Mental disorders in new parents before and after birth: a population-based cohort study

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Background
Mental disorders of women during the postnatal period are a major public health problem. Compared with women’s mental disorders, much less attention has been paid to men’s mental disorders in the perinatal period. To date, there have been no reports in the literature describing secular changes of both maternal and paternal hospital admissions for mental disorders over the period covering the year before pregnancy (non-parents), during pregnancy (expectant parents) and up to the first year after birth (parents) based on linked parental data. The co-occurrences of couples’ hospital admissions for mental disorders have not previously been investigated.

Aims
To describe maternal and paternal hospital admissions for mental disorders before and after birth. To compare the co-occurrences of parents’ hospital admissions for mental disorder in the perinatal period.

Method
This is a cohort study using paired parents’ population data from the New South Wales (NSW) Perinatal Data Collection (PDC), Registry of Births, Deaths and Marriages (RBDM) and Admitted Patients Data Collection (APDC). The study included all parents (n=196 669 couples) who gave birth to their first child in NSW between 1 January 2003 and 31 December 2009.

Results
The hospital admission rate for women with a principal mental disorder diagnosis in the period between the year before pregnancy and the first year after birth was significantly higher than that for men. Parents’ mental disorders influenced each other. If a man was admitted to hospital with a principal mental disorder diagnosis, his wife or partner was more likely to be admitted to hospital with a principal mental disorder diagnosis compared with women whose partner had not had a hospital admission, and vice versa.

Conclusions
Mothers’ mental disorders after birth increased more significantly than fathers. However, fathers’ mental disorders significantly impacted the co-occurrence of mothers’ mental disorders.

Declaration of interest
None.

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(b) compare the co-occurrence of parents’ hospital admissions for mental disorders in the perinatal period.

**Method**

**Study population and design**

This is a population-based cohort study using linked data from the NSW Perinatal Data Collection (PDC), NSW Registry of Births, Deaths and Marriages (RBDM) and the NSW Admitted Patients Data Collection (APDC). The study included all parents who gave birth to their first child in NSW between 1 January 2003 and 31 December 2009. The details of the study population and data linkage are described in Fig. 1.

The mother’s PDC birth records, which included mother’s and baby’s Project Person Number (PPN), were linked with RBDM which included baby’s, mother’s and father’s PPN. The linked PDC-RBDM birth records between 1 January 2003 and 31 December 2009 were linked with parents’ APDC records between 1 January 2001 and 31 December 2010, so that hospital admissions for these parents could be traced back for their pregnancy period (expectant parents), the year before pregnancy (non-parents) and followed up 1 year after birth (parents). The couples were followed up over the three periods from the year before pregnancy, pregnancy to the last month of the first year after birth. The APDC records selection and data linkage are detailed in Fig. 2. Parents’ hospital admissions for mental disorders were identified by APDC records.

The PDC is a population-based surveillance system that includes all births of at least 20 weeks gestation or at least 400 g birthweight in NSW. It includes all births in public and private hospitals as well as home births, and includes information on maternal characteristics, pregnancy, labour, delivery and neonatal outcomes. The RBDM is a database of birth registrations. Under the Births, Deaths and Marriages Registration Act 1995, all babies in NSW must be registered within 60 days of birth, and the Registry therefore includes babies’ and their parents’ information such as age and place of residence. The APDC is a routinely collected census of all hospital separations. It includes all patient hospitalisations in NSW public and private hospitals including psychiatric hospitals and admissions for same day procedures. Since 1999, the diagnoses for admissions have been coded according to the 10th revision of the International Statistical Classification of Diseases and Related Health Problems, Australian Modification (ICD-10-AM).

The data linkage was performed by the NSW Department of Health Centre for Health Record Linkage (CHeReL) using probabilistic record linkage methods and ChoiceMaker software. Identifying information from PDC and APDC data sets was included in the Master Linkage Key constructed by the CHeReL. At the completion of the process, each record was assigned a Person Project Number (PPN) to allow records for the same individual to be linked. Based on the 1000 randomly selected sample of records, the false positive rate of the linkage was 0.3% and false negative <0.5%.

**Definitions**

The principal diagnosis refers to the diagnosis which was chiefly responsible for APDC hospital admission. Mental disorders refer to the principal diagnoses for psychiatric disorders and disorders due to substance use. The first hospital admission refers to the...
first hospital admission between the first month of the year before pregnancy and the last month of the year after birth.

All hospital admissions include the first hospital admission and readmissions in the study periods. Non-parents, expectant parents and parents: the couples in the year before their first pregnancy were regarded as non-parents, during pregnancy as expectant parents and the first year after birth as the parents.

**Diagnosis of mental disorders**

The diagnoses for each admission in this study have been coded according to the Australian modification to the World Health Organization ICD-10 Classification of Diseases and Related Health Problems (ICD-10-AM).25 Parents with mental disorders were identified using ICD-10-AM diagnosis codes: (1) F10–19 [mental and behavioural disorders due to use of alcohol and other substances]; (2) F32–33 [depressive disorder]; (3) F53 [mental and behavioural disorders associated with the puerperium]; (4) F41 and F43 [anxiety and adjustment disorders]; (5) F20 and F31 [schizophrenia and bipolar affective disorders]; (6) others referred to the rest F codes; (7) F00–99 [overall mental disorders].

