



## Care and self-reported outcomes of care experienced by women with mental health problems in pregnancy: Findings from a national survey



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### ABSTRACT

**Background:** mental health problems in pregnancy and the postnatal period are relatively common and, in pregnancy, are associated with an increase in adverse outcome. It is recommended that all women are asked about their emotional and mental health and offered treatment if appropriate.

**Objectives:** to describe the care received by women self-identifying with mental health problems in pregnancy, and to describe the effects of support, advice and treatment on outcomes in the postnatal period.

**Design:** this study used cross-sectional survey data collected in 2014 which described women's experience of maternity care.

**Setting:** England

**Participants:** a random sample of women who had a live birth in January 2014.

**Measurements:** the questionnaire asked about sociodemographic characteristics, whether women were asked about emotional and mental health in pregnancy, support and treatment offered, about postnatal wellbeing, and questions relating to attachment to their baby. Descriptive statistics and logistic regression were used to examine the associations between mental health and outcomes taking account of sociodemographic characteristics.

**Findings:** the survey response rate was 47%. Women with antenatal mental health problems were significantly more worried at the prospect of labour and birth, had lower satisfaction with the experience of birth, worse postnatal mental health, and indications of poorer attachment to their baby. They received substantially more care than other women but they did not always view this positively. Support, advice and treatment for mental health problems had mixed effects.

**Conclusions:** this study describes the significant additional care provided to women self-identifying with mental health problems in pregnancy, the mixed effects of support, advice and treatment, and the poor perception of staff interaction among women with mental health problems.

**Implications for practice:** health care professionals may need additional training to effectively support women with mental health problems during the perinatal period.

### Introduction

One in five women develop mental health problems during pregnancy or in the year after birth (Chief Medical Officer, 2015), most commonly anxiety and depression (Gavin et al., 2005) which are often co-morbid (Henderson and Redshaw, 2013). Such mental health

problems are not normally long-lasting although a small proportion do extend beyond one year (Gavin et al., 2005).

Perinatal mental health problems are associated with an increased incidence of adverse outcome for both mother and baby. For example, there is an increased risk of prematurity and low birth weight in babies of depressed women, especially if the depression is untreated (Grote

**Abbreviations:** AN, Antenatal; EPDS, Edinburgh Postnatal Depression Scale; HCP, Healthcare professional; IMD, Index of Multiple Deprivation; MH, Mental health; NICE, National Institute for Health and Care Excellence; ONS, Office for National Statistics; PN, Postnatal

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et al., 2010). There is also an increased incidence of attachment difficulties, poor mother–infant relationships and developmental difficulties in children of depressed mothers (Murray et al., 1996; Barker et al., 2012). At the extreme, rates of suicide are higher in women with mental health problems (Lindahl et al., 2005), and mental health problems contributed to almost a quarter of maternal deaths in England between 2011–13 (Knight et al., 2015).

The National Institute for Health and Care Excellence (NICE) recommends that all women are asked in early pregnancy about their emotional and mental health (National Collaborating Centre for Mental Health, 2014) with continuing discussions through pregnancy and in the postnatal period. If mental health problems are detected or disclosed, this can generally be dealt with in primary care in the community, with treatment in secondary care in hospital in more severe cases (National Collaborating Centre for Mental Health, 2014). Effective interventions for mental illness include psychosocial interventions, psychological therapies and psychotropic medication (National Collaborating Centre for Mental Health, 2014).

Non-white women and those living in deprived areas are less likely to be asked about mental health (Redshaw and Henderson, 2016), and women's experience of maternity care when they have mental health problems is patchy reflecting inequities in service provision in this area (NHS England, 2016). In addition, women face stigma which may deter them from seeking help (Chief Medical Officer, 2015), and many lack knowledge of what services are available (Khan, 2015).

The aims of this study, which follows on from one focussing on which women were asked about their emotional and mental health (Redshaw and Henderson, 2016), were (i) to describe care received by women self-identifying with mental health problems in pregnancy, and (ii) to describe the effects of support, advice and treatment on outcomes in the postnatal period.

