Position statement about Perinatal Mental Health

Key messages for GPs

- There are current NICE (1), SIGN (2) guidelines, and NICE Quality Standards (3) covering identification and management. However many of the recommendations are based on evidence from other countries, specialist research or consensus and there is a paucity of good evidence directly relevant to UK general practice.
- Many women are reluctant to disclose perinatal mental illness (PMI). However, if a woman does disclose problems this is a “red flag”; it is possible that she is unwell, and the GP should explore in detail before reassuring or normalising her feelings.
- Treatment is usually effective, so that GPs can offer women hope
- PMI not only affects women but can also affect partners and the development and future wellbeing of the child, but this is by no means inevitable.
- GPs need to know about local pathways for perinatal mental health, when to refer to secondary specialist care, how to access it; and about local support services available in the community.
- For information about perinatal mental health look at the RCGP Perinatal toolkit

Background

Perinatal mental illnesses (PMI) are the commonest complications of pregnancy, affecting around 15-20% of all pregnancies. Not all PMI is postnatal depression or even a single diagnosis, for example depression and anxiety are often co-morbid. Table 1 illustrates the rate and diversity of diagnoses (4).

Childbirth and new motherhood carries an expectation of happiness, but it is also a time of emotional upheaval and adjustment to changes in lifestyle and relationships. Mental illness at this time causes enormous distress and can seriously interfere with the adjustment to motherhood and the care of the newborn baby as well as the existing children and a woman’s partner.
Perinatal psychiatric disorder has been a leading cause of maternal mortality for the last two decades contributing to 15% of all maternal deaths in pregnancy and the first six months postpartum (5). Over half of women who tragically die during this time have a previous history of severe mental illness and over half of the deaths are caused by suicide.

Table 1. Rates of perinatal psychiatric disorder per thousand maternities

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Rate per thousand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postpartum psychoses</td>
<td>2/1000</td>
</tr>
<tr>
<td>Chronic serious mental illness</td>
<td>2/1000</td>
</tr>
<tr>
<td>Severe depressive illness</td>
<td>30/1000</td>
</tr>
<tr>
<td>Mild-moderate depressive illness and anxiety states</td>
<td>100-150/1000</td>
</tr>
<tr>
<td>Post-traumatic stress disorder</td>
<td>30/1000</td>
</tr>
<tr>
<td>Adjustment disorders and distress</td>
<td>150-300/1000</td>
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</tbody>
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JCC-MH: Guidance for commissioners of perinatal mental health services. RCPsych 2012 (4)

Postnatal depression, anxiety and psychosis together carry an estimated total long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK (6). Nearly three-quarters (72%) of this cost relates to adverse impacts on the child rather than the mother. Over a fifth of total costs (£1.7 billion) are borne by the public sector, with the bulk of these falling on the NHS and social services (£1.2 billion). The average cost to society of one case of perinatal depression is around £74,000, of which £23,000 relates to the mother and £51,000 relates to impacts on the child.
Mental illness is as common during pregnancy as following birth (7, 8) and covers the same range of psychiatric conditions and severity as after birth. The risk factors for antenatal depression are broadly social vulnerability, childhood abuse, domestic abuse and a previous history of depression (9). The impact of poor mental health can be greater at this time, particularly if left untreated because of the impact on the cognitive, emotional, social, educational, behavioural and physical development of infants (9). Disturbances in the infants are not inevitable; they are increased from 5 to 10%. When disorders occur in the absence of social adversity and if they are of short duration, the risks to the child are generally low, and despite adversity many children in such situations develop normally and remain healthy (10).

Risk factors for postnatal depression are antenatal depression or previous depression (9). Bereavement by miscarriage, stillbirth or neonatal death are also more likely to lead to mental health problems in both parents (11). Bipolar disorder is significantly associated with postnatal psychosis, although 50% of women who develop postnatal psychosis have no history of previous mental illness (12).

GPs are the only health professionals who hold chronological medical records for women and they need to ensure that midwives at booking have access to full records of any psychiatric illness, as this is the most important predictor of future illness. In some Pathfinder areas, such as Lambeth and Tower Hamlets, there are already shared electronic records across primary, secondary and social care and this is facilitating information sharing.