In this study, only the hospital admission with a principal diagnosis of a mental disorder between the year before pregnancy and the first year after birth was included in the analysis.

**Statistical analysis**

Descriptive statistics were used to analyse the rate of hospital admission (including the 95% confidence interval, CI), parents’ age and mothers’ characteristics. Person-year was used as the denominator for the analysis of rates to allow comparison between different periods or between maternal and paternal populations. The analyses were conducted using IBM SPSS (Statistical Package for Social Science) Statistics version 22.23

### Results

The study population were primiparous women who gave birth in NSW between 2003 and 2009 and their partners. First, primiparous mothers were selected from PDC birth records. Then the women’s PDC birth records were linked with their babies’ RBDM records. Finally the births between 2003 and 2009 were selected. There were 199 742 primiparous women who met the inclusion criteria and were linked with their partners through their babies’ RBDM records. Of the 199 742 couples, there were 196 669 fathers (98.46%) who had first births. A total of 196 669 couples were included in the data analysis (Fig. 1). Women’s characteristics and demographic factors are described in Table 1. The fathers (median 31.56, mean 31.95, standard deviation (s.d.)=6.64, range 13.81–82.80) were 3 years older than the mothers (median 29.02, mean 28.49, s.d.=5.78, range 12.01–56.04) (P<0.05).

Table 2 shows the first hospital admission rates of the couples for the principal diagnoses of mental disorders from the year before pregnancy up to the last month of the first year after birth in NSW between 2003 and 2009. Women’s first hospital admission rate for the principal diagnoses of mental disorders was significantly higher than men (Table 2) (P<0.05). In the 196 669 couples, 4896 women (8.87 per 1000 person-year, 95% CI 8.62–9.12) were admitted to a hospital for the principal diagnoses of a mental disorder in the period between the year before pregnancy and the last month of the first year after birth. There were 1287 men (2.33 per 1000 person-year, 95% CI 2.20–2.46) who were admitted to a hospital for the principal diagnoses of a mental disorder in the same period. The women’s hospital admission rate with a mental disorder was 3.81 times greater than the men’s (Table 2).

In the three study periods, the maternal first hospital admission rate for the principal diagnoses of mental disorders was the highest after birth (rate 18.91 per 1000 person-year, 95% CI 18.31–19.51) compared with the year before pregnancy (rate 4.68 per 1000 person-year, 95% CI 4.38–4.98) and during pregnancy (rate 1.61 per 1000 person-year, 95% CI 1.41–1.81). For the diagnoses of depressive disorders (F32–33), anxiety and adjustment disorders (F41 and F43), the pattern was similar; the hospital admission rate was the highest in the period after birth, and lowest in pregnancy (P<0.05). The first hospital admission rate for the diagnosis of mental and behaviour disorders associated with puerperium (F53) was 5.35 per 1000 person-year (95% CI 5.03–5.67), one year after birth. For the diagnosis of mental and behaviour disorders due to use of alcohol and other substances (F10–19), maternal hospital admission rate in the year...
before pregnancy was higher than the periods in pregnancy and after birth \((P < 0.05)\). For schizophrenia and bipolar affective disorders \((F20, F31)\), maternal hospital admission rate in pregnancy was lower than the year before pregnancy and the year after birth \((P < 0.05)\). The rate change however was significantly less than for women \((P < 0.05)\). For the diagnosis of mental and behaviour disorders due to use of alcohol and other substances \((F10–19)\) and depressive disorders \((F32–33)\), paternal hospital admission in pregnancy was lower than the year before pregnancy and the first year after birth \((P < 0.05)\). For schizophrenia and bipolar affective disorders \((F20, F31)\), there was no significant difference in paternal hospital admission rates among the three time periods \((P < 0.05)\).

The paternal first hospital admission rates in the year before pregnancy and especially in the first year after birth were significantly higher than maternal first hospital admission rates in the year before pregnancy and the first year after birth. The rate change however was significantly less than for women \((P < 0.05)\). For the diagnosis of mental and behaviour disorders due to use of alcohol and other substances \((F10–19)\) and depressive disorders \((F32–33)\), paternal hospital admission in pregnancy was lower than the year before pregnancy and the first year after birth \((P < 0.05)\). For schizophrenia and bipolar affective disorders \((F20, F31)\), there was no significant difference in paternal hospital admission rates among the three time periods \((P < 0.05)\).

The maternal first hospital admission rates in the year before pregnancy and especially in the first year after birth were significantly higher than paternal first hospital admission rates.

