Increased rates of perinatal mental illness following COVID-19: the call for sufficient midwifery provision

Abstract

The perinatal period is a known time of increased vulnerability to mental health illnesses, which are associated with significant morbidity and mortality. The COVID-19 pandemic saw rates of perinatal mental illness increase, remaining elevated ever since. In this article, postnatal depression is considered a specific perinatal mental health illness, which demonstrates the unique challenges in defining and diagnosing perinatal mental illness, and mitigating the long-term consequences to the infant. As public health practitioners, midwives are effective in preventing postnatal depression, yet may be limited in their ability to support women because of service constraints. Key drivers in the UK are mandating the parity of esteem of mental health and the improved provision of perinatal services, with the recruitment and retention of a sufficient midwifery service highlighted as priority.

Keywords

Bonding and attachment | COVID-19 | Perinatal mental health | Postnatal depression | Public health

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Mental health provision is more important now than ever before, with mental health named the most significant cause of disability and one in four people experiencing a mental health illness (NHS England, 2014; 2019). In Great Britain, rates of depression doubled during the COVID-19 pandemic and have not returned to pre-pandemic levels (Baker, 2021; Office for National Statistics, 2021; Baker and Kirk-Wade, 2023). Concerningly, women, people with disabilities and those living in socioeconomic deprivation were disproportionately affected (The Health Foundation, 2021). Indeed, McManus et al (2016) found that women's rates of common mental health disorders were steadily increasing and that women were three times more likely to experience mental health problems than men. This is significant for the practice of midwives, who will care for these women if they become pregnant, and for those who experience the onset of new mental illness during the perinatal period.

In this article, the role of the midwife, as a public mental health professional managing perinatal mental health illness, will be critically reviewed with a focus on postnatal depression. Perinatal mental illness has a significant impact on society, through its associated increased risk of mortality and morbidity (Knight et al, 2023), and its impact on mother-infant bonding and attachment (O'Higgins et al, 2013). Therefore, the key drivers and efficacy of current service provision will be discussed and evaluated, considering the impact and the ongoing implications of the COVID-19 virus, and highlighting the need for sufficient midwifery staff and perinatal mental health service provision.

Defining mental health

There is debate surrounding the definition of mental health. To explore this, the concept of 'health' must first be considered. The World Health Organization (WHO, 1948) defined a healthy individual as having complete physical, mental and social wellbeing, as opposed to just being free of disease. They specifically defined mental

health as an individual's resilience to cope with stressors and their ability to contribute to society (WHO, 2022a). The WHO definition takes a holistic biopsychosocial approach, acknowledging that mental health has biological, psychological and sociocultural determinants and impacts, and is experienced by all, not just those with a diagnosed illness (Davidson et al, 2016). This approach can be considered salutogenic (Antonovsky, 1987), with mental health viewed as a continuum where positive or negative factors can alter an individual's wellbeing (WHO, 2022a). The WHO (2022b) uphold mental health as a human right and have declared that urgent global action is required to promote, protect and restore individuals' mental wellbeing. This is particularly essential during the perinatal period when the impact on the pregnant person and the family is heightened.

Considering mental health in pregnancy

For most, changes to mental health are normal during and after pregnancy (NICE, 2014, updated 2020). It is common to experience a changes in appetite and sleep, with 70% of new mothers reported to experience the 'baby blues', transient low mood and tearfulness occurring a few days after birth (Kettunen et al, 2014). Nevertheless, significant changes in mental wellbeing should not be dismissed or normalised, as for some, the changes are not physiological but pathological and require intervention.

In 2018, the Royal College of Midwives (RCM et al, 2018) stated that one in 10 women in the UK experienced a mental illness during or following pregnancy. In a more recent publication, presenting the case to strengthen perinatal mental health, the RCM (2023) suggested that the COVID-19 pandemic may have exacerbated barriers in accessing care and the availability of support, and report that currently one in five women are experiencing mental illness during pregnancy or within a year of their baby's birth. Not only are perinatal mental health illnesses prevalent, they appear to be increasing and can be devastating. In 2020, perinatal women were three times more likely to die by suicide within 6 weeks of birth than in 2017–2019 (Knight et al, 2022). Between 2019 and 2021, mental health-related causes accounted for 10% of all maternal mortalities and 40% of postnatal maternal mortalities (Knight et al, 2023).

