Futuremakers: Brain and Mental Health

Episode 2: Maternal mental health

Professor Belinda Lennox

Welcome to this season of future makers, brain and mental health. I'm Professor Belinda Lennox. I'm a psychiatrist and a researcher here in Oxford, and this season you'll be joining me as we demystify the science behind the most complex object in the known universe, our brains, and look at the wide-reaching impacts of mental illness on individuals and society.

I'll be introducing you to some of Oxford's best academic minds, working to solve the greatest challenges in brain and mental health, and I'll also be speaking to guests from beyond the university to bring their perspectives and lived experience and get a sense of the impact of what we're doing. Join us as we discover how Oxford is shaping the future of brain and mental health research.

So, it's my real pleasure to welcome you all to another episode of The Future Makers Podcast and this episode we're talking about maternal mental health and by that I mean mental illness that exists around pregnancy, either during pregnancy or after giving birth, and sort of the things we're talking about include depression, anxiety, postpartum psychosis or indeed post-traumatic stress disorder and illnesses that can be ranged from mild, moderate, or very severe.

And joining me today I'm really delighted to welcome two, brilliant women. So welcome Professor Fiona Allderdice, and she is a senior social scientist in Oxford at the National Perinatal Epidemiology Unit, and she's also at Queens University, Belfast. And I'm also joined by Professor Marion Knight, who's director of the National Perinatal Epidemiology Unit, and she's Professor of Maternal and Child Population Health, that's a bit of a mouthful. She's a professor of Maternal and Child Health Population Health in Oxford, also still a mouthful, anyway, she's the boss at the MPU. Welcome Fiona and Marian, and it's lovely to have you here with me.

Maybe to start with, I don't know, Fiona, do you just want to say how you got into this area of research and why it's interesting to you?

Professor Fiona Alderdice

Yes, thanks, Belinda. Yeah. So, I'm a psychologist. My background is broadly Social Sciences. I have a Social Science degree, one of the few. Every time people look at my CV they see SSC and think it's a typo. It's not. It is a Social Science degree.

So I'm broadly trained in Anthropology and Social Philosophy and Sociology (Social Policy). But you know, Psychology is my main topic, and I went quickly from that degree in Belfast, to a PhD in the Neuropsychology of Alcohol Abuse, and my undergraduate supervisor had suggested it actually because he knew that I was interested in Clinical Psychology and doing what was then a master’s in Clinical Psychology and said look this. It’s great clinical experience and it's great to get in there for three years. And also, to have very important research skills alongside that. So, I did it, enjoyed it, but in my third year I realised actually this is not where I want to be. I actually want to move upstream and I want to work more in prevention and protection of Mental Health and actually

optimising Mental Health. And they were the thoughts I had at that stage, nothing more formed than that.

But my husband had decided he wanted to do another degree in Oxford for two years, so I was very fortunate to get a post at the National Perinatal Epidemiology Unit for two years while we were there, with our young son. And that's where I found my passion for this work. I was working much more in the area of low-birth-weight babies with Ann Johnson and following them up. But what really struck me about the MP, and still does, is the ethos of the unit that the women and their families are absolutely core to everything that we do. And while parental mental health was not actually a topic of such in the way that we talk about it today, was always very Mental Health aware. And in those days, what was really important was using research to empower women and actually to have informed choices and a good maternity experience. So for me it was a fit, it worked, and I didn't look back.

So when I came back to Belfast and had more children, I worked my way up through Queens and my chair in parental health and well-being. And six years ago, I had the opportunity to come back to Oxford and so here I am.

I co-Direct the Policy Research unit based in the National Perinatal Epidemiology Unit that's funded by the NIHR. And all the work that I do is very much around experiences of care, how we can make that better for women. Looking at gaps in care, measuring psychological well-being, how good are the symptom checklists that we use in clinical practise? So those are the kinds of things that that I continue to work on.