### Table 1

**New mother’s characteristics in NSW, Australia, 2003–2009**

| Characteristic                                      | n     | %    | 95% CI          |
|----------------------------------------------------|-------|------|-----------------|
| Maternal age, years*                                |       |      |                 |
| <20                                                 | 14 001| 7.12 | 7.01–7.23       |
| 20–24                                               | 35 979| 18.3 | 18.13–18.47     |
| 25–29                                               | 59 696| 30.36| 30.16–30.56     |
| 30–34                                               | 57 448| 29.21| 29.01–29.41     |
| 35–39                                               | 24 167| 12.29| 12.14–12.44     |
| 40–44                                               | 5065  | 2.58 | 2.51–2.65       |
| 45+                                                 | 291   | 0.15 | 0.13–0.17       |
| Missing                                             | 22    | 0.01 |                 |
| Total                                               | 196 669| 100 |                 |
| Woman’s country of birth*                           |       |      |                 |
| Australia                                          | 133 085| 67.67| 67.46–67.88     |
| Others countries                                   | 63 584| 32.33| 32.00–33.00     |
| Total                                               | 196 669| 100 |                 |
| Remoteness*                                         |       |      |                 |
| Major cities                                        | 137 243| 70.7 | 70.50–70.90     |
| Inner regional                                      | 43 086| 22.19| 22.01–22.37     |
| Out regional and remote                             | 13 803| 7.11 | 7.00–7.22       |
| Missing                                             | 2537  | 1.3  | 1.25–1.35       |
| Total                                               | 196 669| 100 |                 |
| Smoking during pregnancy*                           |       |      |                 |
| No                                                  | 175 107| 89.31| 89.17–89.45     |
| Yes                                                 | 20 951| 10.69| 10.55–10.83     |
| Missing                                             | 611   | 0.31 | 0.29–0.33       |
| Total                                               | 196 669| 100 |                 |
| Index of Relative SE Disadvantage Quintile*         |       |      |                 |
| Least disadvantaged                                 | 46 102| 23.75| 23.56–23.94     |
| 2                                                   | 40 650| 20.94| 20.76–21.12     |
| 3                                                   | 36 778| 18.94| 18.77–19.11     |
| 4                                                   | 33 424| 17.22| 17.05–17.39     |
| Most disadvantaged                                  | 37 178| 19.15| 18.98–19.32     |
| Missing                                             | 2537  | 1.29 | 1.24–1.34       |
| Total                                               | 196 669| 100 |                 |
| Mode of birth                                       |       |      |                 |
| Vaginal                                             | 134 078| 68.21| 68.00–68.42     |
| Caesarean section                                   | 62 484| 31.79| 31.58–32.00     |
| Missing                                             | 107   | 0.05 | 0.04–0.06       |
| Total                                               | 196 669| 100 |                 |
| Maternal diabetes mellitus*                         |       |      |                 |
| No                                                  | 195 629| 99.47| 99.44–99.50     |
| Yes                                                 | 1040  | 0.53 | 0.50–0.56       |
| Total                                               | 196 669| 100 |                 |
| Gestational diabetes                                |       |      |                 |
| No                                                  | 187 587| 95.38| 95.29–95.47     |
| Yes                                                 | 9082  | 4.62 | 4.53–4.71       |
| Total                                               | 196 669| 100 |                 |
| Maternal hypertension*                              |       |      |                 |
| No                                                  | 194 833| 99.07| 99.03–99.11     |
| Yes                                                 | 1836  | 0.93 | 0.89–0.97       |
| Total                                               | 196 669| 100 |                 |

*Significantly different \((P < 0.05)\)
Table 2  Couples’ first hospital admissions\(^a\) for the principal diagnoses of mental disorders before and after birth in NSW, Australia, 2001–2010

| Admission diagnosis | Women | | | | Men | | | |
|--------------------|-------|----------|----------|----------|-------|----------|----------|----------|
| | The year before pregnancy | Pregnancy | The year after birth | Overall | The year before pregnancy | Pregnancy | The year after birth | Overall |
|---------------------|---------|------------|------------|------------|---------|------------|------------|------------|
| Person-year | 196,669 | 158,903 | 196,669 | 552,241 | 196,669 | 158,903 | 196,669 | 552,241 |
| Mental and behaviour disorders due to use of alcohol and other substances (F10–19) | 1.86 | 0.30 | 0.62 | 0.97 | 1.42 | 0.84 | 1.10 | 1.14 |
| Admission rate (/1000 person-year) | 1.67–2.05 | 0.21–0.39 | 0.51–0.73 | 0.89–1.05 | 1.25–1.59 | 0.70–0.98 | 0.95–1.25 | 1.05–1.23 |
| 95% CI | | | | | | | | |
| Depressive disorders (F32–33) | 0.98 | 0.40 | 2.52 | 1.36 | 0.41 | 0.17 | 0.57 | 0.40 |
| Admission rate (/1000 person-year) | 0.84–1.12 | 0.30–0.50 | 2.30–2.74 | 1.26–1.46 | 0.32–0.50 | 0.11–0.23 | 0.46–0.68 | 0.35–0.45 |
| 95% CI | | | | | | | | |
| Mental and behaviour disorders associated with puerperium (F53)\(^b\) | 0.00 | 0.02 | 5.35 | 1.91 | | | | |
| Admission rate (/1000 person-year) | 0.00–0.00 | 0.00–0.04 | 5.03–5.67 | 1.79–2.03 | | | | |
| 95% CI | | | | | | | | |
| Anxiety and adjustment disorders (F41,F43) | 1.18 | 0.60 | 11.01 | 4.52 | 0.47 | 0.28 | 0.89 | 0.57 |
| Admission rate (/1000 person-year) | 1.03–1.33 | 0.48–0.72 | 10.55–11.47 | 4.34–4.70 | 0.37–0.57 | 0.20–0.36 | 0.76–1.02 | 0.51–0.63 |
| 95% CI | | | | | | | | |
| Schizophrenia and Bipolar affective disorders (F20,F31) | 0.33 | 0.28 | 0.35 | 0.47 | 0.36 | 0.30 | 0.23 | 0.30 |
| Admission rate (/1000 person-year) | 0.43–0.63 | 0.20–0.36 | 0.45–0.65 | 0.41–0.53 | 0.28–0.44 | 0.21–0.39 | 0.16–0.30 | 0.25–0.35 |
| 95% CI | | | | | | | | |
| Others | 1.08 | 0.38 | 0.73 | 0.75 | 0.40 | 0.38 | 0.37 | 0.38 |
| Admission rate (/1000 person-year) | 0.93–1.23 | 0.28–0.48 | 0.61–0.85 | 0.68–0.82 | 0.31–0.49 | 0.28–0.48 | 0.29–0.45 | 0.33–0.43 |
| 95% CI | | | | | | | | |
| Overall mental disorders (F00–99) | 4.68 | 1.61 | 18.91 | 8.87 | 2.66 | 1.64 | 2.56 | 2.33 |
| Admission rate (/1000 person-year) | 4.38–4.98 | 1.41–1.81 | 18.31–19.51 | 8.62–9.12 | 2.43–2.89 | 1.44–1.84 | 2.34–2.78 | 2.20–2.46 |
| 95% CI | | | | | | | | |

