Cynulliad Cenedlaethol Cymru / National Assembly for Wales
Y Pwyllgor Plant, Pobl Ifanc ac Addysg | Children, Young People and Education Committee
Iechyd Meddwl Amenedigol | Perinatal Mental Health
PMH 15
Ymateb gan: Coleg Brenhinol yr Ymarferwyr Cyffredinol Cymru
Response from: Royal College of General Practitioners Wales

4 May 2017

Inquiry into Perinatal Mental Health

RCGP Wales represents GPs and doctors training to be GP across Wales. We welcome the opportunity to respond to the Children, Young People and Education Committee's consultation on Perinatal Mental Health.

Overall Recommendations:

a. Improve public awareness of PMH services
b. Improve communication between health professionals managing perinatal care
c. Improve education about PMH for health professionals
d. Enhance support for all women with mild to moderate PMH with CPN based in localities
e. Improve psychiatric provision for patients requiring specialist mental health service including mother and baby units.
f. Investing adequate resources into primary care including General Practice and other healthcare professionals.

1. General Practitioners are the only professionals, who manage patients and their families in a holistic cradle to grave fashion. GPs now often have limited input into the management of pregnant mothers, which is now mainly done by midwives with or without input from obstetricians and/or GPs. Potentially GPs would be in an important position to identify those patients, who may be at greater risk of Perinatal Mental Health (PMH) problems due to a prior mental health risk, bereavement or adverse childhood experience as highlighted in the recent Public Health Wales report (1). Unfortunately, GPs are often not even aware that their patient is pregnant until there are additional non-maternity concerns around the pregnant woman. Treatment is usually effective, so that GPs can offer women hope. PMI not only affects women but can also affect

fathers and partners, plus wider family and the development and future wellbeing of the child, but this is by no means inevitable.

2. There are current NICE (2), SIGN (3) guidelines, and NICE Quality Standards (4) covering identification and management of PMI. 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.

3. Many women are reluctant to disclose (PMI). However, if a woman does disclose problems this may be an indicator that there may be PMI. PMI is the commonest complication of pregnancy, affecting 15-20%. See table below(5). Post-natal depression is the most commonly recognised but the highest incidence is of adjustment disorders with stress affecting (6). Anxiety and depression may occur together. This is a time of intense life style change and there are expectations that young parents will welcome this change easily. Fathers, partners and other family members may also find the adaptions difficult and this may be enhanced if there are other co-morbid mental health or physical problems in the family as well as social stressors.

Rates of perinatal psychiatric disorder per thousand maternities

Postpartum psychosis	2/1000
Chronic serious mental illness	2/1000
Severe depressive illness	30/1000
Mild-moderate depressive illness and anxiety states	100-150/1000
Post-traumatic stress disorder	30/1000
Adjustment disorders and distress	150-300/100

JCC-MH: Guidance for commissioners of perinatal mental health services. RCPsych 2012 (5)

4. 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 (6). 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.

5. 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 (7). 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.

6. Mental illness is as common during pregnancy as following birth (8, 9) 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 (1,10). 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. 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 (11).
7. Risk factors for postnatal depression are antenatal depression or previous depression (10). Bereavement by miscarriage, stillbirth or neonatal death are also more likely to lead to mental health problems in both parents (12). Bipolar disorder is significantly associated with postnatal psychosis, although 50% of women who develop postnatal psychosis have no history of previous mental illness (13). In most of Wales there has been a move away for GP referral to midwifery services or even joint maternity care with a move to self-referral, which limits the history following the patient.
8. There are a range of effective interventions for mothers affected by PMI (2,3), so potentially if involved GPs can offer women hope about recovery. Many women receive sub optimum treatment (14) and there are no specialist Perinatal Mental Health Units in Wales to care those needing specialists perinatal psychiatric care. In some areas Local Health Boards, have commissioned Clinical Psychiatric nurses (CPN), who can receive referral from community health professionals but may be limited to only patients who are allocated to flying start health visitors. This is in line the Mental Health Delivery Plan (15) and is welcomed but not universal as yet.
9. Following delivery, the care of the patient and baby (if live born) is in the care of first the midwife and then the health visitor. These health professionals may only have limit awareness and understanding of managing mental health problems. Health Visitors visit from 10 days. Although there are reporting mechanisms between midwives, health visitors and GPs, these are often not robust and may not always highlight the concerns of one group to another. The linking of health visitors and midwifes to GPs makes this more robust. In some areas, different teams may deal with a GP practices' patients from geographic or team reasons making this hand over more difficult, e.g. generic and flying start health visitors may have little communication despite having patients on opposite sides of the road. Only one team may attend the GP surgery for baby clinics so concerns about the other's patients are not highlighted to the GP. This leads to inequalities in care based on post code rather than need.
10. GPs may have limited contact with the mother following delivery. When maternity services where shared with GPs visited mothers and babies after delivery and did a post-natal maternal check at 6 week, but these are no

longer part of routine management. A lost chance to highlight potential problems and lack of wellbeing. Removing this element of care has also meant GPs have less experience in this area. These services have been lost due to time constraints and workload issues affecting general practice. This is compounded by as the paucity of services to support patients if identified. The Primary Care Mental Health Support Service can act to sign post patients to services to help mild anxiety and depression, but waiting times are often long and sessions may be difficult to access for a mother with a baby and other young children.

11. Further barriers to disclosure come from public poor awareness of perinatal mental illness particularly among women, their partners and families. There is also considerable stigma and a fear among women that their baby might be taken away if they admit their difficulties. This is enhanced by the lack of mother and baby units for admission of severe mental and physical conditions. In addition women may also feel dismissed or overly reassured when discussing their problems with health professionals. This could be helped by improving public awareness and professional education.

12. 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 (2,3,7). 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.

13. 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.

14. Where specialist medical services have been available in the past they have proved beneficial to both patients their families and health professionals especially GPs. The unit in Cardiff prior to closure had outreach services to monitor patients once they went home and offer support. In patient units if close to family improve family involvement and support enabling the transition home to be easier for all.

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