



Maternal mental health during a pandemic

A rapid evidence review of Covid-19's impact

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[www.centreformentalhealth.org.uk/publications/
maternal-mental-health-during-pandemic](http://www.centreformentalhealth.org.uk/publications/maternal-mental-health-during-pandemic)

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Introduction

We are all living through the most significant crisis facing civil society since at least the second world war. Indeed, the restrictions placed upon us in response to this global pandemic exceed those placed on the ordinary citizen during that war. The pandemic has raised anxiety levels whilst the restrictions have removed access to the type of support we might previously have accessed; not just services, but also contact with family and friends. We expect many people to experience mental health problems as a direct and indirect result of the crisis.

The perinatal period is a time of significant risk to women's mental health, with up to two in ten women suffering some form of mental health problem, ranging from mild to moderate forms of anxiety or depression to a minority who will suffer from more severe mental health problems. For some women, the risk is even higher: half of women with a history of psychosis are at risk of relapse during this period. During the perinatal period, women can be affected by a range of problems such as antenatal and postnatal depression, obsessive compulsive disorder, post-traumatic stress disorder (PTSD) and postpartum psychosis.

Stigma can be a significant barrier to seeking help and women may worry that they appear incompetent or that their children may be taken away from their care if they appear not to be coping. Of most immediate concern is the risk of suicide during this period which is a leading cause of maternal death in the UK.

From early on in the Covid-19 pandemic, Centre for Mental Health and Maternal Mental Health Alliance were concerned about the likely increased mental health challenges that women in pregnancy and early motherhood were facing as a result of the pandemic and government-imposed restrictions introduced to tackle it. We therefore set out to explore just how much of a challenge the pandemic has placed on perinatal mental health and the services that support women, their partners, and families during this time.

The three main activities of this rapid review of the evidence were a literature review of the available published and unpublished/non-peer reviewed literature, which evidenced impact; verbal evidence-giving events; and written submissions of evidence. In addition, we reviewed the public source national data on perinatal mental health services that was available, and conducted a survey of voluntary and community sector providers.

Limitations of this work include important ethical considerations which restricted the availability of first-hand testimony of those women with direct lived experience of being pregnant or having a baby during the pandemic. In addition, we were limited to the available evidence – much of the literature on maternal mental health and this pandemic has been rapidly produced and is either not peer reviewed or has had rapid peer reviews. There will be lessons yet to be learned from the crisis and some of these will only be after a period of reflection: this crisis is far from over and some of the best evidence is yet to be produced. Moreover, evidence received on the impact on dads and partners and their mental wellbeing is very limited, and this may need further exploration in its own right. Finally, whilst this report makes mention of the impact on infants, it is primarily in relation to how this is in turn impacting mothers' mental health. For an overview of the impact of Covid-19 on babies, please see a recent report by the Parent Infant Foundation (Reed and Parish, 2021), as well as an earlier report by Best Beginnings, Homestart, Parent-Infant Foundation, *Babies in Lockdown* (2020).

These findings bear witness to the impact of Covid on maternal mental health (and services) at a snapshot in time with the evidence available. It is our sincere hope that this helps to raise initial alarm bells as soon as possible, rather than waiting until more evidence has been compiled but crucial time lost.

The findings

This is a brief overview of the main themes in our findings; a more detailed account, including an overview of main activities in the review, is provided in the full report.

1. The pandemic has posed mental health challenges for women during pregnancy and early motherhood

As predicted, all evidence sources pointed to a decrease in mental wellbeing amongst women during the perinatal period. This was for a variety of reasons described below, but was often the result of an increase in anxiety due to fear of infection, and experience of infection and bereavements, combined with reduction in available support. Other factors included a reported increase in domestic violence.

A variety of surveys have been (and are still being) conducted across the four nations and all have found evidence of a significant increase in poor mental health for women in the perinatal period.

2. The impact has been unequal

All of us have been affected by the pandemic, but we have not all been affected equally, and some groups have been impacted more severely (see box 2 overleaf). There is clear evidence that Covid-19 has had a disproportionate impact on women (compared to men) as they are more vulnerable to socioeconomic inequalities, gender inequalities, domestic violence and economic insecurity. Further, women from specific communities have been more markedly affected than others.

The evidence we collected strongly pointed to women and families experiencing socio-economic deprivation, and women and families of colour, being the most affected. Indeed, people of colour are over-represented in socio-economically deprived communities. They have also felt markedly more exposed and less protected than other communities over the crisis, with a greater proportion of women of colour and their family members being employed in 'front line' roles.