There are a range of effective interventions for mothers affected by PMI (1, 2), so GPs can offer women hope about recovery. On the other hand a recent international paper suggests that few women receive optimum treatment (13). About 90% of women with perinatal mental health illness will have subthreshold, mild or moderate illness and should be cared for in primary care with input from other universal services, such as health visiting, midwifery or IAPT. Women with severe mental illness should be able to access specialist perinatal psychiatric care. However, only about 50% of CCGs in the UK have commissioned a specialist perinatal mental health service (14), producing huge disparities in the availability of care for women and families with severe illness. The English Department of Health
(DH) has recognised this as a clinical priority and has made £365 million available to increase the numbers of mother and baby units and specialist perinatal community teams. In the UK access to psychological therapies is currently limited and untimely, but the DH have pledged that 30,000 more women will have access to IAPT services throughout England by 2020/21 (15).

For those mothers experiencing impairment of their relationship with their infant, there is also promising evidence that interventions promoting parent/infant relationships can generate improvements in the quality of attachment (1, 2, 6).

In a meta-analysis of adult patients with depression in primary care 47.3% were identified correctly as depressed, although there were more false positive diagnoses than missed diagnoses (16). There is no UK study of the detection of perinatal depression by GPs, but it is probably similar.

The reasons that these illnesses are poorly recognised and treated are complex and include maternal and GP factors. One qualitative paper, conducted in areas of the country where there was poor access to specialist perinatal services, suggested that women with postnatal depression had made a conscious decision about whether or not to disclose their feelings to their GP or health visitor (17). In this paper GPs described a reluctance to label women with a diagnosis of postnatal depression, as they had few personal resources to manage women with postnatal depression themselves, and no specialist perinatal services to refer to for further treatment.
**RCGP Clinical Priority**

In April 2014 the RCGP recognised the importance of perinatal mental health for GPs and made it a clinical priority for a duration of three years. Dr Judy Shakespeare is in post, assisted by Dr Carrie Ladd, Clinical Fellow.

**Aims of the Clinical Champion Programme 2014-7**

- **Awareness raising**

  To pro-actively increase the profile and awareness of the impact of perinatal mental ill-health on the mother, her infant and her family among general practitioners, the wider primary health care community, and patient-related organisations and groups.

- **Education**

  To promote best clinical practice by developing a range and quality of educational and information resources in perinatal mental health for GPs.

- **Collaborative working**

  To spearhead collaborative and partnership working with midwives, health visitors and specialist perinatal psychiatry teams in addition to other stakeholders.

**Stakeholders**

The major umbrella stakeholder is the Maternal Mental Health Alliance (MMHA), a coalition of over 80 UK organisations, including Royal Colleges, committed to improving the mental health and wellbeing of women and their children in pregnancy and the first postnatal year. The MMHA is currently running an “Everyone’s business campaign” in which the RCGP is an active member of the campaign working group. This has just been awarded a second grant of £750k by Comic Relief to continue from 2016-2108.
Outputs from the Clinical Champion programme

Falling through the gaps: perinatal mental health and general practice.

A report by the Centre for Mental Health, working with the RCGP (18) has shown that the greatest barriers to providing better support to women is the low level of disclosure and identification. This report was based on a survey of 1547 women who had responded to a questionnaire run by NetMums (19). A number of barriers to identification were identified, including:

Barriers to identification for women

- Poor awareness of perinatal mental illness among women, their partners and families
- Considerable stigma and a fear among women that their baby might be taken away if they admit their difficulties
- Women feeling dismissed or overly reassured when discussing their problems with GPs

Barriers to identification for GPs

- Time pressures on GP consultations
- Lack of training and confidence among GPs in managing PMI
- Reduced contact between GPs and women during pregnancy and fragmented primary health care team working between GP practices and midwives and health visitors

Potential opportunities

There were potential opportunities to increase the chances of identification, including:

- The six-week maternal postnatal health check by GPs offered a crucial safety net for women disclosing later
- Improving the quality of GP responses when women raise concerns about their wellbeing. It is so difficult for women to be honest about their feelings that if they do disclose to a GP they may well have a problem. This should be
regarded as a “red flag” and should prompt a clinical assessment. Having their feelings dismissed as “normal” or being given false reassurance was distressing for women and made them less likely to present their symptoms again.

- GPs need longer consultations times if they are to manage women with PMI effectively. Providing compassionate human care for these women is the very essence of quality general practice.

