Perinatal and Infant Mental Health

Summary

During the 'perinatal period' that lasts from conception to one year after birth, mothers are at greater risk of developing new mental health conditions such as depression and anxiety. They are also at greater risk of experiencing a decline in existing psychiatric conditions or a recurrence of a former mental health illness[1].

The effects of perinatal mental ill-health are often felt by the wider family, particularly partners/ fathers. For example, maternal depression is the strongest predictor of paternal depression during the postpartum period[2]. However, data on perinatal mental ill-health in new fathers is limited, partly because of under-diagnosis but also because of insufficient research.

National research suggests that up to one in five women and one in ten men suffer from mental health problems during the perinatal period. Unfortunately, only 50% of these are diagnosed[3].

The Confidential Enquiry into Maternal Deaths in the UK in 2018-20[4] showed that nationally, 40% of deaths occurring within a year after the end of pregnancy were from mental-health related causes (suicide and substance misuse), with suicide being the leading cause.

In Bristol, it is estimated that between 500 and 800 women each year will develop mild to moderate depression and/or anxiety in the perinatal period, while approximately 10-15 will develop serious perinatal mental illness[5].

The potentially stigmatising effects of mental health illness can lead to reluctance to seek the treatment and support needed to reduce harm and recover. Untreated and on-going perinatal mental health issues can affect parent-infant emotional attachment and adversely affect child health outcomes that may last into adulthood[6].

Local prevalence

In 2022, there were just over 5,000 births in Bristol[7]. In the absence of precise local data national prevalence rates of new mothers with perinatal mental health conditions[8] have been used to estimate approximately how many women may be affected locally (Table 1). Limited research on prevalence rates in men means that local estimates would be unreliable. This is recognised as a gap locally and nationally, with actions planned to address this.

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[1] NHS England (2019): https://www.england.nhs.uk/mental-health/perinatal/
[2] Goodman, J, H (2004): https://onlinelibrary.wiley.com/doi/abs/10.1046/j.1365-2648.2003.02857.x
[3] Royal College of GPs (2019): www.rcgp.org.uk/clinical-and-research/toolkits/perinatal-mental-health-toolkit.aspx
[4] MBRRACE-UK Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20: MBRRACE-UK_Maternal_MAIN_Report_2022_UPDATE.pdf (ox.ac.uk)
[5] Royal College of Psychiatrists (2015): https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr197.pdf?sfvrsn=57766e79_2
[6] Maternal Mental Health Alliance (2019): https://www.maternalmentalhealth.org.uk/
[7] Locally collated dataset of maternity data on deliveries in the care of local maternity providers (North Bristol Trust and University Hospital Bristol and Weston, 2021)
[8] Royal College of Psychiatrists (2021): college-report-cr232---perinatal-mental-heath-services.pdf (rcpsych.ac.uk)

Perinatal mental health	Rates per thousand maternities	Estimated numbers in Bristol 2022
Postpartum psychosis	2 per 1,000	10
Chronic Serious Mental Illness	2 per 1,000	10
Severe depressive illness	30 per 1,000	150
Mild/moderate depressive illness and anxiety states	100-150 per 1,000	510-760
Post- traumatic stress disorder	30 per 1,000	150
Adjustment disorders and distress	150-300 per 1,000	760-1,520

Table 1: Rates of perinatal mental health conditions (per 1000 maternities) and estimated local prevalence rates.

Equalities data:

Some women are at increased risk of developing perinatal mental health illness, and some of the risk factors are linked to health inequalities. For example, women who have experienced a number of Adverse Childhood Events (ACEs), migration, domestic abuse, young mothers, care leavers, and women living in poverty, are all at increased risk of perinatal mental ill-health[9] [10]. Previous pregnancy loss such as a stillbirth, a neonatal death or recurrent miscarriage can also increase the risk of developing psychological problems perinatally. There is also a need for a greater focus on partners/ fathers in relation to perinatal mental health.

Parent-infant relationships

Early relationships are crucial to infant mental health, sensitive and responsive parenting helps to ensure that babies emotional needs are met. However, things can go wrong because of factors such as neglect and abuse, parental stress or absence, parental illness including mental health, alcohol/substance misuse or childhood illness[11].

Approximately 50% of babies are securely attached to their parents/carers, while 40% are insecurely attached, and 10% have a 'disorganised' attachment style, which is associated with the poorest developmental outcomes[12]. In the absence of precise local data estimates have been calculated based on the just over 5,000 births in Bristol during 2022 (Table 2).

Attachment style	Number of infants
Secure	2,500
Insecure	2,000
Disorganised	500

Table 2: Attachment style; Bristol estimates

[9] Public Health England (2019): https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/4-perinatal-mental-health

[10] MBRRACE-UK Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20: MBRRACE-UK_Maternal_MAIN_Report_2022_UPDATE.pdf (ox.ac.uk)

[11] Poverty, Deprivation & Attachment_Hoffman and Drury_PP Drury and Simpson (swansea.ac.uk)

[12] (PDF) Beyond the ACE score: Examining relationships between timing of developmental adversity, relational health and developmental outcomes in children (researchgate.net)

Relationships, emotional wellbeing and development in the earliest years of life predict later wellbeing across a range of indicators such as educational attainment, income, mental and physical health, relationships, risky and antisocial behaviour and parenting ability[13].

Further data / links / consultations:

- Mental Health in Pregnancy, the Postnatal Period and Babies and Toddlers. Report for Bristol Local Authority (2017)
- Joint Strategic Needs Assessment Toolkit: Perinatal Mental Health

Covid-19 impact:

The Covid-19 pandemic has had widespread impacts on many aspects of health and wellbeing, both directly on the health of those infected and indirectly because of the impact on many determinants of health (such as access to services, work and education, lifestyles and social support networks).

The Office for Health Improvement and Disparities (2021)[14] have stated that multiple sources of evidence suggest that mental health has deteriorated since the start of the pandemic. Particularly during periods of national lockdown but this has been followed by periods of recovery when restrictions have eased. The following groups have been more likely to experience poor or deteriorating mental health during this period; women, young adults, adults with pre-existing mental or physical health conditions, adults experiencing loss of income or employment, adults in deprived neighbourhoods, some ethnic minority populations and those who experienced local lockdowns. However, women, young people, people with lower levels of education and those living with children have also experienced an improvement when the lockdowns eased.

The Confidential Enquiry into Maternal Deaths in the UK in 2018-20[15] found that in 2020 women were times more likely to die by suicide during or up to six weeks after the end of pregnancy compared to 2017-19.

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[13] Parent-Infant Foundation (2022) Securing Healthy Lives: Securing-Healthy-Lives-ENGLISH.pdf
[14] Office for Health Improvement and Disparities (2021) 2. Important findings - GOV.UK (www.gov.uk)
[15] MBRRACE-UK Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20: MBRRACE-UK_Maternal_MAIN_Report_2022_UPDATE.pdf (ox.ac.uk)