Box 1: Issues identified in our review which have caused an increase in maternal anxiety during the pandemic

- Anxiety of new mothers about catching the virus
- Worries over their baby's wellbeing and that of other family members
- Concerns about being able to cope without normal support being available
- Fears over partners being able to be present in hospital for labour and birth
- Worries over lack and clarity of information on maternity services
- Worries about being penalised if seeking support that falls outside of government guidance
- Concern over job security for expectant mothers, new mothers and their partners (seemingly an even greater concern for women of colour).

Box 2: Women who were disproportionately affected by the pandemic and restrictions

- Women from diverse ethnic communities, including South Asian and travelling communities
- Refugee and asylum-seeking women
- Women and families where language is a barrier
- Single parent families
- Women with a relationship already under strain
- Women and families with a history of experiencing domestic violence, abuse or coercive control
- Pregnant women working in high-risk settings
- Women and families who lack access to online services
- Women who would have been receiving support from organisations that did not operate during the lockdown
- Mothers who would have been anxious in normal times, including mothers who have lost one or more previous pregnancies, or who have been made more anxious by the restrictions and the fear of infection
- Women and families who have experienced a bereavement
- Women with poor mental health or a history of mental health problems
- Women with a history of severe postnatal mental illness.

3. Perinatal mental health services had worrying gaps even before the crisis

Recognition of the risk to mental health posed during the perinatal period has resulted in government investment across the four nations in perinatal mental health care, most significantly in England with the development of new specialist perinatal mental health teams and investment in psychological provision through the Improving Access to Psychological Therapies (IAPT) programme. The economic argument for such investment is compelling, as the cost of perinatal mental health to the UK economy is estimated at £8.1 billion per each year's cohort of births.

However, whilst there is evidence of investment in perinatal mental health support, this has not been implemented to the same extent across all four nations. Specialist perinatal mental health services and IAPT (or equivalent) are not able – on their own – to provide support to

the numbers of women with a perinatal mental health problem. There is also evidence of a decrease in investment in other services, such as maternity, that interact directly with women in the perinatal period, due to public spending austerity policies.

The review received evidence of cuts to statutory services such as health visiting, and also within the voluntary and community sector. Such services are as vital to many women's mental wellbeing as specifically targeted mental health provision (e.g. for women with a history of previous serious mental illness), perhaps more so, and are critical to early detection, intervention and ongoing wellbeing monitoring.

Whilst there had been some investment in perinatal mental health care (especially in specialist services) there is evidence of cuts in recent years to some services for women and families during the perinatal period, and so provision was not at its most optimal even prior to the crisis.

4. Informal support has been detrimentally impacted

The most significant support for any of us, and especially those going through pregnancy and early parenthood, is often informal in nature and both pragmatic and emotional; it is the support of family, friends and neighbours. Parents will often form informal support bonds with others who are also expecting a baby or have recently given birth, and such support and friendship can often be sustained for many years. The support of grandparents and adult siblings can also be vital. Of course, some of this remains in place and has been sustained through distanced virtual platforms. But virtual support cannot replace practical support such as providing a mother with a break, fetching shopping etc. We received reports of a dramatic reduction in the informal support available, and that women and their immediate families have been more isolated than ever before. Much of what would be considered ordinary daily activity has become unlawful for extended periods, including much of the last year.

We know that this has impacted on women and family mental wellbeing in the short-term, but we do not know what the longer-term impact will be.

5. Changes to labour and birth because of the pandemic have increased stress and anxiety

The most significant difference to the experience of labour during the crisis was the restrictions placed on partners being present during labour and births. Early on in the crisis, some partners could not be present at all and later many were restricted to attending only the latest stage of birth. This reportedly resulted in greater stress on expectant mothers, which in turn made for a more stressful birth experience.

It could also impact partners negatively, through increased worry about their partners and missing the most significant milestone in the pregnancy journey - the birth.

6. Concern for infants and babies has increased stress and anxiety

The enforced isolation imposed by the restrictions has meant that infants born in and around the time of the pandemic have experienced far less socialisation than those born previously. Many of the professionals who contributed to our research commented on the differences this appears to have made for these infants, and that mothers have reported their concerns. We were told that children have shown more clinginess, more introversion and greater alarm at strangers. Face-to-face contacts are also a very different experience, especially those with professionals, where masks and other PPE create a barrier between the parent and the child, and between professionals and infants.

