RCGP Royal College of General Practitioners

GPCPC
GPs Championing Perinatal Care

Antenatal and postnatal mental health NICE guideline CG192. Practical implications for GPs

Click here to link to guideline

10 questions a GP should ask themselves (and their team)

1. Why is perinatal mental health important?

Perinatal mental health problems are common. Between 10% and 20% of women* will develop a mental disorder during pregnancy or within the first year after having a baby. 90% of women diagnosed with perinatal mental health problems are cared for in primary care.

Most women will have mild to moderate problems, but some will have severe or complex problems, such as severe depression, pre-existing illness like schizophrenia or bipolar disorder. Some women will have drug and alcohol problems. Health inequalities and other medical conditions are strongly linked to risk of perinatal mental health problems. The most common cause of direct death in the perinatal period for women is death by suicide.

The consequences include immense distress for women and their families. Intervening early reduces the impact of the problems on the mother, her child and family.
The first two years of a baby's life are the building blocks of their long-term social and emotional development. The huge economic impact of perinatal depression, anxiety and psychosis carries a total long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK, with two-thirds of the cost being linked to short and long term problems for the child.

All areas in England now have access to specialist perinatal mental health services for women with severe illness. In England. Specialist Maternal Mental Health Service (MMHS) will also be in place across England by 2024, providing assessment and psychological care for women experiencing moderate to severe or complex mental health difficulties arising from their maternity/perinatal/neonatal experience. This may include birth trauma, perinatal loss (for any reason, including loss due to removal for safeguarding reasons), or tokophobia (severe fear of childbirth).

Treatment is **effective** and there are NICE guidelines for care.

- *This document uses the terms 'woman' or 'mother' throughout. These should be taken to include people who do not identify as women but are pregnant or have given birth.*

2. As a GP how could you improve detection and outcomes?

Poor detection

Only about half of cases of perinatal mental health problems are detected. There is clear room for improvement.

Maternal factors for poor detection	GP factors for poor detection
Stigma	Not asking
Putting on a brave face	Time constraints
Fear of being thought a 'bad mother'	Lack of training or confidence
Fear the baby may be taken away	Lack of access to specialist service
Not knowing what is 'normal'	Normalising or dismissing symptoms

Communication tips

- Be proactive.
- Ask open and interested questions about how she is finding being a mother, even if she is smiling!
- Ask about the birth - every woman has a story to tell & it is important to know the context of how she is feeling when considering her symptoms.
- Ask about mental health every time you see her; don't assume someone else has done it.
- Remain vigilant throughout the first year following birth.
- Ensure women know they can access help and support if they feel they are struggling and will be prioritised

Recognise the exceptional opportunity of the 6-8 week maternal postnatal consultation

This may be the only time a GP sees a mother in the entire pregnancy and postnatal period.
Consider asking about a possible mental health problem **BEFORE** focusing on the physical tasks.
This check should be distinct and separate from the baby check.

Disclosure is a 'red flag' to explore symptoms. It's so difficult for a woman to raise this with a GP; if she says she has a problem, assume she does. Don't dismiss her or normalise her symptoms until you have explored.

3. How do you recognise and manage a perinatal psychiatric emergency?

This will usually be caused by severe depression or perinatal psychosis.

Red Flags for Suicidal Risk

Successive confidential enquiries into maternal deaths suggest that women with the following symptoms may be at higher risk of suicide and therefore require referral, preferably to a local specialist PMH service. Use your local pathway or emergency crisis perinatal pathway, (urgent referrals should be made by phone and triaged by the team within **four** hours):

- recent significant change in mental state or emergence of new symptoms
- new thoughts or acts of violent self-harm
- new and persistent expressions of incompetency as a mother or estrangement from the baby

4. Can you involve her partner?

Make it clear that the partner is welcome to come to the appointments. They can help with detection if they know what to look out for and offer practical and emotional support.

But:
Make sure you see her by herself on at least one occasion as she will not be able to tell you about problems with their relationship if they are present (women with perinatal mental health problems are three times as likely as other women to be suffering from domestic violence).

Remember the partner could also have a mental health disorder: around 10% of partners have depression, anxiety or other mental health problems and they may also need treatment.

5. How should I care for women with a history of serious mental health illness?

- Women with a history of severe mental illness, such as bipolar disorder, schizoaffective disorder or severe depression need specialist care, preferably by a specialist perinatal psychiatrist pre-pregnancy, during pregnancy and during the postnatal period, even if they are well at the time.

- Bipolar women (2% of the population) have a high risk of developing postpartum psychosis of around one in four, or one in two if they have a personal or family history of postpartum psychosis.

- Medication for these women pre-pregnancy, during pregnancy and immediately after delivery should be the responsibility of the perinatal psychiatrist **NOT** the GP.

6. How do you manage these problems in primary care?

Do not stop psychiatric drugs immediately/suddenly if a woman becomes pregnant.

Stopping treatment suddenly may carry a high risk of relapse. There is time to make a considered decision. See here for advice. If you are not confident as a GP to give this advice, seek help or refer.

General management

Offer a range of treatment options (including medication if indicated) and **give hope** by explaining that treatment is effective.

NICE states that the treatment of choice for depression/anxiety is stepped psychological therapy

Identify one health professional as **the lead professional** who will develop a shared plan to co-ordinate her care with the woman and where appropriate her partner and family. The lead could be a health visitor, midwife, or GP: it does not necessarily have to be the GP. Health visitors can play an important role in identifying and managing mild to moderate problems through a variety of low intensity therapeutic psychological interventions.

It is vital that HVs, GPs and other others working with mother and family communicate with each other.

- Ensure this plan is coordinated with other perinatal support.
- **Self-help:** self-care activities, such as maintaining hobbies, developing a support network around a woman accessing local peer support activities, post-natal exercise classes, online resources.
- **NHS Talking Therapies for Anxiety and Depression:** rapid access to primary mental health is important. For women in the perinatal period the NICE standard is assessment within 2 weeks and start treatment within 4 weeks. In some areas there may be delays in accessing this help but support and follow up should be offered in the interim.
- **Medication** (antidepressants)

  A woman (and her family, if appropriate) need to be involved in making an informed decision. NICE recommendations on prescribing in pregnancy and breastfeeding can be viewed here.

Medications in pregnancy
For GPs: UKTIS but you need to register (free) to access complete monographs
Patient-facing information on at Bumps

Medications in breastfeeding UKDILAS

If the woman fails to attend a booked appointment or make contact as expected, follow up.

7. What should you consider when caring for women of childbearing potential who have new or existing mental health problems?

Around 50% of pregnancies are unplanned, so preconception care of any woman who has the potential to become pregnant needs to be built into routine care.
If you are starting or reviewing a medication, such as an antidepressant, routinely raise the possible risks in pregnancy, ask about contraception and, if necessary, offer a dedicated appointment to give information and make an individualised plan for any future pregnancy, planned or not.

9. Should you consider how the woman is interacting with her baby?

Perinatal mental problems can sometimes affect interaction and lead to longer term problems for the infant. Some mothers describe feeling numb and having worries about this. Look at attachment between the mother and infant and if you have concerns, consider with the mother referral to your health visitor or infant mental health service for assessment. Early and simple interventions help (and can improve maternal mental health as well).

10. What resources are available locally for maternal and infant mental health (health service and voluntary sector) and how do you access them?

Is there a local pathway and how can you access it? If there isn't, this is an opportunity to gather these resources together, ensure the whole practice is aware and consider an in-house teaching session.
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