**NICE Guidance on improving the identification of PMI**

NICE guidance suggests that health professionals should consider asking the Woolley questions (for possible depression) and GAD-2 questions (for possible anxiety disorders) at every contact with a pregnant or perinatal women (1). If either of these are “positive” the recommendation is a full clinical assessment, usually by the GP. A GP is in the position of being a trusted professional, responsible for women across the life-course and able to offer continuity and compassionate care. Other non-judgemental ways of opening the conversation about feelings could be considered, such as asking “Has motherhood been what you expected?” The Edinburgh Postnatal Depression Score is not recommended for screening women in the UK (1, 2, 20)

**Recommendations and actions for the RCGP champion (from Falling through the gaps)**

1. The 6-8 week maternal postnatal check is an opportunity for GPs to detect mental health problems. The evidence base for this check is poor, needs to be developed and should recognise the parity of esteem between mental and physical health.
   **Action:** JS has lobbied DH and spoken to Dame Julia Cumberlege during the NHS England maternity review consultation process. This document contains a possible framework for the maternal postnatal check, based on JS advice (21).

2. GPs need training to develop the knowledge, skills and attitudes needed for this work. Perinatal mental health is now included in the GP curriculum, but
established GPs need opportunities to maintain and develop their skills in this area through their CPD.

**Action:** Five sessions of eLearning are available on the eLfH website, with open access. JS was the editor for this programme and was involved in developing all the sessions with the authors.

3. GPs and their patients need easy access to appropriate resources.

**Action:** A perinatal mental health toolkit, written by Clinical Fellow, Dr Carrie Ladd and Dr Louise Santhanam was launched on July 22<sup>nd</sup> 2016

4. Produce an accessible guide to recent NICE guideline on antenatal and postnatal mental health.

**Action:** “NICE guideline antenatal and postnatal mental health: CG 192”. This was launched in June 2015 to make NICE guidance more accessible for GPs.

**Recommendations for NHS England**

5. NHS England should invite RCGP to be represented at the Perinatal Mental Health Transformation Board.

**Recommendations for RCGP**

6. The “Put patients first: Back general practice” campaign should continue to lobby for longer consultation times within general practice, using PMI as an example of an important part of a GP’s work that cannot be done adequately within a 10-minute consultation.

**Recommendations for commissioners**

7. Commissioners should urgently address postcode inconsistencies in the availability of community specialist perinatal mental health teams/consultants and good quality integrated care pathways (ICPs) to support women facing or with perinatal mental illness.

8. Consistent with NICE Guidance, commissioners should ensure that local IAPT services fast track mothers with common perinatal mental health difficulties into treatment on the basis of the dual risks to mother and infant mental health.
9. Commissioners should ensure that there is adequate commissioning of parent-infant interventions and that these are well publicised to GP practices and mothers and integrated within ICPs.

10. Commissioners should collate a portfolio of local resources to include currently commissioned services for perinatal mental health and relevant local charities and voluntary led groups.

11. Commissioners should aspire to making shared electronic records between primary, secondary and social care a reality in all areas.

Recommendation for every GP practice

12. Proactively develop positive working relationships with midwives and health visitors attached to the practice for the benefit of women and families.

Recommendations for every GP

13. Maintain/develop knowledge and skills in perinatal mental illness.

14. Ensure attached community midwives can access information about the medical history of all pregnant women, either by direct access to the electronic record or by an established system of communication.

15. Know the local pathway of care and about local service provision

16. Know that the RCGP perinatal mental health toolkit will be able to answer their general queries about PMI.

RCGP Council

Is asked to consider adopting the views and recommendations in this document as College policy.
References


14. Maternal Mental Health Alliance Everyone’s Business campaign website: UK Specialist community perinatal mental health teams (current provision) http://everyonesbusiness.org.uk/?page_id=349

15. Prime Minister Office January 11th 2016


https://www.tommys.org/sites/default/files/Perinatal_Mental_Health_Experiences%20of%20women.pdf


http://legacy.screening.nhs.uk/postnataldepression


Judy Shakespeare Date July 2015, review July 2016, review August 2016

Declaration of interests: Judy Shakespeare is the RCGP Clinical Champion in Perinatal Mental Health. She was on the Guideline development group for NICE 192: Antenatal and postnatal mental health published Dec 2014. In addition she is a co-collaborator on the MBRRACE-UK collaboration, in particular working with the Maternal Death Enquiry. She has received travel and accommodation expenses for all these pieces of work. She has been paid for training by BMJ Masterclass, BMJ Webinars and RCGP One Day essentials.

This document has been commented on by Carrie Ladd and Margaret McCarthy