We do not know what the longer-term impact on the wellbeing of these children could be, but it was a concern for those who provided us with evidence.

7. There have been missed opportunities for understanding or fully responding to what being classed as 'vulnerable' really means in the perinatal period

Whilst it was commendable that pregnant women and new mothers were identified as being at 'moderate risk (clinically vulnerable)' early on in the crisis, it seems this risk was viewed only through the lens of clinically vulnerable to infection, and the potential impact on the baby. There is no evidence that this understanding of 'vulnerability' acknowledged the critical importance of supporting perinatal mental health, both for the woman and her baby. Given what we know about perinatal mental health during 'normal times', there is a clear argument for at least maintaining "normal" levels of intervention and accessible support during such a crisis. We would further argue that there was a clear rationale for increasing such support; such provision was already under-resourced and additional challenges to mental wellbeing could be predicted at the outset of the crisis.

The evidence given for this review suggested that the identification of pregnant women as clinically vulnerable resulted in little action and the immediate impact of the crisis was a reduction in service provision (e.g. face to face contact and appointments with professionals). Delays in moving to digital support, delays in accessing PPE, staff redeployments, increased caseloads, and challenges to the voluntary and community sector filling gaps in public provision were all part of this.

8. Whilst still awaiting data, significant concerns exist for women with pre-existing mental health conditions

We did not get clear evidence on what had happened to women with histories of mental illness during the crisis, but all those we spoke to had particular concerns for this group, recognising that these women were at greatest risk. Perhaps because of this, various professionals reported prioritising these women, particularly for face-to-face contact once this was permitted. There was some limited evidence of reductions in specialist perinatal service referrals in England at the first lockdown's outset, but it is yet unclear what negative impact this may have had. It may also be too early to report on anything other than anecdotal data for this group. Data on any resultant increase in admissions to mental health care, for example, may take longer to filter through. It is also too early to know if suicides have increased for women in the perinatal period, as it is not yet clear how rates of suicide have changed over the crisis (NCISH, 2021). It is important to note that the crisis is ongoing and, because it is unprecedented, we do not know what sustained negative impact it might have had, nor how adaptations might have mitigated the harm caused.

9. Despite increased need, services supporting women and families were impacted detrimentally

As stated, there was a reduction in services supporting women and families during the perinatal period, at least initially. GP consultations, contact with midwives and health visitors, contact with some voluntary and community sector services, and with mental health services, all initially reduced. All these services, to a greater or lesser extent, became available within a few weeks after PPE was in place and after new virtual services became established. We do not know enough yet to judge if the move from face-to-face to virtual assessments has caused any harm, though our contributors were worried virtual appointments might make mental health monitoring more difficult with some women. There was significant redeployment of health visitors and other professionals in some areas, a resultant increase in caseloads (less time for more people), and use of less experienced staff.

10. The workforce supporting women and families in the perinatal period is facing its own wellbeing challenges and needs support

Just as we have had reports of increased challenges to the wellbeing of women and families, so we were given evidence of the increased stress felt by staff, in both the public and voluntary and community sectors. Those who work in these sectors are just as exposed to Covid-19 and the anxieties about it as those they support. Some have experienced infection, illness, and bereavements. In addition, many have faced additional work burdens due to the redeployment and sickness of colleagues and issues like home schooling.

Some professionals routinely face major psychological challenges because of the work they do in this area. For example, most midwives witness multiple traumatic births and a considerable proportion suffer at least secondary psychological trauma, which in turn significantly increases their risk of developing PTSD. We did not receive data on increased traumatic births during the crisis, but there were reports of women delaying their hospital admission to a much later point due to restrictions on partners, potentially increasing the risk of a traumatic birth.

The ‘battle weariness’ of staff working with patients infected with Covid-19 is well reported. Less well reported is the impact on those who have remained in other areas of health care. We also received evidence of the weariness of staff working in the perinatal sector, and this is to be expected given all the issues described above.

11. Increased demand for voluntary and community services, which themselves have been impacted

Our survey and some of the verbal evidence reported an increase in demand for voluntary and community services, in significant part to make up for reduced public sector support. This included increased demand for mental wellbeing support. However, the voluntary and community sector was also impacted by the crisis, including having to furlough staff, and relatively few organisations could do much to meet the increase in demand. Services reported longer waits for women and families to access some voluntary and community services. Furthermore, those responding to the survey were pessimistic about the future. They expected there to be less funding available for the sector after the pandemic, as potential funds would likely be directed to rebalancing the economy.