Professor Belinda Lennox

Thank you. Marion, do you want to introduce how you got into this area. Because you're an obstetrician and an epidemiologist?

Professor Marian Knight

I was and its interesting hearing Fiona reflect on how she ended up in almost the same place from a very different background.

So yes, I'm medically trained, and I did start life training to be an obstetrician, but actually as part of that I increasingly began to recognise that actually there's much wider influences on health of women around pregnancy and indeed beyond. And so actually I then moved into and trained as a public health physician, hence my title, which is from maternal and child population health, because as a public health physician, you work very much at a population level.

I moved entirely into research and research around severe pregnancy complications and as part of that role, about 10 years ago now, took on the role of lead for the confidential inquiries into maternal deaths in the UK, which is a programme that investigates the care that all women who die during pregnancy or up to a year after pregnancy have received. With the important aim of preventing women from dying in the future. So, we know we can't prevent a death, once a woman has died, clearly, we can't prevent her death, but the ultimate tragedy for me would be not learning from her death, to try and prevent women from dying in the future.

And what's very clear when you look at the pattern of things that that women are dying from, is that by and large, now women are not dying from typical pregnancy complications, preeclampsia, or high blood pressure, or severe bleeding around the time of pregnancy, but from medical and specifically with relation to this topic, mental health related problems. Particularly at that period postnatally,

between six weeks and a year, that's when maternal mental health is one of the most important causes of maternal death, and tragically, maternal suicide.

And that for me then, and it's much less recognised, much less well researched and as Fiona's pointed out, services in general, much less well developed and so clearly an area where we need to focus.

Professor Belinda Lennox

I know it really is shocking. I mean, it still shocks me that suicide is the leading cause of direct maternal death within a year of having a baby. Is that right?

Professor Marian Knight

That's exactly right, yes. And yet, it's great that in the UK we're recognising it, we're counting these women's deaths, and we're learning from them. But globally, in too many countries, these women's deaths are not even counted, not recognised. And so, no learning going forward. So, we'll probably end up by saying this, but you know there's still so much to do. I think Fiona and I could multiply ourselves several times and we'd still not have scratched the surface.

Professor Belinda Lennox

Yeah, that absolutely. I don't know. Fiona. Where do you want to go? What's the sort of most fascinating thing for you that you've sort of been uncovering or, you know, researching around maternal mental health?

Professor Fiona Alderdice

Well, I suppose one of the things that I think is probably most urgent to talk about is one of the questions actually that you asked earlier around post natal depression and perinatal mental health issues. Have they increased in recent times, or is it that just there's more awareness because there is Marian's work, there's lots of things happening to raise awareness and probably the biggest thing to raise was in 2014, when the National Institute for Clinical Excellence launched their recommendations for parental mental health, and in that the recommendation was that we should ask all women in the antenatal period and after birth, about their mental health. And just asking 2 simple questions, in the past month have you experienced low mood, also are you disinterested in life, and really bringing that awareness to everybody, to the health professionals, to women who are being asked the question.

So I think that's raised awareness and probably also helped us identify more women. But we are also seeing an increase in the problem and that's actually really quite hard to work out because the statistics, internationally, are not good. The prevalence data is very complicated and messy, so why is that? There's lots of reasons, but one of the reasons is how we measure that. You know, we have lots of different measures of varying quality. We use lots of different cut offs. We look at lots of different populations and so study designs are often quite poor. So, the statistics are quite difficult and hard to interpret in terms of how we got this increasing trend.

Now we're quite fortunate in Oxford that we have. in the national Parental Epidemiology Unit, a national maternity survey that we've been doing since 1996. It's a huge population-based survey. We randomly select from women through birth registration and send out questionnaires to 10 thousand, 15 thousand women at a certain point of time, it's usually six months after birth, and we asked them about their experience of care. And in 2014, we then introduced the Edinburgh Post

Natal Depression Scale because we were interested to looking at the prevalence. And so, we have had that in the two surveys since as well.