\(^a\) The first hospital admission refers to the first admission between the first month of the year before pregnancy and to the end of the 12th month after birth.

\(^b\) F53 refers to the diagnosis of mental and behaviour disorders associated with puerperium, not elsewhere classified. The disorders occur after birth. But in this study data, three women (0.02/1000 person-year) were mistakenly recorded with the diagnosis of F53 before birth.
| Admission diagnosis                                                                 | Women                                                                 | Men                                                                 |
|-------------------------------------------------------------------------------------|----------------------------------------------------------------------|----------------------------------------------------------------------|
|                                                                                    | The year before pregnancy | Pregnancy | The year after birth | Overall | The year before pregnancy | Pregnancy | The year after birth | Overall |
|                                                                                    | Person-year                |           |                     |         | Person-year                |           |                     |         |
| Mental and behaviour disorders due to use of alcohol and other substances (F10–19) | Admission rate (1000 person-year) | 2.73      | 0.74                | 1.43    | 1.69                      | 2.14      | 1.76                | 2.21    |
|                                                                                    | 95% CI                     | 2.50–2.96 | 0.61–0.87           | 1.26–1.60 | 1.58–1.80                | 1.94–2.34 | 1.55–1.97           | 2.00–2.42 | 1.94–2.18 |
| Depressive disorders (F32-33)                                                      | Admission rate (1000 person-year) | 1.50      | 0.80                | 4.36    | 2.32                      | 0.66      | 0.46                | 1.14    | 0.77          |
|                                                                                    | 95% CI                     | 1.33–1.67 | 0.66–0.94           | 4.07–4.65 | 2.19–2.45 | 0.55–0.77 | 0.35–0.57 | 0.99–1.29 | 0.70–0.84 |
| Mental and behavioural disorders associated with puerperium (F53)a                 | Admission rate (1000 person-year) | 0.00      | 0.02                | 6.24    | 2.23                      |           |                     |         |
|                                                                                    | 95% CI                     | 0.00–0.00 | 0.00–0.04           | 5.89–6.59 | 2.11–2.35               |           |                     |         |
| Anxiety and adjustment disorders (F41, F43)                                        | Admission rate (1000 person-year) | 1.76      | 0.84                | 11.86   | 5.10                      | 0.64      | 0.42                | 1.45    | 0.86          |
|                                                                                    | 95% CI                     | 1.57–1.95 | 0.70–0.98           | 11.38–12.34 | 4.91–5.29                | 0.53–0.75 | 0.32–0.52 | 1.28–1.62 | 0.78–0.94 |
| Schizophrenia and Bipolar affective disorders (F20, F31)                           | Admission rate (1000 person-year) | 0.84      | 0.81                | 1.12    | 0.93                      | 0.47      | 0.54                | 0.49    | 0.50          |
|                                                                                    | 95% CI                     | 0.71–0.97 | 0.67–0.95           | 0.97–1.27 | 0.85–1.01 | 0.37–0.57 | 0.43–0.65 | 0.39–0.59 | 0.44–0.56 |
| Others                                                                             | Admission rate (1000 person-year) | 2.43      | 1.32                | 1.77    | 1.87                      | 0.64      | 0.78                | 0.54    | 0.64          |
|                                                                                    | 95% CI                     | 2.21–2.65 | 1.14–1.50           | 1.58–1.96 | 1.76–1.98 | 0.53–0.75 | 0.64–0.92 | 0.44–0.64 | 0.57–0.71 |
| Overall mental disorders (F00–99)                                                  | Admission rate (1000 person-year) | 9.26      | 4.53                | 26.79   | 14.14                     | 4.54      | 3.96                | 5.83    | 4.83          |
|                                                                                    | 95% CI                     | 8.84–9.68 | 4.20–4.86           | 26.08–27.30 | 13.83–14.45 | 4.24–4.84 | 3.65–4.27 | 5.49–6.17 | 4.65–5.01 |

a. F53 refers to the diagnosis of mental and behaviour disorders associated with puerperium, not elsewhere classified. The disorders occur after birth. But in this study data, three women (0.02/1000 person-year) were mistakenly recorded with the diagnosis of F53 before birth.
There was no significant difference between maternal and paternal first hospital admission rates during the period of pregnancy (Table 2).

