Informing the development of a fathers' and partners' pathway in perinatal mental health

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The fathers' and partners' pathway in perinatal mental health: a service development initiative

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Abstract

The NHS Long Term Plan for England committed to the mental health assessment and signposting for the partners of women involved with perinatal mental health services. This article describes the process of consultation to inform the development of a fathers' and partners' pathway in a perinatal mental health service in the north of England using the philosophy of coproduction. The ideas for the potential service, drawn from four focus groups, emphasised the need to validate new fathers' and partners' feelings, provide peer support and create safe, inclusive spaces for the family. It also produced a list of questions that could be asked when talking with fathers or partners about their wellbeing. It was also thought that preparing couples for the possibility of perinatal mental health issues during the antenatal period could be beneficial. This paper will be useful for any perinatal mental health service planning to develop their work with new fathers and partners of their service users.

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Background

The NHS Long Term Plan (2019) made a commitment to provide evidence-based mental health assessment and subsequent signposting to support the partners of women involved with perinatal mental health services. The importance of working with fathers and partners is also referred to in policy and guidelines including The Competency Framework for Professionals working with Women who have Mental Health Problems in the Perinatal Period (Health Education England 2018).

There has been an increase in studies aimed at improving knowledge of paternal perinatal mental health (Philpott et al 2017, Baldwin et al 2019). An understanding of the unique needs of fathers during this time – defined as from conception until two years post birth – has the potential to positively contribute to the whole family's wellbeing. Depression has been found to affect about 10% of fathers in the perinatal period (Paulson and Bazemore, 2010) with increasing evidence to show a broad variety of factors related to its development (O'Brien et al 2017).

Paternal mental health problems in the perinatal period have been associated with poor experiences in healthcare environments during labour and birth (Johansson et al 2015), during which some men feel isolated and excluded from communications between healthcare staff and their partners (Baldwin et al

2019). Increasing evidence has identified that new fathers can experience post-traumatic stress disorder due to witnessing traumatic deliveries (Daniels et al 2020) and when having a child admitted to a neonatal intensive care unit (Alexander et al 2020).

The benefits for children of having a father who has good mental health and is involved in their life can contribute to secure attachments throughout their life course (Ramchandani et al 2011). Having a father with poor mental health in the perinatal period can contribute to insecure attachment between father and child and has been associated with delays in language development and social and behavioural problems (Kvalevaag 2015). Recent evidence suggests that the impact of poor paternal perinatal mental health on child development may not manifest until after the child is 12 months old although the authors suggest further studies are needed (Rogers et al 2023).

Research has shown a positive correlation between maternal and paternal perinatal mental health problems (Thiel et al 2020) and despite the positive effect of social support on the mental wellbeing of new fathers, many find themselves isolated and report losing friendships in early fatherhood (Hodgson 2021).

There is a dearth of literature concerning the experiences of non-birthing female partners during the perinatal period. However, there are some similarities with new fathers in experiences with healthcare professionals, facing relationship changes and in the development of their identity as a parent (McInerney et al 2021, Howat et al 2023). In McInerney et al's (2021) study, non-birthing mothers experienced uncertainty in legitimising their parental identity from both the community and care providers. Other studies have also found that non-birthing female partners face challenges in having others recognise their role, including navigating their place within traditional healthcare systems, (Howat et al 2023) all factors which may impact upon their mental health in the perinatal period.

It is clear from the evidence that fathers' and partners' mental health requires further attention and support and the families experiencing these challenges are best placed to inform the development of services to meet these needs (Darwin et al 2021a).

Aim

To identify what fathers and partners, service users, perinatal mental health practitioners and stakeholders from local organisations want partners to be offered from perinatal mental health services.

Objectives

To understand the mechanisms by which improved/positive mental wellbeing can be facilitated for fathers and partners of women engaged with perinatal mental health services at an NHS trust in the north of England. To find out what fathers and partners would like to be asked and how they would like to be supported and followed up.

