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The impact of routine assessment of past or current mental health on help-seeking in the perinatal period

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ABSTRACT

Background: Clinical practice guidelines now recommend that women be asked about their past or current mental health as a routine component of maternity care. However, the value of this line of enquiry in increasing engagement with support services, as required, remains controversial.
Aim: The current study aimed to examine whether assessment of past or current mental health, received with or without referral for additional support, is associated with help-seeking during pregnancy and the postpartum.
Methods: A subsample of women drawn from the Australian Longitudinal Study on Women's Health (young cohort) who reported experiencing significant emotional distress during pregnancy ($N = 398$) or in the 12 months following birth ($N = 380$) participated in the study.
Results: Multivariate analysis showed that women who were not asked about their emotional health were less likely to seek any formal help during both pregnancy (adjOR = 0.09, 95%CI: 0.04–0.24) and the postpartum (adjOR = 0.07, 95%CI: 0.02–0.13), as were women who were asked about these issues but who were not referred for additional support (antenatal: adjOR = 0.26, 95%CI: 0.15–0.45; postnatal: adjOR = 0.14, 95%CI: 0.07–0.27). However, considerable levels of consultation with general practitioners, midwives and child health nurses, even in the absence of referral, were evident.
Conclusion: This study demonstrates that enquiry by a health professional about women's past or current mental health is associated with help-seeking throughout the perinatal period. The clinical and resource implications of these findings for the primary health care sector should be considered prior to the implementation of future routine perinatal depression screening or psychosocial assessment programmes.

1. Introduction

The importance of optimising the mental health of women during the perinatal period has been recognised internationally.[1] In an effort to minimise mental health morbidity associated with childbearing, a growing number of regions have developed and implemented programmes for the early identification, treatment and management of depression and related disorders during pregnancy and the postpartum.[2–8] Several clinical practice guidelines now recommend routine enquiry about a woman's mental health history during the perinatal period,[2,6,8,9] as well as routine screening for current symptoms of depression using the Edinburgh Postnatal Depression Scale[2,9] or other case-finding questions[6] or approaches.[8] Although research has shown that women who are asked about their current or past mental health are more likely to be referred for further support or management than women who are not asked about these aspects of their health,[10] there remains a lack of definitive evidence relating to whether this line of enquiry in turn facilitates help seeking among women who experience significant emotional distress during pregnancy or in the year following birth.

The few international studies that have addressed this issue have reported equivocal findings. For example, an evaluation of the New Haven Healthy Start Depression Initiative reported no significant difference in treatment rates before or after deployment of its depression screening programme,[11] and an examination of

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New Jersey's state-wide screening program was unable to demonstrate any policy-associated changes in initiation of treatment among women enrolled in Medicaid.[12] In contrast, a recent cluster-randomised trial in the United States, which aimed to examine the effect of a practice-based programme for screening, diagnosis and management of depression in postpartum women, reported greater uptake of treatment (counselling, medication, or a combination of these) among women with elevated depression screening scores in the intervention arm compared to those receiving care as usual.[13] Similar increases in treatment rates have been reported in a randomised-controlled trial of integrated depression screening among postpartum women in Hong Kong.[14] Evaluations of other perinatal depression screening programmes, including those implemented in Australia, have been limited by the absence of a 'care as usual' or 'not screened' comparison group[4,15–21] making it difficult to examine the independent impact of routine assessment of current mental health on initiation of treatment. These discrepancies and gaps in the evidence-base have contributed to a number of reports cautioning against routine depression screening both during pregnancy and in the postpartum.[22–24]

Compounding this, no studies to date have addressed whether routine enquiry into a woman's mental health history during the perinatal period impacts positively on help seeking at this time. This is despite a history of mental health issues being consistently identified as a risk factor for poorer perinatal mental health outcomes,[22,25–30] and despite such questions being central to the psychosocial assessment, prediction or risk reduction components of clinical practice guidelines in a number of countries.[2,6,8] In addition, although more well-designed perinatal depression screening or psychosocial assessment programmes include systems to ensure referral for further treatment or support if required (e.g., 13), none have isolated the role of this referral, over and above the role of the screening or assessment alone, in their evaluations of service use outcomes.