We've also introduced anxiety measures and because of course, most of the work that has been done has been on depression and we know far less about the prevalence of anxiety and post-traumatic stress and other common disorders. So that survey has been really important because it's allowed us to look, with one measure, a very well-known measure, with one cut off, over time, on the changes in those populations. And basically in 2014 when we introduced it there was about 10% of women that would have been diagnosed with probable depression, above the cut off of thirteen on that scale. By 2018 it was 16%, and then during the pandemic it rose to 24%.

So, I think we can say there has been an increase. I think the next survey, which is due next year, is going to be a really important survey in helping us work out where it goes next, because of course, we're post pandemic, the NHS is in a very difficult place, and we have a cost-of-living crisis, so that's going to be an important one.

Professor Belinda Lennox

How fascinating. I Suppose that this sort of obvious, probably impossible question is, do you have any thoughts as to what's going on? Is that different increase in rates different to the rest of the population? Is it that everyone's mental health is deteriorating over the last 10 years?

Professor Fiona Alderdice

That's a good question and I actually can't answer that

Professor Marian Knight

I could come in with a little bit of a similar information. So, I should have started out by pointing out that dying during or after pregnancy in the UK is very rare. So I don't want anyone listening to become more concerned about that, but we do know that rates of maternal suicide are increasing amongst young women in particular, but that pattern is also being seen in the general population as well.

So, I think that there definitely is some deterioration across the general population in mental health as you'll probably be aware, so I think we do have to recognise that there are probably elements of both. The important thing that I think this picks up on is actually your first question or is it, is it that women are reporting more, or they're more likely to report their symptoms. I hope that is the case because one of the most important things, and one of the reasons that I wanted to come and do this is to emphasise that it is a common problem. There are many women who will be experiencing mental distress of various kinds during and after pregnancy, and the most important thing is to tell someone.

We do know one of the good things about maternal mental illness is that it is very treatable and so recognising that there is stigma around mental illness, but actually, you know we need to get over this and recognise that this is as normal, as common, as many other physical conditions and actually talking about it and telling somebody, whether it be family, friends or healthcare professionals is really important.

One of the patterns that we've seen when we look at the care that women have received is that they have told multiple people in different bits of their health service, or their GP, their midwife, they might have gone to the emergency department, or their family, and nobody's recognised that escalating pattern of illness and it just takes one person to recognise that pattern and to signpost

that to make sure that that that women get to the right professionals. And I'm sure I'm sure we'll come on to services soon, getting over the stigma, and making sure that we're speaking about this, it's really important.

Professor Belinda Lennox

It's such an important point, isn't it? Sorry, Fiona. I'm interrupting.

Professor Fiona Alderdice

I wanted to add to that because I think it is really the biggest ups to go on and I know it's a big problem throughout mental health, but actually stigma around the time of birth is bigger really because of shame and this guilt around being a bad mother and concerns that women have about their babies being taken away from them. All of those things contribute to it being very big and people not wanting to talk about it, and you know, we have to address that in some way and it's easy to say we have to address it.

But how do we do it? What we have been trying to do that is through the play that Marion mentioned earlier after birth. So, that's a collaboration that we have in the unit. Marie and myself and Rachel Rowe, have been working with an Oxford playwright called Zina Foster. Zina had heard about the statistics and was like you, shocked about the suicide and basically what we decided to do was she started talking to us a little bit more about all our research and started talking to women with lived experience, and she developed a play. She wrote this wonderful play, called afterbirth. And it's an evidence-based play, but it is truly a work of art. It's one that shocks you. It's one that makes you laugh. It's one that makes you cry. It is a recovery story and it's fabulous, and anybody who's seen it says, you know, it's moving, it's very compassionate. And whether you're woman with lived experience, whether your health professional, just a member of the public, anybody who's seen it said, it's fantastic. And actually, it was highly commended in the Vice Chancellor's Innovation Awards last year, so, widely recognised as a good thing.

