Maternal mental health:

Introduction

Maternal mental ill-health has a long-term effect on maternal wellbeing, family relationships and the mental health, social adjustment and attachment of the child during the first critical years of life, therefore prevention, early diagnosis and intervention is vital.

The mental health of the mother has a significant effect on the health of her children during pregnancy but also throughout the child’s life with a significant influence on foetal and early brain development. Poverty and low socioeconomic status are associated with poor psychological and physical health when women come to pregnancy and are determinants of pregnancy outcome bringing about social disparities in pregnancy. Mental health problems in pregnancy and the postnatal period are associated with adverse outcomes for the foetus and the baby as well as for the woman herself; for example, severe depression is associated with an increased risk of lower birthweight and premature babies, particularly for families affected by socioeconomic deprivation, self-harm and suicide. Perinatal mental illness is complex and covers a range of conditions of varying severity including post-partum psychosis, mental ill-health and depression, perinatal obsessive compulsive disorders and anxiety.

There is emerging evidence that untreated mental health problems in pregnancy may be associated with poorer long-term outcomes for children beyond the immediate postnatal period; for example, depression in pregnancy has been associated with internalising and externalising disorders in the children and depression in adolescents and young adults; and anxiety in pregnancy is associated with an increased risk of internalising problems and emotional and behavioural difficulties in children. Therefore tackling mental health issues is essential.

Depression and anxiety are the most common mental health problems during pregnancy, with around 12% of women experiencing depression and 13% experiencing anxiety at some point; some women may experience both. Depression and anxiety can also affect around 15-20% of women in the first year after childbirth. Anxiety disorders including panic disorder, generalised anxiety disorder (GAD), obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and tokophobia (an extreme fear of childbirth) can occur on their own or coexist with depression.

In addition, psychosis can re-emerge or be exacerbated during pregnancy and the postnatal period. Postpartum psychosis affects about 1 in 1,000 women who have given birth. Women with bipolar (type) I disorder are at particular risk, but postpartum psychosis may also affect women with no previous psychiatric history.

Although the prevalence of anorexia nervosa and bulimia nervosa is lower in pregnant women, the prevalence of binge eating disorder is higher. Low birthweight has been associated with maternal history of anorexia nervosa and women with binge eating disorder have an elevated risk of babies that are large for gestational age, and worse foetal and infant outcomes are reported for drug and alcohol-use disorders.
Risk factors and vulnerable groups

The causes of mental ill-health during pregnancy and following childbirth are not well understood. Some factors known to increase risk are:

- Individual or family history of mental ill-health.
- Being a lone parent or within a poorly functioning couple relationship.
- Low social support and social capital.
- Experience of a recent adverse life event.
- Socioeconomic disadvantage.
- Being a teenage parent.
- Early emotional trauma or abuse.
- Unwanted pregnancy.

Ethnicity and social isolation play an important role in mental ill-health risk. However, there are fewer than expected women from BME groups diagnosed and treated for perinatal mental ill-health despite high levels of morbidity and social risk factors.\textsuperscript{142}

What is the evidence base

The NICE clinical guidelines make recommendations for the recognition, assessment, care and treatment of mental health disorders in women during pregnancy and the postnatal period (up to one year after delivery). It includes advice on the care of women with an existing mental health disorder who are planning a pregnancy, and on the organisation of mental health services.

It recommends that a Clinical Network should be established for perinatal mental health services managed by a coordinating board of healthcare professionals, commissioners, managers, service users and carers.\textsuperscript{142}

The NICE quality statement on postnatal care recommends that women who have transient psychological symptoms (baby blues) not resolved at 10–14 days after the birth should be assessed for mental health problems.\textsuperscript{v}

The Department of Health and Local Government Association have produced six early years high impact areas, one of which is maternal (perinatal) mental health.\textsuperscript{v} The guide suggests that close working with midwives is essential to share risk factors identified during pregnancy eg. by midwives with health visitors. Additionally, health visitors contribute to awareness-raising, education and training of the wider early years’ workforce and working with early years’ professionals in children’s centres. The health visitor is well placed to lead the implementation and delivery of group-based postnatal support and other preventive or early interventions to promote mental health, such as promoting physical activity, peer support groups and fathers’ groups. They also provide information on issues that impact on mental health and wellbeing such as welfare benefits.

Local picture

A perinatal mental health needs assessment was completed in 2014 and aimed to understand the estimated need in Luton for women affected by mental ill-health, the current level of service provision and to identify any gaps in prevention, early intervention and treatment provision.\textsuperscript{117}
The assessment found a high proportion of women with risks that contribute to perinatal mental health. Based on estimates, in Luton:

- 4% of mothers who give birth (approximately 140 women) will require advice and support from a specialist perinatal mental health service, resulting in roughly 14 women admitted to a specialist mother and baby unit.
- 8% (280 women) will require and accept referral for psychological therapies.
- 8% (280 women) will experience mental ill-health but will not require, or do not accept, the offer of, treatment.

The assessment found a lack of local data regarding the number of women diagnosed with perinatal mental illness, although it recognised that this was a local and a national issue. Current information databases capture information regarding ‘at risk’ rather than capturing data regarding diagnosis and severity of illness. The main data source was Luton & Dunstable Hospital midwifery data, cause for concern. Over a 24 month period (2011-13), 15% of women giving birth were identified in this category, with 9% (over a 6 month period) having antenatal mental ill-health and 4.5% having mental ill-health in the post-natal period.

The needs assessment identified that White British women have the highest percentage of diagnosed perinatal mental ill-health, significantly higher than the Luton average and women classified as Indian, other White, Bangladeshi and Pakistani communities, which were significantly lower. Based on estimates, this suggests that ethnic groups are under-represented which may indicate that women in these groups either do not have perinatal mental health need or are not presenting with it to health services and this would indicate undiagnosed and unmet health need.

What is being done locally?
The needs assessment recognised that whilst there are a number of services available to support and treat women with perinatal mental ill-health, there is a gap in knowledge and awareness of these services which suggests that some women are not diagnosed and getting the interventions they require. Recommendations from the needs assessment are being picked up through the Flying Start programme.

Priorities
1. To fully implement the recommendations from the perinatal mental health needs assessment through the Flying Start programme and CCG commissioning. Specifically to:
   - Improve data collection and analysis.
   - Develop a strategy and care pathway that health and social care professionals will use to refer appropriately.
   - Monitor the quality and impact of services through commissioning and performance management of outcomes.
   - Educate staff to recognise signs and symptoms, thresholds for referral and which services to refer women to.

2. In the transition of health visiting to the local authority ensure the service specification includes the high impact action to improve outcomes in maternal mental health.
References


ii C Power, O Manor and J Fox, Health and Class: the early years, Chapman and Hall, 1991