Although there is no complete explanation for the increase in mental health illness during the perinatal period, it is postulated that having a baby creates a myriad of challenges that can threaten wellbeing. In addition to the physiological changes of pregnancy, a woman will undergo a transformation of her identity, role, body image and relationships (Laney et al, 2015; Hennekam, 2016; Ramsdell et al, 2019; Linde et al, 2022). Furthermore, research is being carried out to explore if hormonal changes during pregnancy and the puerperium can contribute to mood changes (Bloch et al, 2022) or if, as is the case for post-traumatic stress disorder, childbirth experiences are a trigger for psychological distress (Ertan et al, 2021). The biopsychosocial changes of childbearing present a challenge and opportunity to maternity services, which need to effectively differentiate between a transient threat to wellbeing or a deterioration into a more severe condition that needs prompt identification and treatment, such as postnatal depression.

Contention in the definition, diagnosis and incidence of postnatal depression

Although it is one of the most common mental health problems experienced following birth (Centre for Mental Health et al, 2022), many do not recognise postnatal depression as a distinct disorder, with academics and clinicians debating whether postnatal depression is a separate condition, or merely a standard depressive episode with postnatal onset, because of the similarity of the symptoms (Batt et al, 2020). The WHO (2022c) do not clearly define postnatal depression, placing it under the broad category of 'mild mental and behavioural disorders associated with the puerperium' in 11th revision of the International Classification of Diseases. The American Psychiatric Association (APA, 2013) refer to postnatal depression as an 'unspecified depressive disorder' with 'peripartum onset' in the Diagnostic and Statistical Manual of Mental Disorders (fifth edition).

There is further inconsistency in the defined timeframe of onset of postnatal depression. Onset has been reported to occur within 6 weeks of birth (Kettunen et al, 2014), within 12 months of birth (Arifin et al, 2018), or speculated to occur in the antenatal period (Postpartum Depression: Action Towards Causes and Treatment (PACT) Consortium, 2015). It is suggested that the unique contributory factors and timing warrant postnatal depression to be considered a disease in its own right (Batt et al, 2020).

In addition to postnatal depression being the subject of nosologic disagreement, there is a lack of consensus in the diagnosis process, which could impact the implementation of timely recognition and treatment of the condition. The International Classification of Diseases and the Diagnostic and Statistical Manual of Mental Disorders require a postnatal depression diagnosis to be made by a mental health professional. This relies on disclosure, which may not be forthcoming as a result of stigma (Davidson et al, 2016); stigma being the experience of disgrace and social disapproval in response to specific characteristics (Goffman, 1963;

Sheehan et al, 2017). Russell et al (2013) found that 30% of women with a mental health problem never disclosed their feelings to a healthcare professional, with 34% hiding their symptoms for fear that, if they disclosed their concerns, their baby might be removed from their care. Furthermore, as a result of additional stigmas associated with several of the social risk factors for postnatal depression, such as teenage pregnancy, immigration status and domestic violence (Henshaw et al, 2018, HM Government, 2021), the ability of vulnerable women to disclose their symptoms and receive diagnosis may be even further reduced, for fear of discrimination from healthcare professionals (Boath et al, 2013; Murray et al, 2015; Morey, 2018; Thornicroft et al, 2022).

Given the challenges in definition and barriers to disclosure and diagnosis, the true extent of postnatal depression is arguably unknown, with Bauer et al (2014) stating that 50% of postnatal depression cases go undiagnosed, although rates appear to be increasing. Historically, the prevalence of postnatal depression was 10–15% (O'Hara and Swain, 1996), whereas it is now 15–20% (NICE, 2016). Arifin et al (2018) found the global prevalence to be 4–63%, identifying that the accepted prevalence rates are likely an underestimation and demonstrating a wide variation in incidence rates across cultures. Wang et al (2021) suggested that the global prevalence of postnatal depression is 17.2%.