But how do we get it out there further? You know that that's the big challenge. It's very hard to take a play like that with so much energy to somewhere else, into another form. So, we're now working with a filmmaker, Jo Elliott, who is a BAFTA winning filmmaker for short films and she's working with us to develop a screenplay for a short film based around the play. But obviously it has to change to be a film, so we're doing a lot of work around that and working to get that out to the public. But also, to then to use that in education, and to use it as a core point of education and to build around that. So, the Sheila Kitzinger programme had given us some money to start that process.

Professor Belinda Lennox

How wonderful. I mean, as you're both still alluding to, it's almost the biggest issue, isn't it? The stigma around developing a mental illness. I mean, it's so common. I mean, if you're saying a quarter of all women. I just remembering back to my own experience, it's such an isolating experience actually sitting at home with a small baby and your whole world is in turmoil. And I know that it's particular, the populations have particular risks, don't they? And that's also sort of the sad reality that women with other difficulties in their lives are also particularly at risk of maternal mental illness. And there's the biases and the discrimination in the access to care amongst particular groups as well.

Professor Marian Knight

Well, yes. One of the perhaps most particularly shocking statistics when we look at maternal deaths overall. We know that black women are four times more likely to die in pregnancy than white women, and it's about double for Asian women. And similarly, when we look at women who live in the 20% most deprived areas and compare those with women living in affluent areas, they're about twice as likely to die, and many of those factors that you alluded to are contributing to those women's deaths. So, we know that the women who are dying from mental health problems, in particular, many of them have complex and intersecting problems and we're a bit siloed in our services now, particularly when we're thinking about mental health we do need to think beyond just maternity services and particularly in that post-natal period. And post-natal care now is incredibly stretched for many women. If they're lucky, they'll get one visit postnatally from a midwife. We do have maternity care assistants, but you know, moving on to health visitors after that really, really stretched and very limited workforce, and yet that's the time when exactly as you know we've all experienced that isolating feeling as a new mother at home, often alone with the small baby, no clue what you're doing. And on top of that, if you've got mental illness, or mental health problems as well, it’s a really challenging time. And so, there's a need for more support and yet we're getting less support.

We've still got a long way to develop our perinatal mental health services. They're much better than they were, but there's still areas of the country where we have gaps. We know with the severest mental illness in pregnancy, sorry, postnatally, mother and baby unit are the right place to be, you know, being able to be admitted for specialist care with your baby. So that you can get the care you need and continue to develop that relationship with your baby is the ideal place to be cared for. But there are big areas, and I think Northern Ireland is one of them, looking where there's no mother and baby unit and the obviously the number of beds are very limited. So there is still lots more we can do to develop the services we need and to train professionals across all of those different bits of the health and care service to recognise mental illness in pregnancy.

Professor Belinda Lennox

Hello, I hope you're enjoying this episode of Future Makers Brain and Mental Health. If you'd like to learn more about our work here in Oxford, head to ox.ac.uk/brain or let us know what you think on social media using the hashtag Oxford brain.

Professor Fiona Alderdice

Being asked about their mental health so nice that we're saying basically everybody should be asked, but actually in 2020, after birth, a quarter of women said they were not asked about their mental health. And here are those women you know are disparities, and yes, there are so right across our national maternity surveys and what we've found is the women who are not asked antenatally or postnatally that doesn't, they're more likely to be women from an ethnic minority background as opposed to a white woman. So, we need to feed that back into the system always, and we need to keep that moving and see what we can do to change that in terms of policy and practise.

Professor Marian Knight

And just picking up on that, that ethnicity aspect, we've got to recognise that how women might express mental distress is going to be very different depending on their cultural background and therefore you know me as a white woman might not necessarily recognise that is an expression of mental distress among somebody from a different culture, and similarly the stigma amongst other cultures can be even higher. I'm a great admirer of Sandra Agway, who's written a fantastic book about her experiences as a black woman of postnatal depression. And you know, her explanation of

the fact that you simply do not disclose that kind of thing in in her community. So, you can see why it might have a disproportional impact on women from different ethnic backgrounds.