12. Virtual contact massively increased, with mixed potential consequences and a need for evaluation

Digital and internet exclusion are not new concepts, but they have come to the fore in this crisis. The pandemic has significantly increased the need for and range of services provided virtually. Exclusion from virtual spaces is now a potential barrier to receiving a vital service. The implementation of virtual communication platforms and their utility has been significant during the crisis, and perhaps having these to sustain communication is one of the few positives we can take from it. However, the virtual offer has not been sufficiently evaluated at this stage to know whether it provides the right type of support for women and babies, and in which contexts. Moreover, there are communities that, through social deprivation or geography, have less access to these platforms. Some people within these communities may also be less able to benefit, for example those for whom English is not their first language.

We collected much of our data after the first lockdown but before subsequent lockdowns and periods of more marked restriction. Services now have PPE and established virtual platforms and thus can provide a combination of face-to-face and virtual contact. However, at the time of writing throughout the UK, expectant and new mothers’ access to all-important informal support remains highly restricted.

The overwhelming view of our contributors was that virtual communication provides both a valuable alternative and an adjunct service, but that face-to-face contact remains vital.

Our recommendations for action

The pandemic has created a mental health crisis for many women in pregnancy and after the birth of their child. Women have experienced a combination of lockdown, economic uncertainty, job insecurity, and the impact of the virus itself, coupled with a reduced ability to gain access to perinatal health services and mental health services. This is likely to have long-term consequences for women and their families as well as for health services.

That's why we are making the following eight urgent recommendations for action:

1. **Assessing the true level of demand.** We call on the Department of Health and Social Care in England, and the equivalent bodies in the devolved nations, to conduct an immediate assessment of the level of need for perinatal mental health services in light of the impact of the pandemic. Previous assumptions will need to be updated to reflect higher levels of need as a consequence of the crisis. This is essential to get the right services and workforce in the right places as soon as possible.
2. **We want to future-proof perinatal mental health services against future pandemics or similar public health crises.** We are calling on the UK Government and devolved assemblies to guarantee a minimum high standard of mental health care and support for pregnant women and mothers of young infants. We want to ensure that perinatal mental health staff numbers are maintained, and where staff redeployment proves necessary in a crisis, mental health services must be maintained.
3. **We need up-to-date data to understand the changing picture.** NHS Digital and equivalent bodies in each of the devolved nations should collect and publish routine data on the mental and physical health of women during the perinatal period. This should include data on the uptake of perinatal mental health services, on deaths from all causes, and on hospital admissions. Data must include robust monitoring across equality groups to identify inequalities in prevalence, experience and outcomes.
4. **We need to tackle racial discrimination within health systems and adverse outcomes for people of colour.** The NHS in all four nations needs to address the disparity in maternal mental health outcomes caused by the crisis, and by longer-term issues, for women of colour. In England, this should be included within the *Advancing Mental Health Equalities* strategy and the *Patient and Carer Race Equality Framework*.
5. **We need better research.** We are calling on those funding and conducting research across the UK to prioritise understanding the longer-term emotional and psychological impacts of the pandemic on young families. This might include research with women with existing mental health difficulties, and groups that have been particularly affected by the pandemic. We need to hear from particularly vulnerable groups of women, and groups whose voices are seldom heard. We recommend research on the impact of women's mental wellbeing on their partners and infants, and research on partners' mental wellbeing and the impact this can have on women.

6. **We need to understand the impact of 'remote' mental health care.** Where face-to-face services have been replaced by remote services, we must understand how they work and whether there is an impact on quality, choice, patient satisfaction and most of all whether they help people with their mental health. We are calling on the NHS to fund new research, to ensure those women who do not have access to digital technology get the support they need, and to make sure digital options are not a way to save money at the expense of face-to-face consultations and therapies.
7. **Government and NHS must recognise the importance of voluntary and community organisations.** NHS organisations commissioning mental health services must recognise and value the role of voluntary and community organisations in meeting women's mental health needs during the perinatal period. We are recommending that funding should extend beyond short-term support for projects and initiatives, to provide organisations working in communities with stable long-term support and help with core costs and adaptations during crises.
8. **We must support the mental health of all health and care staff.** NHS employers in all parts of the UK and in every organisation must support the mental health and emotional wellbeing of staff working with women and families during the perinatal period, recognising the risk of exhaustion, anxiety, depression and post-traumatic stress disorder (PTSD) created during the pandemic.

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