

The Mental Health Gap in Prenatal Education: NorthWestern Ontario women's perspectives

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A collaboration between Lakehead University and
Thunder Bay District Health Unit with assistance from
the Sioux Lookout Meno Ya Win Health Centre.

I have no conflict of interest to declare

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Outline

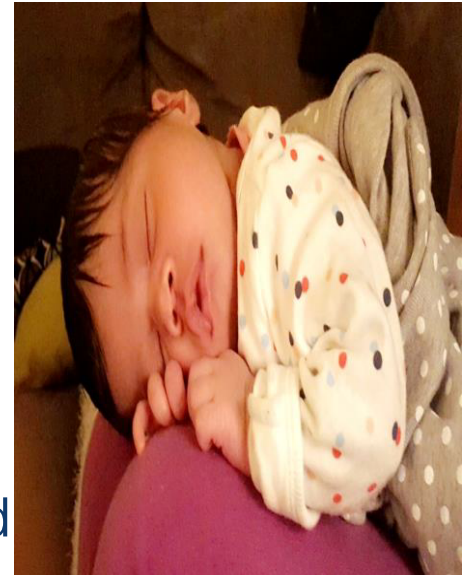
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Background & Context

Prenatal education: programs aim to provide pregnant women and their partners with the information and skills needed to improve pregnancy and birthing outcomes, and to prepare them for early parenting.

However, PNE attendance is low:

- 1 in 3 expectant mothers in Canada ⁶
- 1 in 4 expectant mothers in Ontario, and⁷
- 1 in 5 expectant mothers in Northwestern Ontario ⁷
- Numbers from Thunder Bay, Sioux Lookout, Kenora and districts are reported to be significantly lower ⁸



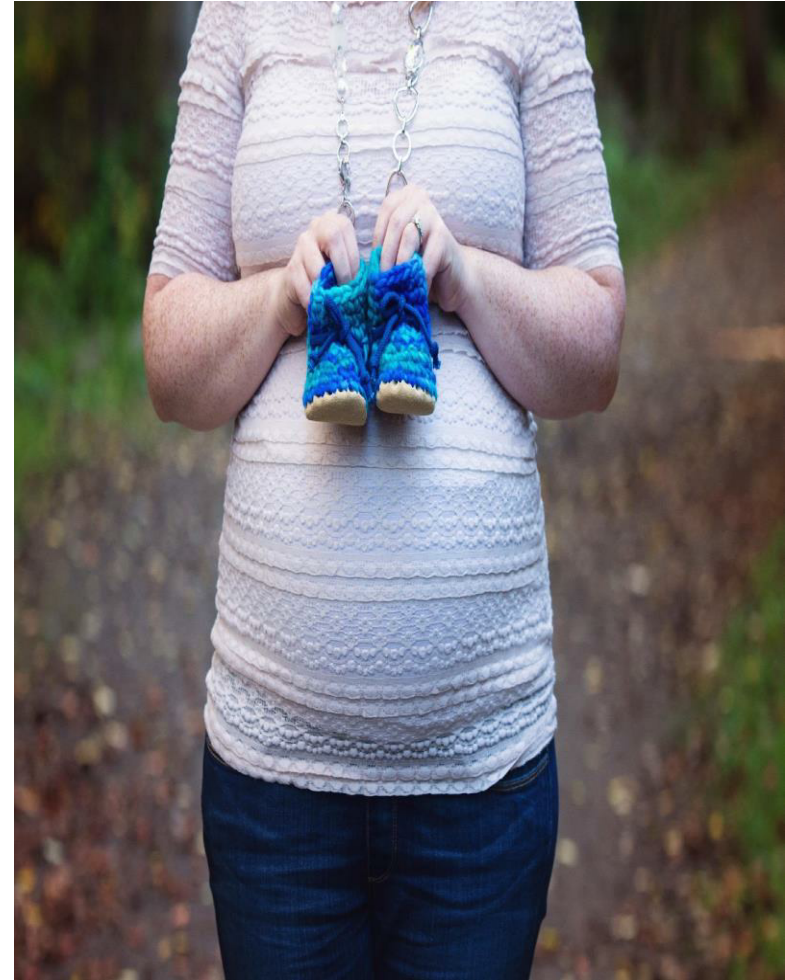
6. Choquette, L. Best Start, 2007 revised 2013; 7. Best Start Resource Centre, 2015; 8. Personal conversation Maggie Pudden, Thunder Bay District Health Unit, October 10, 2017.

Background & Context

Indigenous ^{1,2,3}, immigrant and refugee mothers¹, younger mothers,⁴ and mothers with less education and lower incomes^{1,4} report:

- Poorer maternity experiences than other Canadian women;
- Are less likely to access prenatal education⁵ (PNE); and
- Report a lack of maternity related information^{1,2}

1. Better Outcomes Registry & Network (BORN) Ontario, 2017; 2. Moeller et al., 2015; 3. Smylie, Crengle, Freemantle, & Taualii, 2010; 4. Public Health Agency of Canada, 2009; 5. Heman, et al., 2014.