Implications of postnatal depression

Postnatal depression is thought to impact up to one in five postnatal women, causing a variety of symptoms and problems, including seemingly minor manifestations, such as poor sleep and appetite, through to an inability to concentrate or cope with day-to-day activities, all undermining women's ability to provide responsive care (Cox et al, 2014; Eaton and Fallin, 2019). However, Bauer et al (2014) posited that 72% of the costs of perinatal mental health problems relate to the child, rather than the mother. The cost of one case of perinatal depression was estimated to be £74 000, with £51 000 relating to the child and £23 000 relating to the mother (Bauer et al, 2014).

Exploring the implication to the infant, Rogers et al (2020) assessed mother–child dyads and found that maternal depression was associated with poorer emotional cognition, language skills and adaptive development in their offspring, with outcomes extending into adolescence. They suggested this could be because of impaired cognitive development caused by compromised bonding and attaching (Rogers et al, 2020). Bonding can be defined as the formation of an intense emotional connection, with attachment being the unique relationship between an infant and their primary caregiver (Bowlby, 1958). Secure attachments form when a caregiver is sensitively and consistently responsive to their baby, which lays the foundation for the infant's future relationships with people and the world around them (Ainsworth, 1979). Women with postnatal depression are more likely to be less responsive towards their babies (O'Hara and McCabe, 2013), which can lead to bonding difficulties and the development of insecure attachments (O'Higgins et al, 2013; Hairston et al, 2018).

Human and animal studies have demonstrated that mother–infant attachment contributes to programming the infant brain, influencing the number and the complexity of neurons developed and affecting the growth of the amygdala, hippocampus and prefrontal cortex (Sullivan, 2013; Walsh et al, 2019). Neurobiology may explain why children who develop insecure attachments can display maladaptive behaviour and experience an increase in mental illness themselves (Barlow et al, 2015). The long-term consequences of insecure attachments are not fully known (Raynor and Griffiths-Haynes, 2021). However, there is evidence to suggest that impacts may be transgenerational and epigenetic in nature. Insensitive parenting can cause the infant's hippocampus to be smaller, reducing their ability to regulate stress and affecting their oxytocin production. This can reduce the parenting sensitivity of the infant, if they become a parent later in life, which will affect the size of their infant's hippocampus and so on (Elmadih et al, 2014; Elmadih and Abumadini, 2019). This highlights the need for effective interventions to recognise postnatal depression and support mother–infant bonding to prevent a cycle of suboptimum attachment (NICE, 2014). It is important to recognise that maternal mental illness can have far-reaching consequences, necessitating a public health focus.

A public health imperative and key health drivers' responses

Mental health is fundamental to public health, as it is both a determinant and consequence of physical health (Faculty of Public Health and Mental Health Foundation, 2016). Public health is defined as the extent of disease, disability and mortality within a population, with public mental health being concerned with promoting mental wellbeing, preventing illness and resourcing recovery (Eaton and Fallin, 2019).

In 2014, NHS England (2014) published the 'Five Year Forward View' public heath agenda, announcing their ambition to achieve parity of esteem, the principle that mental health must have equal priority to physical health by 2020. This arguably has not been achieved, although some progress has been made.

In 2016, the Independent Mental Health Taskforce (2016) reported that only 15% of localities provided specialist perinatal services, with 40% having no perinatal mental health service. The taskforce promised to provide access to specialised care to an additional 30 000 women each year. This was accomplished, and further improvements were implemented (Royal College of Psychiatrists, 2021).

To maintain progress, in 2019, the Mental Health Implementation Plan (NHS England, 2019b) mandated that specialist perinatal services be made accessible to an additional 24 000 women each year. The Maternity Transformation Programme (NHS England, 2020), which works to implement Better Births (National Maternity Review, 2016), is also working to improve access to perinatal mental health services. However, despite the promising developments, perinatal quality network standards are only being met in a handful of areas across the UK (Maternal Mental Health Alliance, 2023), and the ongoing staff shortages across the health spectrum (Department of Health and Social Care and Cabinet Office, 2021) will make it difficult for full parity of esteem to be achieved.

