Perinatal mental health and the GP

Perinatal mental health problems are some of the commonest complications of pregnancy, affecting around 12-15% of all pregnancies. They can also be serious: 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 [1] .

Not all perinatal mental illness is postnatal depression [2]. Table 1 illustrates the rate and diversity of diagnoses.

Table 1. Rates of perinatal psychiatric disorder per thousand maternities

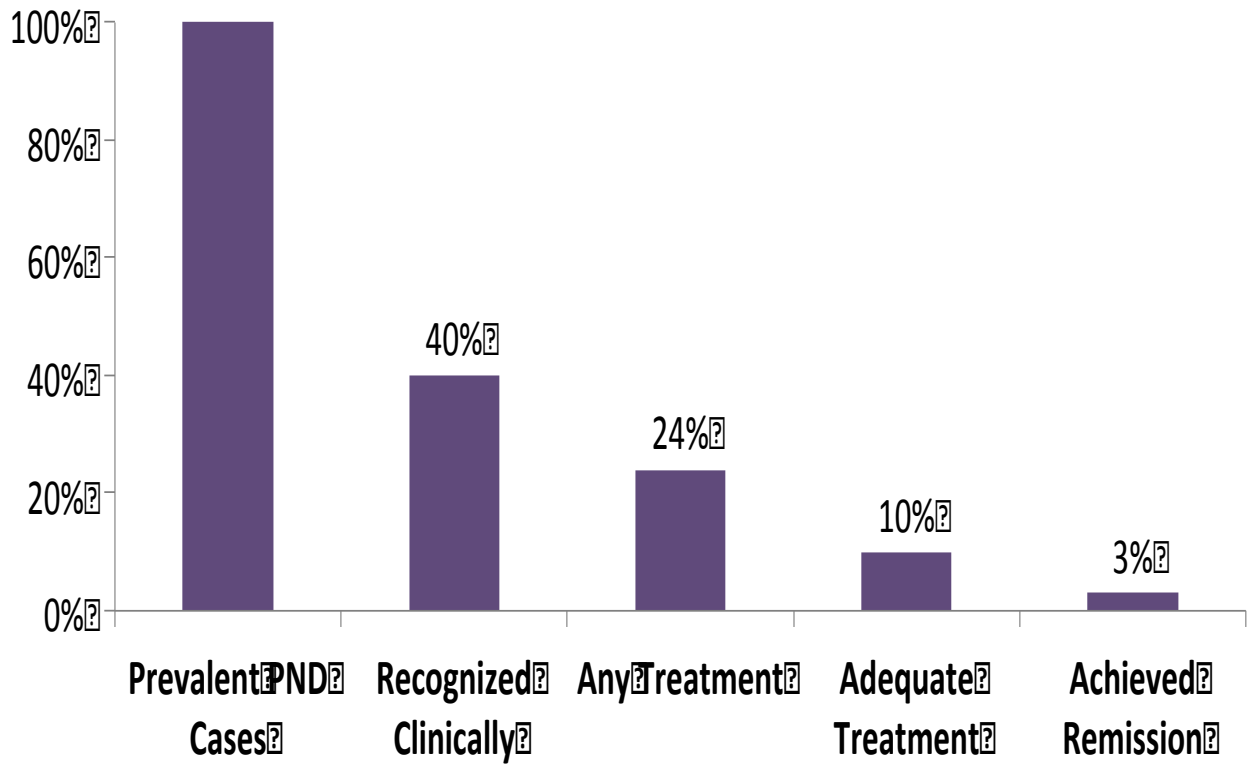
Postpartum psychosis	2/1000
Chronic serious mental illness	2/1000
Severe depressive illness	30/1000
Mild-moderate depressive illness and anxiety states	100-150/1000
Post traumatic stress disorder	30/1000
Adjustment disorders and distress	150-300/1000

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

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. Significant mental health problems at this time cause 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. Poorly managed, perinatal mental health problems can have lasting effects on maternal self-esteem, partner and family relationships. Recent research has shown that if the mother is in the top 15% for symptoms of anxiety or depression while pregnant, her child has double the risk of a probable mental disorder by the age of 13 [(3)]. This is after allowing for a wide range of potential confounders including postnatal maternal mood. The effects of postnatal maternal mood on child emotional, behavioural and cognitive development are well established. There is a window of opportunity when intervention can prevent the development of future mental illness and other neuro-developmental problems in the child.

Table 2. Postnatal depression care



Gavin, Meltzer-Brody, Glover, and Gaynes in press 2014

Clear pathways of care for the management of perinatal mental health were produced by NICE in 2007 [(4)]. The guideline is currently being updated and is due for publication in December 2014.

About 90% of the care for women with perinatal mental health illness will be in primary care and in other universal services like health visiting or midwifery. At present only about 50% of the CCGs in the country have access to a specialist perinatal mental health service [(5)]. These illnesses are poorly recognised and treated by GPs (see example for postnatal depression in Table 2). The reasons for this are complex and include factors affecting the mother and the GP. One qualitative paper, conducted in areas of the country where there was poor access to specialist perinatal services, suggested that women made a conscious decision about whether or not to disclose their feelings to their GP (or health visitor) [(6)]. GPs described strategies used to hinder disclosure and described a reluctance to make 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. In a recent survey of around 1500 women who had suffered from perinatal mental illness for the Boots Family Trust Alliance, 30% had never told a health professional how they were feeling. Even if they did tell a health professional only 18% were always completely honest. Reasons for being less than honest were: too embarrassed: 43%, not admitted to myself: 36%, might take baby: 34%, couldn't help me: 23%, not friendly: 15%. On the other hand, 25% had told a health professional first [(7)]. There is plenty of scope for improvement in care.

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