The current study sought to respond to these issues by using survey data from a sample of women who have recently given birth in Australia. Specifically, the aim of the study was to examine whether assessment of past or current mental health, received with or without referral for additional support, is associated with help-seeking during pregnancy and the postpartum.

2. Participants and methods

2.1. Sample and data source

This research was conducted as a sub-study of the Australian Longitudinal Study on Women's Health (ALSWH)[31,32] and involved the completion of an additional survey by a sub-group of women from the cohort born between 1973 and 1978. At the time of initial recruitment in 1996, the 1973–1978 ALSWH cohort were broadly representative of the population of Australian women in this age group, with some overrepresentation of tertiary educated women and women from English speaking backgrounds.[33–35] These women have been surveyed up to five times over 13 years (in 1996, 2000, 2003, 2006 and 2009).

2.2. Participant sampling frame

Details of the current study's sampling frame have been described elsewhere.[36] To summarise, the sampling frame was restricted to women from the 1973–1978 cohort who: (i) had responded to the ALSWH 5th Main Survey in 2009 and (ii) had given birth to a child during or after July 2007. 2316 women met these criteria and were invited to participate in the ALSWH perinatal sub-study.

2.3. Procedure

Participants were invited to answer mailed survey questions relating to reproductive health and maternity care with respect to their youngest child, and the pregnancy for that child (henceforth referred to as the index child). All sub-study surveys were returned between January 2011 and June 2011. Data were used from both the sub-study survey as well as the surveys from the ALSWH Main Surveys, where appropriate. Written informed consent was obtained from all participants for the collection of sub-study data, and to linkage of sub-study data with previously collected ALSWH Main Survey data. To preserve anonymity and confidentiality, data were de-identified prior to analysis.

2.4. Measures

This study adhered to ALSWH policies and procedures for the development of sub-study survey instruments.[32] A number of questions were directly replicated from the ALSWH Main Surveys for the purposes of item consistency (e.g., item relating to assessment of current mental health during pregnancy and the postpartum; items relating to number of service contacts with a general practitioner (modified from a scale previously used by the Australian Bureau of Statistics[37]) while other questions were developed specifically to address the aims of the current research (e.g., item relating to referral for additional treatment or support).

2.5. Help seeking for emotional health issues in the perinatal period

Respondents were asked if they had consulted with or used a range of treatment or support options for 'emotional issues' during the index pregnancy and postnatal period. Although broad, this terminology was chosen for its accessibility to community samples[38] and comparability with the language of widely distributed Australian consumer resources (e.g., 39), and because it did not restrict the focus of the research to seeking help for depression alone.

Multiple help seeking options were operationalised dichotomously (yes/no) for each of the following categories: mental health professional; general practitioner; midwife (during pregnancy)/child health nurse (postnatal); and medication. Inpatient admission/emergency department presentation were collapsed into a single dichotomous variable (yes/no), as were residential or day-stay parenting service, phone help line/internet, and family/friends/social networks. In addition, an overall dichotomous variable 'any formal health treatment', which combined a number of these help seeking options, was operationalised (see Table 2 for detail).

2.5.1. Assessment of current or past mental health (received with or without referral)

Respondents indicated if they had been asked by their health practitioner/s (general practitioner; obstetrician; midwife; other) about: (a) their 'current emotional health (e.g., given a questionnaire to complete)'; or (b) their 'mental health history'; and (c) if they were 'given a referral for additional treatment, help or support for emotional issues' by their health practitioner/s (general practitioner; obstetrician; midwife/child health nurse; other), and to indicate if this applied for the antenatal or postnatal periods, or both. A woman was considered to have received an assessment if she responded 'yes' to (a) or (b), and to have received a referral if she responded 'yes' to (c).

To facilitate analyses, women were then grouped according to the combination of assessment and referral reported as follows: (i) assessment with referral; (ii) assessment without referral; (iii) no assessment or referral. This approach was applied to the antenatal and postnatal periods separately.