

REPORT

Centre for  
Mental Health



Royal College of  
General Practitioners



Boots  
Family Trust

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

Lorraine Khan

**Tommy's**  
Funding research  
Saving babies' lives



MATERNAL MENTAL  
HEALTH ALLIANCE  
Awareness Education Action



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# FOREWORD

More than one in ten women develop a mental illness during pregnancy or within the first year of having a baby. If untreated, this can have a devastating impact on the women affected and their families.

The Royal College of General Practitioners - which represents 50,000 family doctors across the UK - recognises the importance of addressing this issue. Perinatal mental health is one of our key clinical priorities for the next three years to ensure that all GPs have the knowledge, skills and confidence to effectively identify and treat pregnant women with depression and anxiety.

This report is an important step in understanding women's experiences and the role of GPs in disclosure, identification and support.

It makes important recommendations for policymakers, commissioners of maternal health services and healthcare professionals, and builds on the important work of the Maternal Mental Health Alliance's Everyone's Business campaign; the recent All Party Parliamentary Group's 1001 Critical Days manifesto and the Building Great Britons report.

We hope it will lead to improved consistency and accountability in the provision of mental health care and services for women and their families so that the risk of damaging experiences in later life is greatly reduced.

All professionals working in primary care should find this report an invaluable resource. We will continue to develop GP learning and support in perinatal mental health to ensure that we provide the best care possible to our patients.



**Dr Maureen Baker CBE**

Chair of Council,  
Royal College of General Practitioners

## Executive Summary

Perinatal mental health problems affect up to 20% of women at some point during pregnancy and for the first year after birth, with around 15% of women experiencing common mental health problems such as perinatal depression and anxiety.

The impact of poor mental health can be considerable at this time, particularly if left untreated. Improved identification and prompt evidence-based treatment are particularly important and can be highly effective.

Only around half of mothers with perinatal depression and anxiety are identified despite frequent routine contact with a range of primary care services at this time; and even fewer receive adequate treatment.

Centre for Mental Health has worked in partnership with the Perinatal Mental Health Clinical Champion at the Royal College of General Practitioners, the Boots Family Trust, Netmums and Tommy's to better understand the contribution of GPs to this area of work.

This report analyses data from surveys of GPs and women with experiences of common mental health problems in the perinatal period to understand the interactions between them and how they could be improved.

Current policy and practice guidance largely overlooks the role of GPs in offering improved mental health support to women during pregnancy and in the year after childbirth. Yet GPs have a distinctive role as family doctors, with a lifelong responsibility for the health of their patients, and now additionally as the commissioners of local health services in England.

### Identification

The biggest barrier to providing better support to women experiencing poor mental health in the perinatal period is the low level of identification of need. The evidence we reviewed pointed to a number of barriers to identification, including:

- Insufficient training and confidence among GPs in dealing with mental health problems and in the management of perinatal mental health care
- Poor awareness of perinatal mental illness among women, their partners and families
- A lack of contact between GPs and women during pregnancy and inconsistent team working between GP practices and midwives and health visitors
- A lack of focus on mother and baby wellbeing after initial 6-8 week checks
- Women feeling dismissed or overly reassured when discussing their problems with GPs
- Time pressures on GP consultations
- Significant inconsistencies and discontinuities in the system
- A lack of focus on the mother and baby relationship
- Considerable stigma and a fear among women that their baby might be taken away if they admit their difficulties

We also found that there were some opportunities to increase the chances of identification, including:

- Ensuring equal attention to wellbeing and physical health during every contact with mothers, partners and families during the perinatal period
- The six-week postnatal healthcheck by GPs offering a crucial safety net for women disclosing later or missed by the system
- 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

## Disclosure

Once a woman has asked for help and need has been identified, the way GPs and other professionals respond is then crucial to ensure women get the treatment and support they require.

We found that women had mixed experiences of raising mental health problems with their GPs and that GPs lacked confidence in the screening tools available. Very often women open up to their GPs because they have reached a crisis and other attempts to seek help have been unsuccessful.

It is clear from this study that voluntary disclosure of distress should be regarded as a 'red flag' moment for GPs requiring further active and compassionate investigation.