The approach

A consultation event was held in July 2022. This event brought together 19 participants including perinatal mental health practitioners, women who were service users, their partners and other fathers from the community who had previously expressed an interest in supporting paternal perinatal mental health and local stakeholders. Understanding that in the context of this service development 'partners' means biological fathers, non-biological fathers and female partners.

The event explored multiple perspectives on what a service for fathers and partners should look like and consisted of four facilitated focus groups; one for stakeholders (*n* = 2), one for mothers who were service users (*n* = 3), one for partners of service users; the fathers (*n* = 8), and one for perinatal mental health nurses (*n* = 6). Focus groups have been found to be useful in health research (Hyde et al 2005) particularly when individuals come together to discuss a shared experience.

Recruitment, ethics and the consultation process

This service development was approved by Sheffield Hallam University research ethics committee, Converis number: ER44104381. Participants completed consent forms including information about confidentiality and anonymity and were provided with information about where to access support should their participation prompt any negative feelings.

Invitations to the event were sent via letters and emails to current service users including invitations to pass on to their partners. Further invitations were sent to local stakeholders of the service who were interested in supporting the mental health of the community – those with an interest in perinatal mental health or those who refer to or receive referrals from other organisations, current perinatal mental health practitioners and contacts who were known advocates of paternal perinatal mental health in the community. Posters were also displayed on social media platform X (formerly Twitter) inviting participation from people in the local area. Information sheets were sent out with the invites to the consultation and were referred to on the posters. While the invitation was inclusive of non-birthing female partners of service users, none attended.

The focus groups were conducted in an informal manner and the participants were encouraged to take the lead in the discussions including making notes of key comments, questions and concerns. Prompt questions were used by the facilitator when the discussion paused or when the conversation needed to be re-focused. These questions included:

- In an ideal world, what would a perinatal mental health service for partners and fathers look like?
- What sorts of questions do you think partners and fathers would like to be asked?
- Where do you think partners and fathers would be most comfortable in receiving support?
- What would be useful ways to engage partners and fathers with support?

- Do you have anything else to say that would help us to design our pathways for partners and fathers?

Written notes were made by participants on sticky notes and on a flip chart. Each facilitator made notes throughout the focus groups. These comments, notes and quotes were collated, transcribed and compared to identify commonalities, key points and any significant differences between the groups' perspectives. Refreshments were provided at the end of the consultation and high street vouchers were given to partners and service users to show appreciation for their time. At the end of the event, the four facilitators met to share the main topics from each focus group.

Findings

Findings are presented as a commentary from the focus groups with commonalities and key points between and within the focus groups highlighted. Participants suggested a range of approaches to engaging fathers and partners, the philosophy of the pathway and the types of questions that would be useful to ask fathers and partners (Box 1).

Current experiences

Participants in the fathers/partners' group said they often felt 'left out' by services in the perinatal period and found it hard to access information: 'there's nothing for fathers,' one participant said. The fathers were unsure of who they could talk to and thought that many of their negative feelings about becoming a father related to their experiences in hospital – 'being a visitor and them not wanting fathers to be there'. All the fathers indicated that the language used in the perinatal period and transition to parenthood was key to inclusive practice. They suggested that 'stereotypes are frustrating and prohibit support'. They maintained that services were all focused on helping mothers and 'not focused on fathers' health and wellbeing'. They reported frequently feeling 'pushed out, left out and devalued' in healthcare settings. They describe poor communication within healthcare environments and being 'stood alone in the corridor' after the birth. The fathers were often implicitly or explicitly told 'you'll be fine, it's not about you'. This led to them deliberately ignoring their own feelings suggesting that asking 'what about me?' sounded selfish.

Participants in the mothers' group acknowledged that there was a lack of service provision and attention to fathers' mental health needs. The mothers were concerned about their partners' wellbeing and showed a great deal of empathy for them. Mothers felt hesitant to disclose their feelings to their partners because of the impact this might have on them, and they felt that fathers were constantly walking on eggshells around them. The mothers perceived a significant amount of pressure being placed on partners. They saw that their partners felt they 'had to cope', 'had to do everything', and often 'wanted to fix things'. When the women were unwell, they were worried about their partner and baby and needed to know that 'someone's got him'. They identified their partners as the information gatekeepers for family and friends.

