" (Canadian Public Health Association, https://www.cpha.ca/what-public-health) [23].

It is under the scope of PHNs to work to improve outcomes for babies and their families [24], which the World Health Organization (2018) defines as the most efficient way to guarantee the best start in life. In NL, the document regulating maternal-infant care is the Education and Support Standards for Pregnancy, Birth, and Early Parenting, Gov of NL 2005, but it is in need of an update [25]. An additional challenge encountered in NL is the lack of a standardized approach among the four regions of the province, with each region defining their own policies and/or procedures. One important reason for this challenge is the elimination, in 2015, of the maternal-child health position in public health provincially, which has resulted in a lack of programming and notable inconsistencies in perinatal mental health service. For example, as shown in Table 1 (below), the time and protocol for offering screening vary significantly across regions.

PHNs are well positioned to promote the importance of mental health by applying specialized knowledge in protecting maternal and infant mental wellness in the perinatal period. The prenatal services consistently offered by PHNs provide an opportunity to build a trusting relationship with their clients before the infant is born. These prenatal appointments also allow the PHN to educate and connect the mother with support and services during her pregnancy. After delivery, PHNs have opportunities to continue this contact with the mother through the Healthy Beginning Program. Specialized education on perinatal mental health should be mandatory for all PHNs to strengthen their skills and to enhance the potential to optimize this support.

Table 1 Edinburgh Postnatal Depression Scale (EPDS) Offered to Clients in the PH Program

	Eastern Health	Central Health	Western Health	Lab-Grenfell	Innu First Nation
Prenatally	Offered to all Prenatal referrals. Screenings may occur at time of Tdap vaccine, typically at 27-32 weeks, or anytime based on nursing assessment.	Offered to all Prenatal referrals.	Based on nursing assessment as per BABIES screening tool.	Based on nursing assessment as per BABIES screening tool.	Delivering *Centering Pregnancy* Program in Sheshatshiu, not available in Natuashish.
Postnatally	Based on client need and nursing assessment.	At 2-month Child Health Clinic visit and at any time during the one-year postpartum period based on client need and nursing assessment.	At 2-month Child Health Clinic visit or at a separate Clinic Visit/Home Visit between 4-8 weeks, again at 6 months and at any time during the one-year postpartum period based on client need and nursing assessment.	At 2-month Child Health Clinic visit or at a separate Clinic Visit/Home Visit between 4-8 weeks, again at 6 months and at any time during the one-year postpartum period based on client need and nursing assessment.	EDPS-Language barriers create challenges in direct interpretation of tool; therefore, not the most effective tool for Aboriginal populations.

Recommendations

To conclude, the recommendations for how public health service delivery could be optimized to support perinatal wellbeing include:

1. Assign a permanent leadership position within provincial government responsible for supporting maternal-child health in public health, with a focus on updating and promoting the *Education and Support Standards for Pregnancy, Birth and Early Parenting: NL 2005* [25]. Specifically, there is need to enhance the focus on parental mental health and wellbeing, and work towards a better integrated system of care (health and community services) for parents with perinatal mental health concerns;
2. Support the need for standardized education on perinatal mental health for all PHNs in the four regions of the province. The *Journey to Perinatal Well Being* [26] by the Province of British Columbia is available and recommended by these authors to be supported by the Province of NL to be offered to all PHNs. In addition to professional development opportunities, a systematic mentoring approach is recommended for all;
3. Regulate the application of mental health screening to be completed at defined times, both prenatally and postnatally, with every pregnant mother in NL and identify ways to provide follow-up care to most vulnerable parents.
4. Optimize communication between NL and Natuashish Government to create parallel processes using recommended best practices.

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