The rate of all hospital admissions of the couples for mental disorders principal diagnoses between the year before pregnancy and the first year after birth were described in Table 3. The maternal hospital admission rate 14.14/1000 person-year (95% CI 13.83–14.45) which was significantly higher (rate ratio 2.93 times) than the paternal hospital admission rate (rate 4.83/1000 person-year, 95% CI 4.65–5.01). The change for all hospital admissions with mental disorders principal diagnoses over the periods before and after birth was similar to the first hospital admissions (Table 2). The maternal hospital admission rates in the year before pregnancy and especially in the first year after birth were significantly higher than paternal hospital admission rates (P<0.05). There was no significant difference between maternal and paternal hospital admission rates during the period of pregnancy (Table 3, Figs. 4 and 5).

Figure 3 shows the distribution of the maternal and paternal hospital admissions for the principal diagnosis of mental disorders during the three time periods (the year before pregnancy, pregnancy and the first year after birth). Women’s hospital admissions, including first and all principal diagnoses for mental disorders, increased significantly after giving birth and peaked in the 3rd and 4th month after birth (maternal first hospital admission rate 29.84 per 1000 person-year, 95% CI 28.00–31.68; maternal all hospital admission rate 38.20 per 1000 person-year, 95% CI 36.12–40.28 in month 3–4 after birth) (Fig. 3). Compared with women, men’s hospital admission rates were lower except during the period of pregnancy (Tables 2 and 3) and did not have the same peak in the 3rd and 4th month after birth.

Figure 4 shows that maternal hospital admissions for mental disorders were mainly attributed to anxiety and adjustment disorders (F41 and F43); mental and behaviour disorders associated with puerperium (F53) and depressive disorders (F32–33).

Figure 5 showed that paternal hospital admissions for mental disorders were mainly attributed to mental and behavioural disorders due to use of alcohol and other substances (F10–19); anxiety and adjustment disorders (F41 and F43) and depressive disorders (F32–33).

Table 4 shows the co-occurrence of mother’s first hospital admissions for principal diagnoses of mental disorders with fathers. If a man was admitted to a hospital with a principal diagnosis of a mental disorder (women’s hospital admission rate 12.03, 95% CI 10.21–13.85), particularly in the period after birth, compared with the women whose partner did not have the hospital admission (women’s hospital admission rate 0.86, 95% CI 0.78–0.94).

Table 5 shows the co-occurrence of father’s first hospital admissions for principal mental disorder diagnoses with mothers. If a woman was admitted to a hospital with a principal diagnosis of mental disorder, her partner was also more likely to be admitted to a hospital with a principal diagnosis of a mental disorder (men’s hospital admission rate 3.04, 95% CI 2.56–3.52, particularly in the period before pregnancy, compared with men whose partner did not have a hospital admission for a mental disorder (men’s hospital admission rate 0.21, 95% CI 0.17–0.25).

Women were more likely to be impacted by their partner’s mental health problems compared with men (Tables 4 and 5) (P<0.05). In other words, a man’s mental disorders impacted his partner’s hospital admissions for mental disorders more significantly than woman’s mental disorders on her partner’s (Tables 4 and 5).

**Discussion**

This study provides a complete picture of couple’s first hospital admissions for principal diagnoses of mental disorders during the year before pregnancy (non-parents), pregnancy (expectant parents) and the first year after birth (parents). Compared with non-mothers, mothers had significantly more hospital admissions for mental disorder diagnoses (mother’s first hospital admission rate 18.91 per 1000 person-year, 95% CI 18.31–19.51; non-mother’s first hospital admission rate 4.68 per 1000 person-year, 95% CI 4.38–4.98). Compared with non-fathers, fathers did not have the increased risk for hospital admissions for mental disorders (father’s first hospital admission rate 2.56 per 1000 person-year, 95% CI 2.34–2.78; non-father’s first hospital admission rate 2.66 per 1000 person-year, 95% CI 2.43–2.89). Both expectant parents were less likely to be admitted to hospitals for mental disorder diagnoses compared with non-parents (expectant mother’s first hospital admission rate 1.61 per 1000 person-year, 95% CI 1.41–1.81; expectant father’s first hospital admission rate 1.64 per 1000 person-year, 95% CI 1.44–1.84). The non-mother’s first hospital admission rate for mental disorders was 1.76 times higher than non-fathers. The mother’s first hospital admission rate for mental disorders was 7.39 times higher than that for fathers. There was
no significant difference in the first hospital admission rates for mental disorders between expectant parents.

The increased trend in maternal hospital admissions for mental disorders after birth is well documented in the literature. The hospital admission rates varied over a wide range. The results of this study are consistent with our previous study which reported that mother’s first hospital admission rate for the principal diagnoses of psychiatric disorders (excluding substance use disorders, F10–19) in the first year after birth was 1.67% (95% CI 1.63–1.71). This study showed that mother’s first hospital admission rate for mental disorders (including substance use disorders, F10–19) was 1.89% (95% CI 1.83–1.95) in the first year after birth (Table 2). A Danish population-based cohort study (1973–2005) also showed that the rate of mother’s first-time hospital admission for mental disorders was significantly higher than during pregnancy but the rate levels (the first hospital

![Fig. 4 Mothers’ hospital admissions for the principal diagnoses of mental disorders before and after birth in NSW, Australia, 2001–2010. PY, person-year; NSW, New South Wales.](image)