Professor Belinda Lennox

And this is really the case for specialist services, isn't it? Are, you know, services really focused on the perinatal period that recognise that sometimes the illnesses develop really rapidly and really scarily, and you need to be able to respond in a culturally sensitive way, picking up these illnesses because it isn't that the large lesson, that sort of generic mental health services was really a poorly equipped for dealing with perinatal mental illness.

Professor Marian Knight

Exactly right. So, I mean just repeating your point, but that's exactly the point in that, perinatal mental illness can get worse very, very much more quickly than mental illness in other populations and unless you recognise that and act fast, you know, it genuinely is an emergency, and you need that expertise to be able to recognise that, and institute treatment as quickly as you can.

Professor Belinda Lennox

Yeah, I suppose that I was reading just in in the press this week about, you know, that services are so stretched that often, young women presenting with mental illness tend to get dismissed as being sort of hysterical or histrionic behaviour. And I wonder if there's a lot of minimising of perinatal illness as well as oh, it's the baby Blues, oh, it's just everybody feels like that, you know, basically not taken very seriously.

Professor Fiona Alderdice

Yes, a lot of women actually comment on that. We have a lot of women making those statements and of course there's a lot of distress and they have to talk to a lot of people to actually be heard. And you were talking about young women there, I mean, young parents are particularly at risk of depression and it's really important that actually their voices are heard, and the other thing that we really need to think a lot about is making sure that our interventions are tailored for different groups. So young parents as a case in point, I'm involved in a trial, actually, a colleague of yours, Belinda, Professor Arnstein, and his team are working on an intervention for depression in young parents. And they've used this intervention in different countries with different groups, but recognising that it needs tailored, we're co-producing it, and changing the delivery, changing content to actually really work for those young parents who don't really want to even engage in the system at times. So, I think there's a lot of work to be done tailoring our interventions, tailoring how we engage with them.

Professor Belinda Lennox

Yeah, because I suppose we haven't mentioned about the impact on the wider family, on the baby and their development and of course the wider system as well. I mean, it really is a no brainer, isn't it, to treat these very treatable disorders.

Professor Marian Knight

Yeah, and I think Fiona's point, you know, we're both researchers. I think that the other aspect of Fiona's point is that, you know, as researchers, we need to be involving the right women, women who've had these experiences and families, so that we're asking and answering the right questions. And recognising that impact on the family as well as the woman herself and the lifelong impact on

the child. You know potentially if your mother is mentally unwell, and you don't make that bonding relationship it's going to have an impact for decades. So, I think people perhaps don't think in terms of the long-term impact that we can be having by making things better in this this relatively short period of time.

Professor Belinda Lennox

Yeah, completely. I mean, your work has already had a huge impact in informing policy and the NHS has dedicated money towards perinatal mental health services in the last 10 years and it is a good news story. And I think every NHS area now has dedicated perinatal mental health services and there are more mother and baby units that are opening, so people don't have to travel hundreds of miles, except for Northern Ireland. I want to absolutely acknowledge it's not enough. But I suppose, this is a real example of impact of careful world leading research actually into the lives of people and the health services that they receive. But I suppose where next is my question, you know.

Professor Marian Knight

So, for me, you know, as a researcher, I do what I do to make a difference and recognising that it very much as a team effort, you know, from involving the women who can help us design the research to all of the researchers and obviously the health service. Once changes are made, I guess for me the challenge we have now is that the women who have multiple and intersecting problems often have experienced adverse life events in themselves in childhood, might be care leavers, might be victims of domestic abuse, and perhaps have substance misuse problems as well, and that there's too often a well it's not our problem because we can't treat her mental health because of her problems with substance use and she's homeless, so she's not in our area or she's going to be moved to somebody else's area. So, we can't give her an appointment and that recognising that we will have to be thinking differently about how we care for individual women who've got all of these problems and you know, not just healthcare, we're going to have to think much wider.