PNE Study Goals and Objectives

Goal:

- To improve equitable access to the prenatal knowledge, education, and services that women in North-western Ontario need and desire to optimise their birthing experiences and outcomes

Objectives:

- To understand NWO women's experiences with prenatal education and the knowledge and information they would like about preconception, prenatal health, pregnancy and birthing.
 - Explore the impact of PNE on birthing experiences and outcomes
 - Explore potential barriers and facilitators to desired prenatal education

Methodology

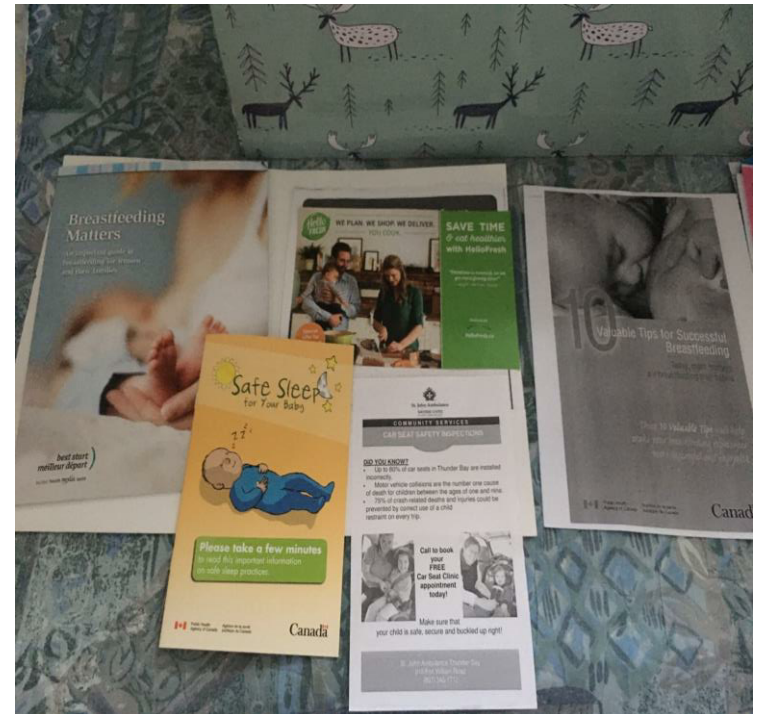
- Ethics: Community Engagement, REB, Consent of participants
- Recruitment: Purposive and Snowball sampling through maternal and infant care-providers/ organizations and local Indigenous and multicultural organizations
- Participants: Diverse mothers from NWO who have given birth within the past two years
- Interviews: Semi-structured interviews were conducted with the use of an interview schedule to maintain consistency⁹
- Nvivo software used to manage the data⁹
- Thematic network analysis used to identify basic, organizing and global themes in the data⁹

9. Creswell ,2013.

Study participants:

40 mothers from Thunder Bay,
Kenora, Sioux Lookout and
districts

- 18 Indigenous mothers
- 9 Immigrant refugee mothers
- 13 Euro Canadian mothers



Findings:

PNE Participation

- Majority of Indigenous and Immigrant women did not participate in formal PNE (2/3)
- Some or all PNE sessions offered during one of several or last pregnancy
- 50% of Indigenous women and immigrant women had not been informed about PNE by care provider
- Most want and think PNE/Prenatal information is beneficial
- Women with midwife supported pregnancies felt they had received adequate information despite not participating in formal PNE. Women with physician supported pregnancies less so (lack of time/fewer visits).

Barriers & Facilitators to PNE

ACCESS Key word

Availability : PNE not being available /Not-informed about the availability / No women only classes available

Travel: Distance/Access to a transportation/ kind of transportation available

Childcare: Availability of formal childcare, Availability of informal childcare (partner, other family members)

Timing: Time of day or week/ Time offered in pregnancy, women felt it would be helpful earlier

Fitting in or not: (fear of being judged): Age, Social circumstances (single mom, addiction).

Significant factors affecting perinatal & postnatal experiences and outcomes

The Gap in Maternal Mental health Education and Management

- ❖ Variation among the women groups (EC, immigrant, Indigenous)
- ❖ Lack of perinatal education information on mental health concerns, supports, and resources.

Barriers - Participant factors

- Lack of awareness about mental illness and that it is treatable (do not recognise their symptom)
- Recognise symptoms, but not seeking help or reporting to others:
 - Stigma (ashamed, “not a good mom”)
 - Fear of losing the child (noted in their file, the baby being taken away)
 - Confidentiality, being in a small community
 - Cultural barriers: EC vs immigrant & Indigenous moms

Barriers- HCP and Service Factors

- Limited Availability/Use of Screening for maternal mental health
 - Lack of screening tool/ Minimizing symptoms

- ★ Reluctance to screen. If screened then what?:
 - challenge in follow up/referral
 - What to do for people screened positive?
 - Where to send them?, no care pathways
 - Lack of culturally appropriate care programming

- “I think it would have been helpful for anyone to talk about kind of the emotional... strain that you go through in the few days after having a baby. That was never discussed and yeah... that was really never... discussed with me. So, I mean I know baby blues are super, super common. I would've loved to know that prior to having the baby blues. And... any sort of coping strategies that could have been presented to me at the time... Yeah. I think that that would've been the biggest thing I could think about that someone needed to tell me” (Int. 15)

“I would ...have loved to **learn about post-partum depression....** I was starting to realize that... I have no energy, I have no patience, I can't sleep at night **I was unhappy and I felt like I wasn't really connecting with my son... . I always felt like a bad mom.** I always felt guilty.... I finally went in to see my doctor... she said – you've been struggling with postpartum depression for almost two years... she put me on medication and I'm going to see a counselor soon and I've been feeling a lot better.” (Int.)

