Perinatal mental health and general practice nursing

Perinatal mental health is a critically important part of understanding the journey of life. Pregnancy and childbirth are a time of great excitement and change, which impacts both personally and professionally on the vast majority of the population. For at least 20% of pregnant women, this life event will also bring emotional disturbances and for some it will have an effect on their mental wellbeing for years after the birth. Consequently, it is vital that healthcare professionals recognise the diversity of mental illness that can impact on the childbearing population, including the need to commission effective services and be aware of how best to support women, fathers and their families during this time. This is particularly relevant for general practice nurses (GPNs) and those working in community settings, as well as nurses and midwives working with women who are pregnant, planning a pregnancy, or who have recently given birth.

KEY WORDS:
- Perinatal mental health
- Impact
- Identification
- Treatment

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Perinatal mental health (PMH) is defined as mental health during pregnancy and the first postnatal year. While pregnancy and childbirth are expected to be a time of contentment and excitement, it is also a time of emotional upheaval and adjustment to changes in lifestyle and relationships, and for about 20% of women, this life event is affected by perinatal mental illness (PMI) (Joint Commissioning Panel for Mental Health [JCPMH], 2012). Women may have pre-existing mental health conditions, or they may develop in pregnancy or the postnatal period. Hogg (2012) reported that depression is the most prevalent illness in the perinatal period, with research suggesting that around 10–14% of mothers are affected during pregnancy or postnatally. Although usually mild, a significant proportion of women will suffer from a severe depressive illness. However, not all PMI involves depression and Table 1 provides an overview of the rates of depression and other types of PMI, which could be used to establish a baseline for commissioning effective services.

Postnatal or puerperal psychosis is the most severe form of unexpected postnatal illness and affects around two in 1,000 women who give birth across the UK per annum (JCPMH, 2012). It is a severe mental illness and symptoms such as confusion, delusions, paranoia, hallucinations (usually hearing voices), and mood symptoms of mania and depression are not uncommon.

The conditions in Table 1 are not to be confused with ‘baby blues’, which affects most women within a few days of birth, and can include feeling upset, mood swings, and feeling mildly depressed and wanting to cry for no particular reason. These feelings tend to disappear after a few days, and are often related to tiredness and the physical and emotional stresses of having a baby.

**PMI can have lasting effects on maternal self-esteem and on partner and family relationships. There is also emerging evidence that 10% of fathers may suffer perinatal depression.**

<table>
<thead>
<tr>
<th>Table 1: Rates of perinatal illness per thousand maternities</th>
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<tbody>
<tr>
<td><strong>Condition</strong></td>
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<tr>
<td>Postpartum psychosis</td>
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<tr>
<td>Chronic serious mental illness</td>
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<tr>
<td>Severe depressive illness</td>
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<tr>
<td>Mild-to-moderate depressive illness and anxiety states</td>
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<td>Post-traumatic stress disorder</td>
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<td>Adjustment disorder and distress</td>
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**IMPACT OF PMI**

These conditions are important because of the devastating effects they can have on women who are not identified early and treated adequately. If poorly managed, PMI is increasingly recognised as an important public health issue, because of the adverse impact on the mother and the potential to compromise the healthy emotional, cognitive and even physical development of the child, with serious long-term consequences (London School of Economics [LSE] and Centre for Mental Health, 2014).

PMI can have lasting effects on maternal self-esteem and on partner and family relationships. There is also emerging evidence that 10% of fathers may suffer perinatal depression (Paulson and Bazemore, 2010), as well as a range of anxiety symptoms, such as ‘feeling on the edge’, nervousness, or the inability to stop or control worrying. Furthermore, severe PMI is one of the leading causes of maternal death (Knight et al 2014).

Therefore, it is critically important that healthcare professionals, including general practice nurses (GPNs), understand that earlier identification, support and treatment of PMI can prevent escalation and limit the negative impact on the whole family.

The assessment, treatment and systems of care for PMI are well understood and covered by guidelines from the National Institute for Health and Care Excellence (NICE, 2014) and the Scottish Intercollegiate Guidelines Network (SIGN, 2012). There is also clear guidance for commissioners (JCPMH, 2012) which recommends effective treatments. While the most severe conditions need managing by specialist PMI services, 90% of less severe illness can be managed within universal community health services (nursing, midwifery, health visiting, general practice and IAPT [improving access to psychological therapies] services), supported by children’s services and the third sector.