Further investment is needed and would not only contribute to the realisation of parity of esteem but could prove financially prudent. Bauer et al (2014) reported that the costs of treating perinatal mental health (£10 000 per birth) were 25 times the estimated cost of bringing perinatal mental healthcare provision up to the recommended standard (£400 per birth). Moreover, the Centre for Mental Health et al (2022) calculated that if £124 million were spent a year to train and employ the additional staff needed, there would not only be improvements to the health of families but net benefits of £490 million over the next 10 years. Part of this investment would be for 347 additional midwives to be instated, highlighting midwives' crucial role in supporting women with mental health illness.

The midwife's responsibility and reality

Although their primary responsibility is identifying mental health concerns and coordinating appropriate multidisciplinary care (NICE, 2014), midwives also have a key role in promoting positive mental health throughout pregnancy and the postnatal period (Raynor and Griffiths-Haynes, 2021). Concerning postnatal depression, midwives should discuss emotional wellbeing and ask the Whooley questions at postnatal contacts:

- 'During the past month, have you often been bothered by feeling down, depressed or hopeless?'
- 'During the past month, have you often been bothered by little interest or pleasure in doing things?'

The two Whooley questions can be effective in identifying mental health disorders, but the practitioner should be sufficiently trained to ask the questions sensitively, as stigma can prevent disclosure (Howard et al, 2018).

If a woman discloses concerns, the Edinburgh Postnatal Depression Scale or Patient Health Questionnaire-9 can be used to screen for mental illness (NICE, 2014). Although screening programmes have been found to improve outcomes for postnatal depression (Waqas et al, 2022), they should be used with an awareness that some tools are not validated for non-White populations (Kingdon, 2015). Additionally, while the Edinburgh Postnatal Depression Scale has been translated into 61 languages it is only validated in 37 (Cox et al, 2014).

It is recommended that midwives create a 'helping relationship' with a mother, to enable her to talk about her feelings (RCM, 2020), and conduct 'listening visits' where the woman's experiences and emotions can be discussed (Raynor and Griffiths-Haynes, 2021). However, the evidence base for listening visits tends to focus on health visitors, concluding that the efficacy of this intervention is dependent on trained and sensitive practitioners (Morrell et al, 2009; Willis, 2018). As a result of staff shortages, midwives report that they often do not have time to explore mental wellbeing sufficiently and that a lack of continuity makes it difficult to build relationships (Russell et al, 2013; RCM, 2022a). However, when compared with other interventions, midwifery-led redesigned postnatal care was found to be the most effective method of preventing postnatal depression (Morrell et al, 2016).

Exploration of the midwife's responsibility and reality in regards to maternal mental healthcare provision highlights the need to recruit and retain midwives to enable them to prevent illness and promote mental wellbeing in perinatal women and their families. Staff shortages affect all aspects of maternity care (RCM, 2022b) but particularly impact the recruitment of specialist perinatal mental health midwives, with trusts reporting a lack of experience or suitably trained applicants for vacant posts (Maternal Mental Health Alliance, 2023). Specialist perinatal mental health midwives not only directly care for affected families but act as local leaders for the service, developing care pathways and providing training for maternity staff (RCM et al, 2024). With specialist midwives reporting little time to support maternity colleagues with training, and with 15% of maternity services not having a specialist perinatal service, the RCM (2023) stated that 347 midwives are needed, in addition to the known national midwifery staffing shortfall, to deliver adequate perinatal mental healthcare, and have called for a comprehensive review of mental health midwifery training.