![Fig. 5 Fathers’ hospital admissions for the principal diagnoses of mental disorders before and after birth in NSW, Australia, 2001–2010. PY, person-year; NSW, New South Wales.](image)
admission rate 0.70/1000 person-year in pregnancy and 1.96/1000 person-year after birth) were significantly lower than the current study.6 The increased hospital admissions after birth were mainly attributed to an increase in mother’s anxiety and adjustment disorders, mental and behaviour disorders associated with puerperium, and depression (Fig. 4).6,9 Alternatively, a survey in the United States showed that there were no significant differences in the prevalence of psychiatric disorders between pregnant (25.3%), post-partum (27.5%) and non-pregnant women of child-bearing age (30.1%).5 A retrospective cohort study based on Western Australia health service data between 1990 and 2005 showed that the maternal hospital admission rate for mental disorders in the 12 months before birth was between 14 per 1000 birth (1990) and 17 per 1000 birth (2005),24 which was about 9–11 times higher than the expectant mothers’ hospital admission rates for mental disorders in this study. The variation of the hospital admission rates for mental disorders may attribute to the difference in study population and time. For example, the study in Denmark was based on the data between 1973 and 2005.8 The study in Western Australia was based on the data between 1990 and 2005.24 Our study was based on the data from 2003 to 2009. The study from Australia showed that the hospital admission rates for mental disorders increased significantly over the past decade.9,24 Other factors, such as the accessibility to health service,25 physical health,26 location of residence,27 country of birth28 and maternal age,24 also impact the hospital admission rate for mental disorders.

The change of paternal hospital admissions for mental disorders before and after birth was not as significant as the rate for mothers. The paternal first hospital admissions for mental disorders did not increase significantly after birth compared with the year before pregnancy. The rate of men’s all hospital admissions for mental disorders after birth increased slightly above that of non-fathers during the period of pregnancy and the year before pregnancy. This was attributed to the increase of father’s anxiety and adjustment disorders, and depression after birth (Fig. 5). The result of this study was different to the report from Denmark which showed that new father’s hospital admission rate for mental disorders in the first year after birth (rate 1.27 per 1000 person-year) was lower than non-fathers (rate 2.08 per 1000 person-year).6 The difference between the study in Denmark and our study may be because of different definitions of non-fathers. In the study of Denmark, non-fathers and fathers were different individuals. In our study, non-fathers and fathers were the same individuals in different periods.

A meta-analysis which was based on survey data showed that the depression rate of men in the 2nd quarter of the year after birth (rate 26%, 95% CI 17–36%) was significantly higher than the period of pregnancy and remaining 9 months of the year after birth (rate 11%, 95% CI 6–18%), in the 1st and 2nd trimester of gestation; rate 12%, 95% CI 9–15%, in the 3rd trimester of gestation; rate 8%, 95% CI 5–11%, on the 1st quarter of the year after birth; and rate 9%, 95% CI 5–13%, between the 3rd and 4th quarter.27 A longitudinal population-based study of American fathers found that father’s depressive symptom scores increased significantly (68%) in early fatherhood (0–5 years after having the child).14 A cohort study of 622 expectant fathers in Hong Kong showed that fathers were more likely to experience depression (EPD-SAS 13) at 6 weeks post-partum (5.2%) than early pregnancy (3.3%) and late pregnancy (4.1%).28 A study in Portugal reported that more fathers experienced mental disorders in the first year after birth than pregnancy.29 A cohort study in 5969 adults aged 18–44 in the United States showed that the rate of depression was lower in men than women.30

Our study showed that both expectant parents were less likely to be admitted to hospital for the principal mental disorder diagnoses compared with non-parents. The result was consistent with the report which was based on Danish health service data.6 The main reason for the decrease was the decline of maternal and paternal hospital admissions for mental and behavioural disorders due to alcohol and substance use disorders during pregnancy (Figs. 4 and 5). A study from the United States reported that pregnant women had significantly lower rates of alcohol and substance use disorders than non-pregnant women.5 Our previous study showed that women’s hospital admission rate for alcohol use disorders was 1.76 per 1000 person-year (95% CI 1.45–2.07) before pregnancy and the rate decreased to 0.49 per 1000 person-year (95% CI 0.36–0.63) during pregnancy and to 0.82 per 1000 person-year (95% CI 0.67–0.97) in the first year after birth.31 However, studies based on community surveys, using self-report screening tools as the measure of mental disorders rather than reported diagnosis, did not show the decrease of mental disorders during pregnancy.12,32

| Table 4 | Co-occurrence of mothers’ hospital admissions for the first principal diagnoses of mental disorders with fathers |
|---------|---------------------------------------------------------------------------------------------------------------|
| Time of admission | Fathers with mental disorders (person-year) | Co-occurrence of mothers with mental disorders | Fathers without mental disorders (person-year) | Co-occurrence of mothers with mental disorders |
|          | Mothers | % | 95% CI | Mothers | % | 95% CI |
| Before pregnancy | 524     | 60 | 11.45 | 8.72–14.18 | 196 | 145 | 8.01 | 0.44 | 0.35–0.53 |
| In pregnancy | 195     | 22 | 11.28 | 6.84–15.72 | 158 | 708 | 234 | 0.15 | 0.09–0.21 |
| After pregnancy | 593     | 65 | 12.92 | 9.99–15.85 | 196 | 166 | 364 | 1.86 | 1.67–2.05 |
| Overall | 1222 | 147 | 12.03 | 10.21–13.85 | 351 | 019 | 4749 | 0.86 | 0.78–0.94 |