## Interventions

The surveys shed light on what treatment is offered and how it is experienced by women and their GPs. Many women said that the range of options they were offered tended to be narrow: the majority described GP responses being strongly reliant on prescribing. This may be related to a lack of faith described by GPs in the availability of timely help from local specialist services.

Women who were referred quickly for psychological therapies found them helpful. But some had to wait a long time to get treatment and this required a great deal of persistence.

Women appeared most positive about the care they received when it felt personalised and integrated, when they were involved in making decisions about their care and when it was experienced as wrapping around their needs. For some, multifaceted care packages were put in place after disclosure to health professionals and following diagnosis by GPs. But there was little evidence of most GPs linking women up with broader sources of support in the community.

Very importantly, some women had concerns about the impact of their poor mental health on their developing relationship with their infant; hardly any women accessed mother and baby interventions which have potential to improve the mental health and wellbeing of both mothers and babies.

## Recommendations

To support improvements in practice we have made a number of recommendations for policymakers and commissioners:

1. The Government should commission a taskforce to examine how to ensure that NICE guidance on perinatal mental health is implemented in full during the next Parliament.
2. The Government and NHS England should take action to reduce pressure on general practice to enable longer consultations to be offered to women at risk of or with perinatal mental health problems.
3. The Government should commission targeted work to reduce stigma among women with perinatal mental health difficulties.
4. The Department of Health should ensure that there are more systematic opportunities to focus on the mental health and wellbeing of mother and infant before a child's first birthday. This may include improved focus on this by health visitors and practice nurses during the second half of the first year following birth.
5. The Department of Health should identify opportunities to collect monitoring data to reinforce the importance of supporting mother and infant mental health and wellbeing.
6. Health Education England (HEE) should work with the RCGP Clinical Champion to support specific perinatal mental health training provision for qualified GPs.



7. Local Education and Training Boards and Deaneries should develop curriculum competencies relating to perinatal mental health through their GP training programme and these competencies should be assessed by workplace-based training and Membership of the Royal College of General Practitioners (MRCGP) assessments.
8. NHS England and clinical commissioning groups 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.
9. Consistent with NICE Guidance, clinical commissioning groups 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. Waiting times should be routinely measured for this target group. GPs will also need to be made aware of fast tracking systems.
10. Clinical commissioning groups 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.



## 1. Introduction

Perinatal mental health problems affect between 10% and 20% of women at some point during pregnancy and for the first year after birth, with around 13% -15% of women experiencing common mental health problems such as perinatal depression and anxiety (O'Hara & Swain, 1996; Heron *et al.*, 2004; Bauer *et al.*, 2014). Poor mental health is as common during pregnancy as following birth (Austin, 2004; Milgrom *et al.*, 2008) and covers a range of psychiatric conditions of differing levels of severity ranging from mild to moderate anxiety and depression to more severe mental illness such as bipolar disorder, post-traumatic stress disorder and postpartum psychosis.

The impact of poor mental health can be greater at this time, particularly if left untreated. Improved identification and prompt evidence-based treatment are particularly important at this time for a range of reasons:

- perinatal mental illness remains a leading cause of maternal death (Knight *et al.*, 2014) with over half of women who tragically die during this time having a previous history of severe mental illness and half of deaths caused by suicide.
- it causes significant anguish to mothers and partners, affecting family relationships (Chew-Graham *et al.*, 2008).
- if chronic, it can also be doubly damaging in its impact, not only affecting mothers' outcomes but also compromising the cognitive, emotional, social, educational, behavioural and physical development of infants (Sutter-Dallay *et al.*, 2011).
- inadequate identification and treatment are associated with significant costs to society over time with the majority of these costs associated with poorer child mental health and outcomes (estimated at £8 billion for each one year cohort) (Bauer *et al.*, 2014).

Only around half of mothers meeting diagnostic thresholds for perinatal depression and anxiety are identified (Ramsay, 1993; Hearn *et al.*, 1998) despite frequent routine contact with a range of primary care services at this time; and even fewer receive adequate treatment (Bauer, *et al.*, 2014). Poor identification and delays in treatment are particularly unfortunate since treatment responses are generally good and a range of interventions are considered effective in supporting improved outcomes for mothers affected by perinatal mental illness (SIGN, 2012; NICE, 2014). Furthermore, 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 (Bauer *et al.*, 2014; SIGN, 2012; NICE, 2014).