Apart from a concern about the PMH knowledge base among health and social work professionals and the wider public, there is emerging evidence about the cost of not recognising and managing this illness early (LSE and Centre for Mental Health, 2014), as well as concern around the inconsistency in the quality, availability and accessibility of antenatal and postnatal mental health care (LSE and Centre for Mental Health, 2014).
Campaigners, both local and national, are working to increase awareness around maternal and neonatal mental health, especially the Maternal Mental Health Alliance (MMHA), which is a coalition of UK organisations. It includes professional bodies, such as royal colleges (Royal College of Nursing [RCN], Royal College of Midwifery [RCM], Royal College of General Practitioners [RCGP], etc) and organisations that represent, or provide care and support to parents and families (see http://maternalmentalhealthalliance.org/ for a list of national organisations). It has clear aims of improving the provision of care through awareness-raising and commissioning research to demonstrate the impact this often hidden illness can have on individuals and society as a whole. The MMHA has three pillars of activity towards these goals:

- Awareness
- Education and action
- Campaigning for equal access to high quality services for women with, or at high risk of mental illness in pregnancy and postnatally.

One of the most useful outputs from the alliance has been mapping specialist PMI services for pregnant women and new mothers across the UK. This demonstrated that in almost half of the UK, perinatal women do not have access to specialist mental health services. (The map highlighting the gaps in provision can be viewed at: http://bit.ly/1Wxa1w.)

The LSE and Centre for Mental Health (2014) were commissioned by the MMHA to consider the economic and social impact of maternal mental ill health. The report’s shocking findings, including the current cost of care, were that:

*Taken together, perinatal depression, anxiety and psychosis carry a total long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK. This is equivalent to a cost of just under £10,000 for every single birth in the country. Nearly three-quarters (72%) of this cost relates to adverse impacts on the child rather than the mother.*

### IDENTIFYING PMI

However, there are barriers to the identification of PMI. A study by Coates et al (2015) demonstrated the challenges faced by new parents in having their symptoms identified and recognised, which can lead to a lack of efficient and effective care during the early months after birth. Only around half of mothers meeting the clinical diagnostic thresholds for perinatal depression and anxiety (NICE 2016) are identified, despite frequent routine contact with a range of primary care services at this time; and even fewer receive adequate treatment (Gavin, 2015).

A further report by the Centre for Mental Health, working with the RCGP (Khan, 2015), has shown that the greatest barrier to providing better support to women is the low level of identification of need. Barriers to identification for women, include:

- Poor awareness of PMI among women, their partners and families
- Considerable stigma and a fear that their baby might be taken away if they admit their difficulties

### Risk factors

**Antenatal:**
- Previous history of depression
- Low self-esteem, antenatal anxiety, low social support, negative cognitive style, major life events, low income
- History of childhood abuse, especially sexual

**Postnatal:**
- Antenatal depression
- History of depression

### Resources

- There are a number of online CBT opportunities, such as the Welsh group TwoInMind (www.twoinmind.org), or other online parenting support such as Netmums (www.netmums.com).
- For more information about perinatal mental health, see the Royal College of General Practitioners’ resource page: www.rcgp.org.uk/clinical-and-research/clinical-resources/perinatal-mental-health.aspx
- Feeling dismissed or overly reassured when discussing their problems with GPs.

While barriers to identification for GPs include:
- Time pressures on consultations
- Insufficient training and confidence in managing PMI
- Lack of contact between GPs and women during pregnancy and inconsistent team-working between GP practices and midwives and health visitors
- Lack of focus on mother and baby wellbeing after initial 6–8-week checks
- Lack of focus on the mother and baby relationship
- Lack of specialist resources for referral.

These barriers could equally be applied to GPNs and those working in primary care and community settings.

Khan (2015) also identified potential opportunities to increase the chances of identification, such as:
- Ensuring equal attention to wellbeing and physical health during every contact with mothers, partners and families during the perinatal period
- The six-week postnatal health check by GPs offers a crucial safety net for women who have been missed previously by the system, or who have not disclosed any concerns in earlier appointments
- Improving the quality of GP
responses when women raise concerns about their wellbeing
- Support for partners to understand and act on the signs of distress.