| Table 5 | Co-occurrence of fathers’ hospital admissions for the first principal diagnoses of mental disorders with mothers |
|---------|---------------------------------------------------------------------------------------------------------------|
| Time of admission | Mothers with mental disorders (person-year) | Co-occurrence of fathers with mental disorders | Mothers without mental disorders (person-year) | Co-occurrence of fathers with mental disorders |
|          | Fathers | % | 95% CI | Fathers | % | 95% CI |
| Before pregnancy | 921     | 68 | 7.38 | 5.69–9.07 | 195 | 748 | 456 | 0.23 | 0.16–0.30 |
| In pregnancy | 189     | 9  | 4.75 | 1.72–7.78 | 158 | 714 | 251 | 0.16 | 0.10–0.22 |
| After pregnancy | 3719    | 70 | 1.88 | 1.44–2.32 | 192 | 950 | 433 | 0.22 | 0.15–0.29 |
| Overall | 4829    | 147 | 3.04 | 2.56–3.52 | 547 | 412 | 1140 | 0.21 | 0.17–0.25 |

a. The number has been adjusted to person-year.
The results of this study found that parents' mental disorders influenced each other, and women were more likely to be impacted by their partner’s mental health problems compared with men. A study based on community data from England showed that men’s depressive symptoms were correlated with their partners’ depressive symptoms before (r = 0.24) and after (r = 0.26) the birth. A cross-sectional study from Italy found that maternal distress was significantly associated with paternal distress (r = 0.486). A study in Japan reported that father’s depression was impacted by partner’s depression (adjusted odds ratio 1.91, 95% CI 1.05–3.47). An integrative review showed that maternal depression was a strong predictor of paternal depression during the post-partum period.

The strength of this study is that the study data are relatively complete (all new parents in NSW were consecutively followed up for 3 years, from non-parents, expectant parents to parents) and accurate (women and men were paired by birth). As a result, both maternal and paternal hospital admission rates can be described consecutively through the stages of non-parents, expectant parents to parents. This allows a comparison of rates between men and women, and between non-parents, expectant parents and parents in hospital admissions with mental disorders. The data also allowed us to examine the impact of maternal and paternal mental disorders on each other.

There are some limitations that need to be considered when interpreting the results of this population study. The study neither includes epigenetic data nor data on community and out-patient mental health services, which may be differentially accessed by both populations and impact rates of hospital admission. Second, some researchers have suggested that hospital admissions for mental disorders may be over-enumerated because admissions could occur for medical reasons associated with the perinatal period. To minimise the potential overestimation of incidence rates, we included only those admissions with a ‘principal’ diagnosis of mental disorder. Birth registration data describe the family structure at the time the birth was registered, which is not necessarily the family structure at the time of the birth. The baby’s father on the RBDM birth registration file was not necessarily the biological father. The data did not allow us to examine the impact of biological and non-biological fathers’ mental disorders on mothers respectively.

The incidence rate of mothers’ mental disorders after birth increased more significantly than the fathers’ rate. There was an association between mother’s mental disorders and father’s mental disorders suggesting that development and testing of parents-based intervention would be important to explore to address family well-being.

Acknowledgements

We would like to thank data custodians of the Ministry of Health and staff of the Centre for Health Record Linkage (CHeLs) for providing the data, undertaking data linkage and providing advice. We acknowledge the families who have contributed their data and professional staff who were involved in the data collection and management for this research.

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First received 3 Feb 2016, final revision 2 May 2016, accepted 16 May 2016