And again, it brings me back to sort of, you know why I moved into to public health, population health, bringing together, thinking about social services, thinking about housing, thinking about drug and alcohol services. I don't have an answer yet, but unless we think about those women, they will get left further and further behind and will be the population who have the most problems.

I guess the bit we haven't talked about that I'd love to talk about, is actually what I really like about Fiona's work, is turning things around. So, Fiona talks about mental well-being rather than mental ill health and I don't know if you want to talk a little bit about how you've been looking at measures of well-being rather than measures of ill health so that we can think positively about how we're making a change and improving well-being, rather than preventing ill health.

Professor Fiona Alderdice

Yeah, I think you were talking about stigma earlier. It was one of the reasons I got involved in well-being measurement was, you know, of another way of maybe addressing stigma when you're actually working with, you're asking all women questions about their mental health. You don't want them to be thinking about having a mental health problem unnecessarily and you want to make sure that you are getting the women with mental health problems. But also, again going back to the point I made earlier, optimising people's mental health when they have lots of contact with services so probably before 2014 I started doing some measurement around well-being subjective well-being, looking at positive emotional states as well as negative emotional state and also how we think about

our well-being, you know how satisfied we are with our lives and actually I stopped it for a while, around 2014.

And because we were bringing in these measures in the hospital and people were very interested in what I was doing with the well-being measurement because they absolutely agreed, like most women are healthy physically and mentally. So, this absolutely makes sense, but we're just bringing this in now and we don't want to take away from that, and I didn't want to take away from that either. It was really important that mental health came to the fore, and in the way that they were doing so for a couple of years. I pulled back from that, but returning to Oxford, I've had lots of opportunities now to take that forward again and actually to ask to develop that question further. So, it's pregnancy specific measure, and it's asking women about how they feel about their pregnancies and it's applying it to pregnancy, in that specific circumstance, and I look at that in relation to other well-being measures. And you know these are highly correlated with the symptom checklists and correlated. So, I think there is a lot of potential for that kind of measurement, whether we use those measures, or whether we just reframe how we talk about mental health, I don't mind. You don't use my measure, I don't mind. What's much more important to me is that we encourage every woman to think about their mental health, we all think about our mental health and that we try and give it a little bit more parity of esteem with physical health. And I think until we do that, we're in trouble. You know we are so far behind in terms of how we value mental health in comparison to physical health and if we can just start adjusting that, I think it's a big thing. I think we really need to do that in the perinatal field because pregnancy is such a big event, physically, and psychologically, and understanding those interrelationships are hugely important. And so, for me, that reframing I think is really important as well.

Professor Belinda Lennox

Yeah, completely. It's such a big area. We can have another podcast just on this sort of relationship because I'm really interested in the relationship between well-being or mental well-being and mental illness. In that mental illness isn't the absence of mental well-being if you see what I mean, they're not. They're actually the same concept. Would you agree with that, Fiona?

Professor Fiona Alderdice

I absolutely agree with that, and I think people conceptually do struggle with that and there's a lot, and as you say, that's a podcast and itself. But I think we need to start changing our language a little bit. I think there's a lot of terms out in our communities. We all use the term depression, I'm feeling anxious. I'm feeling stressed. I think it's engaging people more in their understanding of their well-being. And yes, mental illness is a very different category. I do not see them necessarily as continuing. I think that they are different things, but they are interconnected. And I think we need to encourage people to see that bigger picture. The fact that we talk about mental health means we do often mean mental illness, don't we? So that's why I think looking at other terms bringing other ways of thinking into it's really important.§

Professor Belinda Lennox

Quickly, I suppose, and also just thinking a bit more broadly from my perspective, I think we understand so little about why women in childbirth this huge trigger for the development of mental illness is more than anything else in a woman's life, I would say. And why? Why that's the case? I mean we're really so naive really, in understanding it. Aren't we Marian?