Participants in the stakeholders group suggested that it was perhaps not the 'norm' for fathers and partners to ask for help and that they were often not included or not able to be present at antenatal appointments. There were cultural barriers highlighted and the need for a service for fathers and partners to be accessible to all cultures. They identified a lack of culturally bespoke services for example, for fathers who misuse substances and fathers in more vulnerable communities.

What is needed?

Participants in the fathers/partners' group said that they would want a 'normal conversation' and for it to 'not be clinical'. They wanted to be told 'this one's about you' giving them permission to be focused on their own mental health and wellbeing.

The fathers suggested that more information and support about perinatal mental health was needed before problems occurred, from conception or even pre-conception. They wanted 'the equivalent information about mental health' as information given on physical health needs 'such as massage and pain relief in labour'.

Participants in the mothers' group felt that discussions about family mental health with professionals needed to be delivered well and that services needed to consider the mental wellbeing of the whole family. They mirrored the fathers' perspectives related to an understanding of what was usual in the postnatal period, so that they were more equipped to deal with anything unusual. They highlighted a lack of adequate information about potential mental health problems in antenatal classes.

The fathers wanted 'father-centred advice' on matters such as their role, proactive signposting, physical and mental health services and 'more understanding about how relationships change' in the perinatal period. They wanted 'ways to tackle issues as a parental team and about relationship support and collaboration'.

The fathers suggested a 'pre-emptive check' followed by 'regular check-ins and signposting about life changes for fathers, and signs of mental health problems in mothers and fathers'. Alternatively, a separate group or phone call to 'check how the partner is doing in the transition to fatherhood, changing relationships and getting back to work'. They wanted services and practitioners to be 'open, visible, informal and friendly'. The contact needed to be accessible and scheduled when they could be free. Participants in the partners' and stakeholders' groups asked whether anything face to face could take place where childcare was available particularly if the mother was acutely unwell as partners would be reluctant or unable to leave them alone.

The mothers thought that fathers and partners needed practitioners to explain the mother's illness to help them understand it. The mothers suggested that a couple-based approach would be useful, with meetings early on when mental health problems arose so they could find commonalities in their experiences to build on. They highlighted that fathers and partners were able to see through the symptoms to the person behind them but that they needed support in knowing what to say to their partners when they are unwell.

The mothers' group felt that fathers needed to be empowered. They wanted fathers to have tools to be able to articulate their feelings and for professionals to validate their feelings. They felt that 'not feeling okay' needed to be endorsed for fathers and framed this as 'you don't have to be ill for something to be difficult'.

The stakeholders' group suggested a range of activities for fathers and partners which did not involve face-to-face encounters and perhaps in an environment where eye contact was not necessary, for example, while playing snooker, driving, or on walks. The location should be where the fathers and partners felt comfortable and suggested that different options should be available, for example, a football ground, a café or at home. They felt that the fathers needed to be in environment where they could 'decompress afterwards' and that they might benefit from their partner not being present, as this would perhaps encourage honesty and openness.

The stakeholders suggested that all services available to families in the perinatal period should casually promote the uptake of the perinatal mental health service for fathers and partners via their routine contacts with the family. They thought that the service should work with other key stakeholders to ensure they know all about the 'partners' pathway'. To increase motivation, any visual promotional materials need to be relatable and positive and avoid using images of 'frazzled looking kids and parents'. Using phrases such as 'let's support you to be the best father you can be' was suggested by the stakeholders' group.

The practitioners' group considered what the fathers' and partners' perinatal service might involve and thought about alternative means of providing support such as via a website that could be accessed at any time. Practitioners felt that the pathway should be offered to all fathers and partners of women who were users of perinatal mental health services. They wondered about a separate pathway running parallel with the mothers' service. The practitioners discussed both formal and informal support and suggested there should also be events for fathers, partners and families that were more accessible for example, outside of regular working hours.

Practitioners felt that an option to talk to a male practitioner should be considered for male partners. They discussed that during home visits, fathers and partners may be at work and when they were present they tended to remove themselves from the conversation which presented a barrier to encouraging access to services and validating their experiences.