Situations when GPNs may come into contact with women with perinatal mental illness could include any consultation or referral, but in particular:
- Blood tests in pregnancy
- Primary immunisations of infants at two, three, four and 12 months
- Maternal postnatal examinations
- Cervical cytology tests
- Contraception consultations
- Minor injuries for the woman or her children.

If a PMI is suspected or identified by a GPN or any healthcare professional, NICE recommended the GP as the first line of assessment and management (NICE, 2016). It is therefore important that all those working in community primary care settings (e.g. GPNs, school nurses, health visitors and midwives) are fully aware of the pathway for referral and follow-up.

Knowing and engaging with a local pathway of care can also identify resources available to help women and their families, including self-help and voluntary groups (NICE, 2016). Self-help can include accessing social support through parent and baby activities, postnatal exercise classes, and cognitive behavioural therapy (CBT) — a well-recognised ‘talking therapy’ that is commonly used to treat anxiety and depression. Many health visitors have been trained to offer support and low intensity psychological therapies.

In addition to self-help, there are two main approaches to treatment:
- Psychological therapies
- Medication.

Psychological therapies
Early access to psychological therapies, such as counselling, CBT or cognitive analytical treatment for specific conditions is recommended by NICE (2016) to reduce the impact on the mother and her child. These are provided by Improving Access to Psychological Therapies (IAPT) in England and CBT/talking therapies in Wales. However, surveys carried out by the ‘Everyone’s business’ campaign (Maternal Mental health Alliance, 2014) found that access was variable, and the National Society for Prevention of Cruelty to Children (NSPCC) report in

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2014 was clear about the need for consistent access to services (Hogg, 2012). Rapid access is important and was reiterated by NICE (2016), which stated that assessment within two weeks and starting treatment within four weeks are key standards to attain.

Medication
Antidepressants may be helpful for moderate-to-severe depression (NICE, 2014). There is a higher threshold for pharmacological interventions arising from the changing risk-benefit ratio for psychotropic medication at this time. However, as with any pharmacological treatments, clinicians need to be mindful of the contraindications if women are breastfeeding.

Following extensive evidence reviews by NICE (2014), psychological therapies are recommended as the treatment of first choice for women with mild-to-moderate disease. However, in the authors’ clinical opinion, with increasing severity of mental health problems and with current delays in accessing psychological therapies, the balance may shift towards prescribing medication. A woman (and her family, if appropriate) should always be involved in making an informed choice.

It is also important to remember that some women may become suicidal and not only will it become critical to manage their care urgently, but there may be safeguarding issues for their baby. GPNs need to have a good understanding of the local safeguarding processes and know how to contact the safeguarding lead, especially during out of hours’ services.

There is limited current evidence about the role of GPNs and PMI. However, there is some evidence in the care of patients with depression by GPNs from the ProCEED trial (Bennett et al, 2013). In this trial, pro-active care reviews using GPNs as case managers were found acceptable by the majority of patients and GPNs, and this may be a suitable way to provide care for patients with long-term depression in primary care. Motivated and interested GPNs could be an appropriate and valuable resource for continuing to support women with PMI (further information on the output from this trial can be found at the Mind Guide website: http://bit.ly/13jo6xw).

CONCLUSION

One of the key messages for GPNs is recognition of the opportunity for making a positive difference, simply by being aware of the possible impact of PMI. Listening to women and supporting them with lifestyle factors, such as diet, exercise and physical health issues, can help with anxiety or depression.

The recent ‘Better births Improving outcomes of maternity services in England’ report has a central theme running throughout, which concentrates on making the woman the focal point of maternity services, and champions family-focused integrated care as
an all-inclusive multi-professional and multi-agency pathway to care (National Maternity Review, 2016). This plays a key role in providing the best possible care for all women, and particularly vulnerable women, their partners, babies and families. This is also reiterated by the 1001 campaign and the Maternal Mental Health Alliance (MMHA, 2016).

To maintain a gold standard of care, services should be locally commissioned to be available when needed, especially if the need is critical or ongoing.

The message here is also about raising awareness of the complexity of mental health issues that may arise during pregnancy or postnatally, and knowing how to recognise them, best support those affected, and improve the outcomes for all. It is the responsibility of all healthcare professionals to tackle the stigma that still exists around poor mental health, recognising the need to be alert to symptoms, while ensuring that colleagues understand the potential devastating effects that poorly managed mental ill health can have on a whole family. 

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