Professor Marian Knight

So yeah, I was terrified. You were going to ask me the question about why? You know, this is a period of increased risk, we know there are many changes to the body as a consequence of being pregnant. We know there are hormonal changes. What we know there are physical changes. We know obviously there are huge changes in in women's lives. Going from being an individual person to then having a very dependent baby to care for. But we don't really know what aspects of any of those are the triggers for mental ill health. I don't know what terminology it is and it's probably a reflection you started this podcast by saying to women actually emphasising this is an area of Women's Health, and we know that many areas of Women's Health are under researched and add to that mental health, which is also itself an under researched area, and that probably gives you part of the answer why there's so many, don't knows. And because it's historically been an under researched area, and I mean good that it's not as under researched as it was, but there's still lots of scope for lots more, and if we get some of those answers, we may be then be able to think about different treatments and I hesitate to guess when we last had a new treatment around maternal mental health, but I don't think it's recent.

Professor Belinda Lennox

I don't think there's ever been one. I can't think of any treatment that's specific for women after childbirth or anything specific for women at all. Maybe ‘Fullstop’. I mean, you know, we don't treat mental illness in mothers any differently to any other mental illness.

Professor Fiona Alderdice

That's right, yeah, and I suppose even in terms of, you know, the checklists that we use, a lot of people still use general checklists and I suppose we've moved away from that slightly and the parental feels because a number of those measures. We're asking questions around fatigue and sleep that just are not for new mothers. You know, you're going to store. Really, we can show it really easily. And so, we do need to be to be thinking more about what is the impact of pregnancy here? What is pregnancy and what is mental health? You know what do we need to be looking out? For and, when we look at what we know about risk factors for postnatal mental health problems, you know the biggest one is always a pre-existing mental health problem. And yet, what are we doing about that? When a woman comes into services, I'm not convinced or care as collaborative as it could be. And I think there's an awful lot more that we need.

Professor Belinda Lennox

Completely. Completely.

Professor Marian Knight

I guess the one thing that I, and forgive me if I've already said it, and we've already, but I mean I guess my plea to women is don't If you've got symptoms, if you've got concerns, don't hide them. Tell someone. If you're a family member and you are hearing strange things from a relative or friend who is a new mother, recognise that might be a symptom of mental illness and know who to call for help. It could be your GP, it could be your health visitor, could be your midwife, could be an obstetrician if you're still pregnant. And the main thing is speak to someone, and if you don't feel you're being heard, speak to someone else, and that's the biggest challenge. Fiona alluded to it earlier, that women often do feel dismissed.

There is this tendency to normalise things, in pregnancy, in the postpartum period, and we have to recognise that it gets to a stage when things simply aren't normal. You know, in the last investigation we did into women who died by suicide, we were looking at Insomnia.

So, picking up on Fiona's point, we know that that every woman with a new baby will be having sleepless nights. But not having been able to sleep for two whole weeks is not a normal symptom. You know, it's not normal sleeplessness of pregnancy. But for some women, that was still being dismissed. You know it's because your break, it's because you've got a new baby. So, you know we need to recognise those sort of the red flags. We, in the inquiry I've talked about red flags being so any woman who expresses a suicide, who expresses any thoughts about violent suicide. Because we know, sadly, that women who take their lives tend to use violent means, so that that is a red flag.

If you, or your relatives express those kinds of thoughts that's something that's really concerning that means you need to get help. We all feel incompetent as mothers, but you know, out of proportion expressions of incompetence as a mother can be a concerning symptom of perinatal mental illness. Aas I say that insomnia, and a sudden change in mental health, picking up on Fiona's point, we do know that that that the biggest risk factor for mental illness in the perinatal period is previous mental ill health. And If you see a step change in either your symptoms, or your relatives, or friends symptoms, you know that that's a concerning red flag as well. So, knowing when to seek help, who you can ask, and who you can ask if you don't feel you're being listened to, is one of the most important messages to get across.