Where and how?

Participants in the fathers/partners' group indicated that the location of support was crucial, but that one size would not fit all. Support which could be accessed in the perinatal mental health service setting and out in the community was suggested to be beneficial to different fathers and partners. Many of the fathers thought that pub-based support was a good idea for some fathers. Others indicated that small groups in informal settings such as a park or a coffee shop might be useful.

The fathers thought that an initial group setting could lead to further one-to-one support if needed. They discussed the concept of gaining support by default for example via doing an activity together that was not explicitly about discussing mental health. They thought that side-by-side support while engaging in a mutual activity appealed to the 'fix it mentality' and would 'give them a job'.

Participants in the mothers' group wondered whether fathers and partners would go to see their GP for perinatal mental health concerns and wondered whether one-to-one support from perinatal services would be more beneficial. Mothers thought that peer support and putting fathers in touch with other fathers and partners would be useful and would provide a means of gaining validation and reassurance.

Stakeholders felt that fathers and partners would want something that was easily accessible, considering that they might be looking after children alone with an unwell partner which may also include going to work and maintaining the home. Stakeholders suggested that fathers and partners might benefit from a keyworker model to promote continuity and they thought that this relationship would be enhanced if the father or partner could choose their own keyworker from a list of accessible staff, for example: health visitor, peer supporter or GP. Alongside this was the idea of surrounding the father or partner with 'excellent peer support' and that there should be local champions in communities.

Concerns and complexity

Perinatal service practitioners' comments and concerns related to the practicality of the prospective service, their education and training needs and a potential conflict with the philosophy of current services. Further concerns discussed by the practitioners included an already oversubscribed service and heavy workloads where they were working at full capacity. They were concerned about taking on an additional role with fathers and partners and how they would manage this. Concerns around confidentiality was significant for the practitioners with a potential conflict of interest by seeing both mother and partner and they thought that different practitioners should see fathers and partners. They debated the barriers to delivery of and access to the fathers' and partners' pathway. They had concerns about the funding of this pathway alongside a lack of male practitioners in the team.

Some members of the practitioners focus group spoke about training they had already had in relation to working with fathers and partners and the things they had learned from this. They indicated that they had experience of fathers opening up to them about their struggles but how it can be difficult for them to deal with this due to a lack of specific provision.

Box 1. Questions suggested by the focus groups which fathers may like to be asked as part of the pathway.

How are you?/How are you doing?/Are you alright?
How have things been?
How do you actually feel right now?
Is there anything you're worried about?
How are you finding juggling work with being a father?
Are you finding anything difficult? What are the toughest bits at the moment?
How are you finding being a father? How are you finding parenthood?
What is the most challenging thing for you as a father at the moment?
If you were struggling, do you know that you can tell us?
How predictable is life? Do you feel like you know what the day will be like?
On a scale of 1-10, 10 being miserable and the worst you have ever felt, where are you at?
How have your relationships with your partner, parents and friends changed?
How's work?
What have you been up to? How has your week been so far?
How have you been bonding with your new baby?
What do you normally do week to week?
What's on your mind? What else? Have you been getting out and about?
How are you coping? Is there anything you're struggling with or finding hard?
In response to an issue: A large proportion of men/fathers/people experience this issue; it's common. Do you relate to any of this?
What do you usually do with your time? Are you able to do that now?
Do you have time for yourself?
What have you done for yourself (this week)?
What can we do to bring 'a bit of you' back?
Are there times when you don't recognise your partner's behaviour?
What's normal for your partner?
How is your partner? Have you been worried or scared by anything she has been doing or saying?

Discussion

All participants agreed that the partners of women involved with perinatal mental health services required more support. This mirrors several previous studies indicating that new fathers' psychological needs are neglected or ignored by current service provision (Ruffell et al 2019, Daniels et al 2020, Mayers et al 2020). Participants felt that fathers carried a significant burden when their partners were experiencing perinatal mental health problems including financial provision for the family, caring for other children and being the gatekeepers of information for friends and the wider family. Existing studies have acknowledged the barriers to fathers accessing and accepting support including a lack of information and awareness in their social groups (Doucet et al 2012) and a lack of attention form perinatal mental health services (Ruffell et al 2019).