“So I would have loved to learn about that because I didn't even know the signs and I thought – and I always thought that I wasn't the kind of woman to get depression because I'm a happy person. It takes a lot to get me angry. It takes a lot to get me sad. I'm always happy and I just didn't feel right. I was thinking –oh my God – I don't want to tell anyone – everyone's going to think I'm a bad mother and they're going to think that I can't handle it. And it was kind of maybe my ego getting in the way as well. I wanted to be a good mom, so I hid it away and it started building up and finally I thought – oh my God, enough is enough – I can't do it anymore” (Int. 17)

“And then I remember **getting really depressed** and stuff and then I remember five days in, my mom and me started talking more. And I didn’t know I had it. And we prayed and stuff and then I felt better. It kind of went away slowly. ..and then I started talking – **I was ashamed**. I didn’t want to tell anyone like I had these thoughts. **I was scared they were going to take my kids away. I was scared they would rip my family apart.** .. That’s what happened there and I didn’t know I had it until – but then when I talked to doctors and I told them how I felt back then, they told me that I had it” (Int. 29)

Discussion

- ❑ Increased mental health challenges in the north due to geographic isolation, economic issues, and historical and intergenerational trauma (10)
- ❑ Limited access to care providers, mental health specialists and culturally appropriate programs (10)
- ❑ PPD is frequently undiagnosed and undertreated and Ontario lacks a coordinated system of care to address PPD concerns for women and their families (11)

Depression and anxiety disorders common but not well recognised, monitored or supported in perinatal care ⁽¹²⁾

- Worldwide about 10% of pregnant women and 13% of new mothers experience a mental disorder, primarily depression ⁽¹⁶⁾
- In Canada 7.5% women reported depression in the postpartum period ⁽¹⁵⁾
- As many as 1/5 women in BC will experience significant depression or another mental health disorder during pregnancy or post partum; few will seek help, or receive the help they need ^(p11. 14)
- **In Ontario the most tragic consequences of maternal mental problems are maternal suicide and infanticide.**
 - **1 in 19 perinatal death is suicidal (13)**
 - **39% of the women who died by suicide during pregnancy or postpartum sought mental health support in the last month of their lives (13)**
- Women who are pregnant are less likely to see a psychiatrist and more likely to see a family doctor (13)

Early Strong mental health support peri- and postnatally

- Awareness: Perinatal Education
 - Women, partner, family
 - recognize symptoms of mental health disorders , know how to ask for help.
 - Partner could develop depression and anxiety themselves.
 - Emphasis on early detection, the idea that mental health concerns are common and are not a sign of weakness)
 - ways to support women through pregnancy and post partum period (p7)
 - HCP
 - awareness among caregivers that mental health concerns and disorders other than PPD are also common among pregnant women (depression, anxiety disorders, bipolar, psychoses)
 - “Ask about previous or current severe mental health illness as this is predictive of illness during pregnancy and post partum”(14).
- Screening
 - **GOOD NEWS:** The Ontario Antenatal Record has been updated!
 - Updates to the 2017 OPR include:
 - A total of **five pages** including a page of mental health screening resources and a standardized postnatal visit record
 - Inclusion of mental health screening questions and tools
- Access: Increasing/provide resources (Cognitive therapy)

The Royal College of Midwives, U.K. recommend using The National clinical guideline on Antenatal and postnatal mental health developed by: National Institute of Health and Clinical Excellence (NICE)

Guidelines **suggests screening at first contact** antenatally and postpartum using **two questions**

- ✓ “During the last month, have you often been bothered by feeling down, depressed or hopeless?”
- ✓ “During the last month have you often been bothered by having little interest or pleasure in doing things?”

If yes, a third question should be asked:

- ✓ “Is this something you feel you need or want help with?”

Often **symptoms of depression or anxiety do not meet clinical criteria.**

Guideline recommends that symptoms are monitored and providers proactively seek information on psychological and social supports beneficial to clients to aid with stresses and challenges contributing to their mental health and well being. ⁽¹⁴⁾

Conclusion

- Access to and experiences of PNE in NWO are diverse
- A major gap identified by mothers is education and support for mental health concerns in pregnancy and the post-partum period
- Resources and supports need to be more widely advertised and available.
- Early detection and support for maternal mental health is key to better outcomes for all
 - A key issue is continuity of care (14).
- More education for both care providers and pregnant women is needed
- Screening tools and best practice guidelines from other jurisdictions may be useful (12, 14)

Prenatal Education Project Video Link

- https://www.youtube.com/watch?v=WT9_qqTEAFM&feature=youtu.be

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Thank You.
Questions??