Professor Belinda Lennox

It's really important, and that there's a lot of as well as these specialist perinatal mental health services now across England. There's also a quite a lot of good web resources that I want to highlight. The maternal mental health alliance, which is a great combination of, I think over 120 organisations, who have come together and really have great information available and campaign for improved awareness and services as well. So, lots of help out there, and people that understand, and your main point, this is absolutely treatable. You know that we can improve the situation. That's why it's so completely vital that people do seek our help.

Professor Fiona Alderdice

You were mentioning the maternal mental health alliance, it's a fabulous resource. But they are also interested in research and getting good research done, and we're working with them, myself and a couple of colleagues, in putting together a funding application actually for what James Lind Alliance research priority setting exercise. So, working with people with perinatal mental health problems in their families, and health professionals, to try and identify the top priorities. You know, we've all got wish lists, but actually that's what really matters is what's going to make a difference for you. And we hope that will take off in the next year.

Professor Belinda Lennox

Do you want to say a bit more about our priority setting partnerships, Fiona? What they're about?

Professor Fiona Alderdice

Yeah, sure. So, I've been following a few, and so has Marian, and so, and interestingly, Ian Chalmers, who was our first director at the MPU, when he left, he said he first set up the Cochrane collaboration and then he moved on to what he called the James Linda Lyons. And in all of Ian's work, you know consumers as they would have been called in his programmes of work were central and he recognised that we all, as researchers, bring our biases and our needs and our careers to that table. And that actually what we need to do is make sure everybody else's voices are heard, that they are the priority. So, what we do in those priority exercises, there's a number of different stages, and will you ask, put out a survey to tell me what is the most important research priority for you in

this particular area in relation to your parental mental health or your partners or whoever. And then we shortlist that down and then another survey goes out and at some stage we check what research been done. You know, people may be interested in this, but maybe we just don't know. And so, we do a check of that and then we get everybody together in a room at the end. We say here's where we are, here's the list, let's start prioritising that, let's try and identify your top 20. And it's a big discussion and debate across different groups and we arrive there and that's information for researchers, but it's information for funders because we have such limited resources.

Professor Marian Knight

Yeah. So that was where I was going to come in because one of the exciting new roles I have is actually with the with the National Institute for Health and Care Resort. And actually, taking these priorities that that have been developed with the public and clinicians to then actually turn those into the research, so provide the funding to do the research, to answer the questions. It's very nice to be on to be on that side and really exciting to actually be able to push to get the research funding as well.

Professor Belinda Lennox

Wonderful. Thank you both so much. And yeah, for a very energising and well fascinating discussion. Also, slightly depressing. But you know, it's such an important area, isn't it? And thank goodness for both of you and for all the work that you do. Anything else that you wanted to raise?

Professor Fiona Alderdice

So just to go back to the point, you just in terms of where we are in the UK, that there has been investment and to me it's a drop in the ocean, but we're going in the right direction and I think you know, we're in a far better place than many other countries in terms of actually that awareness and we shouldn't overlook that. And yes, it can be quite depressing thinking about this, but I think, for me, the absolute priority is to get people talking about mental health and their well-being and things that we can do, you know, we know that support is a really important protective factor for people's mental health always, but particularly during pregnancy and the postpartum. Just getting people to think about those things, making it easy.

Professor Marian Knight

Yeah. And we've got a huge job. You know, when I look where we were ten years ago to where we are now, there's been a huge improvement. And so, I hope in another 10 years' time we'll have the same improvement again. And so then maybe we won't have to have this conversation in 10 years time.

Professor Belinda Lennox

And well, you're on. That's it, we're coming back in 10 years. Thank you.

I hope you enjoyed this episode of Future Makers, Brain and Mental Health. You can find more episodes of future makers wherever you get your podcasts and more on Oxfords research @ox.ac.uk/brain. Thanks for listening.