There was an understanding from participants that new fathers and partners were vulnerable to their own individual experiences of distress during the perinatal period and that supporting a mother with perinatal mental health problems increased their vulnerability, which concurred with findings from a recent systematic review (Thiel et al 2020). Participants felt that there was still a long way to go in raising the profile of paternal mental health, and in changing social norms and perspectives about fathers' involvement in the parenting of infants from birth.

Peer support was identified by the participants as being an important approach in supporting new fathers and partners. Increasing evidence demonstrates the importance of peer support in the transition to fatherhood with benefits including shared experience, legitimising feelings, emphasising the role of the father and reduced feelings of isolation (Doucet et al 2012, Archibald 2019). Participants in this service development consultation and in previous studies also indicated that professionals such as midwives and health visitors did not acknowledge their mental health and that they were made to feel that it was not important because they had not given birth. The good practice guide for working with partners, fathers and family members in perinatal health services (Darwin et al 2021b) emphasises the need to validate and legitimise fathers, partners and other family members' distress.

The evidence gathered from these consultations points to the value of both joint and individual approaches where couples could be seen together, but where mothers, fathers and partners are also provided with individualised support. There was strong agreement from all participants that both mothers and fathers needed their own space to be able to decompress and have some time for themselves. Concern was raised about how this could be possible when mothers were very unwell and both partners were worried about safety. Safety concerns have been raised in other studies where fathers identified feelings of helplessness and powerlessness in relation to concerns about how to keep their child and partners safe (Engqvist and Nilsson 2011). This warrants consideration and could involve collaboration with external partners in providing recreational spaces for partners and fathers while providing a safe space for mothers and babies and vice versa.

Both the mothers and the partners wondered why perinatal mental health was not discussed more openly. The emphasis on physical aspects of pregnancy, labour and birth during antenatal classes needs to be altered to accommodate more information about perinatal mental health and associated support. Research has shown that prospective and new parents lack significant knowledge and understanding of perinatal mental health problems including diagnosis, treatment and recovery (Engqvist and Nilsson 2011).

Practitioners' concerns were predominantly around safety, confidentiality and workloads and were entirely valid in the current NHS context where demand outstrips provision and where they already feel the strain when providing services to mothers. Further professional development and adequate funding to support services for fathers and partners is required.

Limitations

The partners in attendance at this event were all men and the biological fathers of their partners' babies. There is a need for more research exploring the experiences of non-birthing mothers in same-sex relationships to further inform the partner pathway within perinatal mental health services. A more inclusive approach to research of this nature such as a specific event for same-sex parents may provide a safe space and encourage them to share their perspectives. Further consideration is needed regarding supporting fathers with existing mental health and substance misuse problems and for fathers from diverse groups and backgrounds to embrace ethnic and gender diversity. to ensure that provision takes these factors into account and is provided in a culturally responsive and inclusive way.

Conclusion

This service development achieved its aim and objective of identifying what fathers and partners, service users, perinatal mental health practitioners and stakeholders want from a fathers' and partners' pathway in perinatal mental health services and how this might be achieved.

The mental wellbeing of new father and partners could be improved through acknowledgement and support from professionals, from peer support and help to engage in recreational activity. There are various options for how services might develop but practitioners need reassurance that adequate resourcing and investment in their professional development is forthcoming.

Recommendations for policy and practice

- A well-resourced service for partners and fathers, individualised to specific partners' needs and circumstances, should be considered, combining options such as online, text-based or face-to-face support from perinatal mental health services.
- A peer support approach for fathers and partners should be considered, incorporating recreational activities.

- Fathers and partners who are experiencing significant perinatal mental health problems should receive referrals with the emphasis on clearly identifying this as a perinatal mental health concern.
- All parents should be provided with information about perinatal mental health problems during the antenatal period and there should be targeted support for prospective parents who are assessed as being potentially vulnerable to experiencing perinatal mental health problems.

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