## Methods

This study used data collected in a cross-sectional national maternity survey carried out in 2014 (Redshaw and Henderson, 2014). Women who gave birth during a two week period in January 2014 were randomly selected from birth registrations by the Office for National Statistics (ONS). Women were excluded if their baby had died or if the mother was aged less than 16 years. Women were not excluded for mental health reasons. The questionnaire, together with a letter, information leaflet, and contact information in 18 non-English languages, asked women to complete the questionnaire (by phone with the help of an interpreter if necessary, or online) and return it in a Freepost envelope. Ten thousand questionnaire packs were sent out when the babies were 12 weeks of age. Using a tailored reminder system (Dillman, 2007) up to three reminders were sent as required.

Women were asked about events, care and experience of pregnancy, labour and birth and about the postnatal period, and questions about sociodemographic characteristics. They were asked if they had a mental health problem during pregnancy. Specifically, following questions about mental health more generally, women were asked 'If you had a mental health problem during pregnancy, did you receive support, advice and/or treatment' with answer options Yes/No/Does not apply. Thus 'mental health problem' was as understood by respondents rather than being explicitly defined. Women were also asked to complete a checklist of 15 antenatal symptoms including anxiety and depression and to indicate whether they consulted a healthcare professional for this reason.

## Outcomes

Outcomes included in the questionnaire included three validated measures:

- The Birth Satisfaction Scale (Revised) (Hollins Martin and Martin, 2014), which has subscales of *Quality of care provision*, *Women's*

*personal attributes*, and *Stress experienced during labour*. It has been demonstrated to be robust, valid and reliable with an overall Cronbach's alpha of 0.79.

- The Oxford Worries About Labour Scale (Redshaw et al., 2009), which has three subscales of *Labour pain and distress*, *Pre-labour uncertainty*, and *Interventions*. It has been shown to have good divergent and discriminant validity with an overall Cronbach's alpha of 0.85.
- The 10 item Edinburgh Postnatal Depression Scale (Cox et al., 1987) is widely used to screen for postnatal depression. It had satisfactory sensitivity and specificity when tested against a diagnostic interview, and was also found to be sensitive to changes in severity over time.

The questionnaire also included a postnatal symptom checklist, questions about postnatal general health and wellbeing, feeling of when the baby first belonged to the mother, and how easy or difficult she was finding caring for her baby.

## Analysis

ONS provided information about each woman's age group, country of birth, marital status, and Index of Multiple Deprivation (IMD) (an area based measure) in quintiles, which enabled comparison of responders and non-responders.

A descriptive analysis was carried out using raw percentages to establish how care was modified to help women with mental health problems, to examine outcomes, and to evaluate the impact of advice, support and treatment on outcomes. Logistic regression was used to examine the associations between mental health and outcomes taking account of sociodemographic characteristics. Continuous variables were offset in binary logistic regression because assumptions regarding their use as ordinal variables were violated.

## Ethical approval

Ethical approval for the survey was obtained from the NRES committee for Yorkshire and The Humber – Humber Bridge (REC reference 14/YH/0065).

## Findings

In total 4578 women responded to the survey (47% response rate after exclusion of undeliverable questionnaires). Of these women, 352 (7.7%) indicated that they had a mental health problem in pregnancy. The sociodemographic characteristics of these women compared to women without an antenatal mental health problem are shown in Table 1. Women aged less than 30 years, ethnic minorities, multiparous women, those living in deprived or difficult circumstances, those with long-standing mental health problems or learning difficulties, and those with health problems affecting the pregnancy or pregnancy specific problems were significantly more likely to report mental health problems in pregnancy. There were no significant differences by indicators of the baby's health such as prematurity, low birthweight or the baby's health at three months.

Outcomes were generally significantly poorer for women with antenatal mental health problems as shown in Table 2. They were significantly more worried at the prospect of labour and birth, and less satisfied with their experience of birth, finding it especially stressful. At one month postpartum, women with antenatal mental health problems were significantly more likely to experience anxiety and depression, and at three months all aspects of mental health were significantly poorer compared to women without antenatal mental health problems. Furthermore, these mothers were significantly more likely to feel that their baby belonged to them 'only recently' or 'not quite yet', they used fewer positive adjectives about their baby, and were twice as likely to consider their baby 'more difficult than average' compared to women without antenatal mental health problems.

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