Key points

- Perinatal mental health illnesses are prevalent and leading causes of maternal morbidity and mortality.
- Specifically, rates of postnatal depression appear to be increasing, with the COVID-19 pandemic being an ongoing factor compounding the increasing incidence and prevalence of perinatal mental illness.
- A lack of agreement on the definition and onset of postnatal depression can make the distinction between common physiological changes in mood during pregnancy and pathological deterioration into mental illness unclear, impacting identification and diagnosis.
- The biopsychosocial context of the perinatal period creates a unique context and vulnerability to mental health illnesses, such as postnatal depression, requiring the midwife to play a key public health role in promoting positive mental health and identifying mental health illness.
- Beyond maternal morbidity and mortality, postnatal depression can impact the bonding and attachment between the parent and the newborn, and may have a transgenerational and epigenetic impact on the child's development and vulnerability to perinatal mental illness in the future.
- Midwifery care is effective in both recognising perinatal mental illnesses and preventing mental illnesses, necessitating investment to ensure there are sufficient midwives to meet the needs of the service.

Post-pandemic: the contemporary picture

The COVID-19 pandemic contributed to increased rates of mental illness in the perinatal population (Kasavan et al, 2023). Data from the pandemic and research investigating the impact of COVID-19 on perinatal mental health highlight the threat it poses to the wellbeing of service users, their families and offspring, and the ongoing burden it places on arguably already inadequate perinatal mental health services. The mental health charity Mind (2021) highlighted that a third of adults reported that their mental health had worsened since the first lockdown in March 2020, and the WHO (2022d) reported that following the first year of the COVID-19 pandemic, there was a 25% global increase in anxiety and depression.

The impact of COVID-19 on mental health appears to disproportionately affect women, who reported worse symptoms and a more significant deterioration in their wellbeing than men (Department of Health and Social Care and Cabinet Office, 2021). Filippetti et al (2022) found that COVID-19 culminated in a mental health crisis for expectant women, with the prevalence of depression increasing by 47%, and anxiety by 60%, with high depressive symptoms being associated with a reduced attachment between the women in the study and their unborn baby.

The cause of the disproportionate vulnerability of expectant mothers' mental health in relation to the COVID-19 pandemic has been attributed partly to the loss of a 'normal' pregnancy experience, where lockdowns lead to isolation and restrictions on inpatient birth partner support (McKinlay et al, 2022). Another study found possible physiological causation, with depressive psychopathology reported in 35% of patients with severe COVID-19; the epidemiology was thought to be linked to the inflammation response triggered by the virus (Mazza et al, 2022). With COVID-19 still prevalent today, and with pregnant women more susceptible to COVID-19 than the general population (Mota et al, 2022), this physiological connection, along with the psychological distress and disruption to everyday life that COVID-19 causes, may explain the increasing prevalence of perinatal mental illness in the wake of the pandemic and suggests COVID-19 may continue to place increased demand on perinatal mental health services, and wider society, in years to come.

Conclusions

It is apparent that perinatal mental health is associated with significant global and local morbidity and mortality, which not only impacts the individual but may have a long-term impact on the child. Postnatal depression highlights some of the challenges and opportunities in defining, diagnosing and responding effectively to perinatal mental health illnesses.

As a public health practitioner, the midwife is a pivotal part of perinatal mental health provision, not only able to identify perinatal mental health illness but having the potential to prevent it. Although there have been promising developments in terms of service provision in the UK, investment in maternity services is required, specifically toward a sufficient number of midwives, in light of increasing rates of perinatal mental health illness, potentially as a result of the ongoing effects of the COVID-19 virus, to achieve parity of esteem, reduce morbidity and mortality in perinatal women and optimise newborn bonding and neurodevelopment. **BJM**

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CPD reflective questions

- How can you provide parity of esteem through the care you give? Do you give equal importance to the mental wellbeing of your patients alongside their physical wellbeing needs?
- Can you reflect on a time when sensitive questioning and cultivating a helping relationship facilitated a patient to disclose mental health concerns, enabling you to ensure the support they needed could be put in place?
- When providing postnatal care, how do you assess and promote mother–infant bonding and attachment formation?
- Are you aware of the extent of the perinatal mental health service provision available to the patients you care for and the referral pathways you can access if screening tools identify a concern?

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