References

1. Almond P. Postnatal depression: a global public health perspective. Perspect Public Health 2009; 129: 221–7.
2. World Health Organization. Mental Health Aspects of Women’s Reproductive Health: A Global Review of the Literature. WHO Library, 2009.
3. Wisner KL, Chambers C, Sib DK. Postpartum depression: a major public health problem. JAMA 2006; 296: 2616–8.
4. Kendall RE, Chalmers J, Platz C. Epidemiology of postpartum psychoses. Br J Psychiatry 1987; 150: 562–73.
5. Vase-Lopez Q, Blanco C, Keyes K, Olsson M, Grant BF, Hasan DS. Psychiatric disorders in pregnant and postpartum women in the United States. Arch Gen Psychiatry 2008; 65: 805–15.
6. Munk-Olsen T, Laursen TM, Pedersen CB, Mors O, Mortensen PB. New parents and mental disorders: a population-based register study. JAMA 2006; 296: 2982–9.
7. Xu F, Austin MP, Reily N, Hilder L, Sullivan EA. Major depressive disorder in the perinatal period: using data linkage to inform perinatal mental health policy. Arch Womens Ment Health 2012; 15: 333–41.
8. Woolhouse H, Gardland D, Perlen S, Donath S, Brown SJ. Physical health after childbirth and maternal depression in the first 12 months post partum: results of an Australian nulliparous pregnancy cohort study. Midwifery 2014; 30: 378–84.
9. Xu F, Sullivan EA, Li Z, Burns L, Austin MP, Slate T. The increased trend in mothers’ hospital admissions for psychiatric disorders in the first year after birth between 2001 and 2010 in New South Wales, Australia. BMC Womens Health 2014; 14: 119.
10. Munk-Olsen T, Laursen T, Mendelson T, Pedersen C. Perinatal mental disorders in native Danes and immigrant women. Arch Womens Ment Health 2010; 13: 319–26.
11. Ibanez G, Blondel B, Prunet C, Kaminski M, Sauleau-Cubizolles MJ. Prevalence and characteristics of women reporting poor mental health during pregnancy: findings from the 2010 French National Perinatal Survey. Rev Epidemiol Sante Publique 2015; 63: 85–95.
12. Milgrom J, Gemmill AW, Bilizta J, Hayes B, Barnett B, Brooks J, et al. Antenatal risk factors for postnatal depression: a large prospective study. J Affect Disord 2008; 108: 147–57.
13. Goodman JH. Paternal postpartum depression, its relationship to maternal post-partum depression, and implications for family health. J Adv Nurs 2004; 45: 25–35.
14. Garfield CR, Duncan G, Rudolph J, McCabe TW, Adam CK, Coley RL, et al. A longitudinal study of paternal mental health during transition to fatherhood as young adults. Pediatrics 2014; 133: 836–43.
15. Wise KY, Skouteris H, Pier C, Richardson B, Milgrom J. Correlates of ante- and postnatal depression in fathers: a systematic review. J Affect Disord 2011; 130: 358–77.
16. Deater-Deckard K, Pickering K, Dunn JF, Golding J. Family structure and depressive symptoms in men preceding and following the birth of a child. The Avon Longitudinal Study of Pregnancy and Childhood Study Team. Am J Psychiatr 1998; 155: 818–23.
17. Pinheiro RT, Magalhaes PV, Horta BL, Pinheiro KA, da Silva RA, Pinto RH. Is maternal distress significantly associated with paternal distress (adjusted odds ratio 1.91, 95% CI 1.05–3.47)? An integrative review showed that maternal depression was a strong predictor of paternal depression during the post-partum period.
18. Edward KL, Castle D, Mills C, Davis L, Case J. An integrative review of paternal depression. Am J Mens Health 2015; 9: 26–34.
19. New South Wales Government. Birth: Registry of Births, Deaths and Marriages, 2015 (http://www.bdm.nsw.gov.au/Pages.births/births.aspx).
20. National Centre for Classification in Health. The International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM). National Centre for Classification in Health, 1999.
21. Department of Health Centre for Health Record Linkage. How Record Linkage Works, 2016 (http://www.cherel.org.au/how-record-linkage-works).
22. Australian Institute of Health and Welfare. Australian Hospital Statistics 2008–09. Health Services series no. 17. Cat. no. HSE 84. AIHW, 2010.
23. IBM. SPSS Software, 2015 (http://www-01.ibm.com/software/analytics/spss/).
24. O’Donnell M, Anderson D, Morgan VA, Nassar N, Leonard HM, Stanley FJ. Trends in pre-existing mental health disorders among parents of infants born in Western Australia from 1990 to 2005. Med J Aust 2013; 198: 485–8.
25. The Department of Health. Key Findings from the Program Evaluation of the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative: Fact Sheet, 2015. (http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-be-eval-fact).
26. Buller AE, Austin MP, Hajes BA, Speelman C, Bilizta J, Gemmill AW, et al. Postnatal mental health of women giving birth in Australia 2002–2004: findings
from the beyondblue National Postnatal Depression Program. Aust N Z J Psychiatry 2008; 42: 66–73.

27 Paulson JF, Bazemore SD. Prenatal and postpartum depression in fathers and its association with maternal depression: a meta-analysis. JAMA 2010; 303: 1961–9.

28 Koh YW, Chui CY, Tang CS, Lee AM. The prevalence and risk factors of paternal depression from the antenatal to the postpartum period and the relationships between antenatal and postpartum depression among fathers in Hong Kong. Depress Res Treat 2014; 2014: 127632.

29 Areias ME, Kumar R, Barros H, Figueiredo E. Comparative incidence of depression in women and men, during pregnancy and after childbirth. Validation of the Edinburgh Postnatal Depression Scale in Portuguese mothers. Br J Psychiatry 1996; 169: 30–5.

30 Anthony JC, Petronis KR. Suspected risk factors for depression among adults 18–44 years old. Epidemiology 1991; 2: 123–32.

31 Xu F, Bonello M, Burns L, Austin MP, Li Z, Sullivan E. Hospital admissions for alcohol use disorders before, during, and after pregnancy: a study based on linked population data in new South Wales, Australia. Alcohol Clin Exp Res 2013; 37: 1706–12.

32 O’Hara MW, Weiner KL. Perinatal mental illness: definition, description and aetiology. Best Pract Res Clin Obstet Gynaecol 2014; 28: 1–12.

33 Epifanio MS, Genna V, De Luca C, Roccella M, La Grutta S. Paternal and maternal transition to parenthood: the risk of postpartum depression and parenting stress. Pediatr Rep 2015; 7: 5872.

34 Nishimura A, Fujita Y, Katsuta M, Ishihara A, Ohashi K. Paternal postnatal depression in Japan: an investigation of correlated factors including relationship with a partner. BMC Pregnancy Childbirth 2015; 15: 108.

35 Jones I, Heron J, Blackmore ER, Craddock N. Incidence of hospitalization for postpartum psychotic and bipolar episodes. Arch Gen Psychiatry 2008; 65: 356.

36 Matthey S, Ross-Hamid C. The validity of DSM symptoms for depression and anxiety disorders during pregnancy. J Affect Disord 2011; 133: 546–52.