This publication was funded by the Boots Family Trust and focuses specifically on common perinatal mental illnesses such as depression and anxiety and women's experiences of disclosure, identification, help-seeking and support with particular reference to the role of the general practitioner. Centre for Mental Health has worked in partnership with the Perinatal Mental Health Clinical Champion at the Royal College of General Practitioners, the Boots Family Trust, Netmums and Tommy's to better understand the contribution of GPs to this area of work. It also builds on the work of the Maternal Mental Health Alliance (MMHA) and the 'Everyone's Business' Campaign ([www.everyonesbusiness.org.uk](http://www.everyonesbusiness.org.uk)) which seeks to increase awareness of and accountability for better access to good quality and consistent care for mothers suffering from common perinatal mental illnesses (such as postnatal depression, antenatal depression and anxiety) and their families.

## Methodology

This report triangulates findings from multiple sources including:

- survey responses on perinatal mental health issues from 43 GPs. The survey was distributed by the Royal College of General Practitioners (RCGP) Clinical Champion for Perinatal Mental Health in the summer of 2014 and aimed to replicate an earlier survey responded to by midwives and health visitors in 2013 as part of the Boots Family Trust Alliance Survey.
- survey responses from 1,547 women responding to the Boots Family Trust Alliance Survey in 2013 (accessed through collaboration with Tommy's and Netmums). This survey produced an earlier publication focusing mainly on quantitative results (Russell *et al.*, 2013). The current analysis focused mainly on detailed qualitative data relating to mothers' experiences of GPs, seeking help, disclosure, identification, treatment and their general recovery stories.
- semi-structured interviews with four mothers recruited through Netmums.
- semi structured interviews with three GPs recruited from RCGP survey respondents.
- a review of the literature on perinatal mental health and general practice.

Qualitative findings were subjected to in-depth analysis and coding using interpretive phenomenological approaches (Smith *et al.*, 2009) building an overarching hierarchy and thematic framework. Emerging themes were then cross referenced and compared with limited quantitative data available from the GP survey and contextualised within literature review findings.

Finally, emerging themes were shared with a small focus group of GPs recruited via the RCGP. Findings are designed to form a basis for the three-year RCGP Clinical Champion for Perinatal Mental Health's action plan to support improvements in GP practice.

## Research limitations

The GP survey was distributed to an unknown but large number of GPs through virtual portals. Only 43 GPs responded. This self-selecting group are likely to be unrepresentative since they may be those most interested in or curious about the subject matter. In order to add context and robustness to these findings, GP survey responses were cross referenced with responses from the 2013 survey of a much larger sample of women (1547) and their experiences of common mental perinatal mental health problems, from which we focused on descriptions of GP contact and broader care.

## GP survey respondents

Those responding to the GP survey were mostly from England but with two respondents from Wales and Scotland and one from India. Over half had less than 11 years' experience in General Practice with just over a third of respondents being relatively newly qualified practising for 1-3 years. Just over a quarter had more than 20 years' experience.

The majority of those responding (79%) did not consider themselves to be specialists in perinatal mental healthcare in their profession with a further 14% feeling that they held a partially specialist role in this field.

## 2. Policy and practice guidance

Improving perinatal mental health services was identified as a priority area in the Government's recent publication '*Closing the Gap: Priorities for essential change in mental health*' (DH, 2014). It emphasised the importance of a stepped care approach to supporting mothers affected by perinatal mental illness with the majority being supported by 'extended primary care teams' (including midwives, health visitors, GPs and Improving Access to Psychological Therapies [IAPT] services). Only a minority are supported through secondary care. NICE recommends specialist community perinatal mental health teams and if necessary, in severe instances, accessing inpatient care in bespoke mother and baby units. This policy guidance aimed to focus local energy on addressing 'unwarranted regional variation' in specialist perinatal mental health services, to address knowledge and skill shortages in perinatal mental health through health visitor and Health Education England training and to increase the number of health visitors in training.

However, the contribution of GPs was not addressed in this drive for improvement and, overall, there have been mixed policy messages on the extent and nature of GPs' involvement in perinatal mental health care. On the one hand, guidance recognises particular advantages GPs have in terms of:

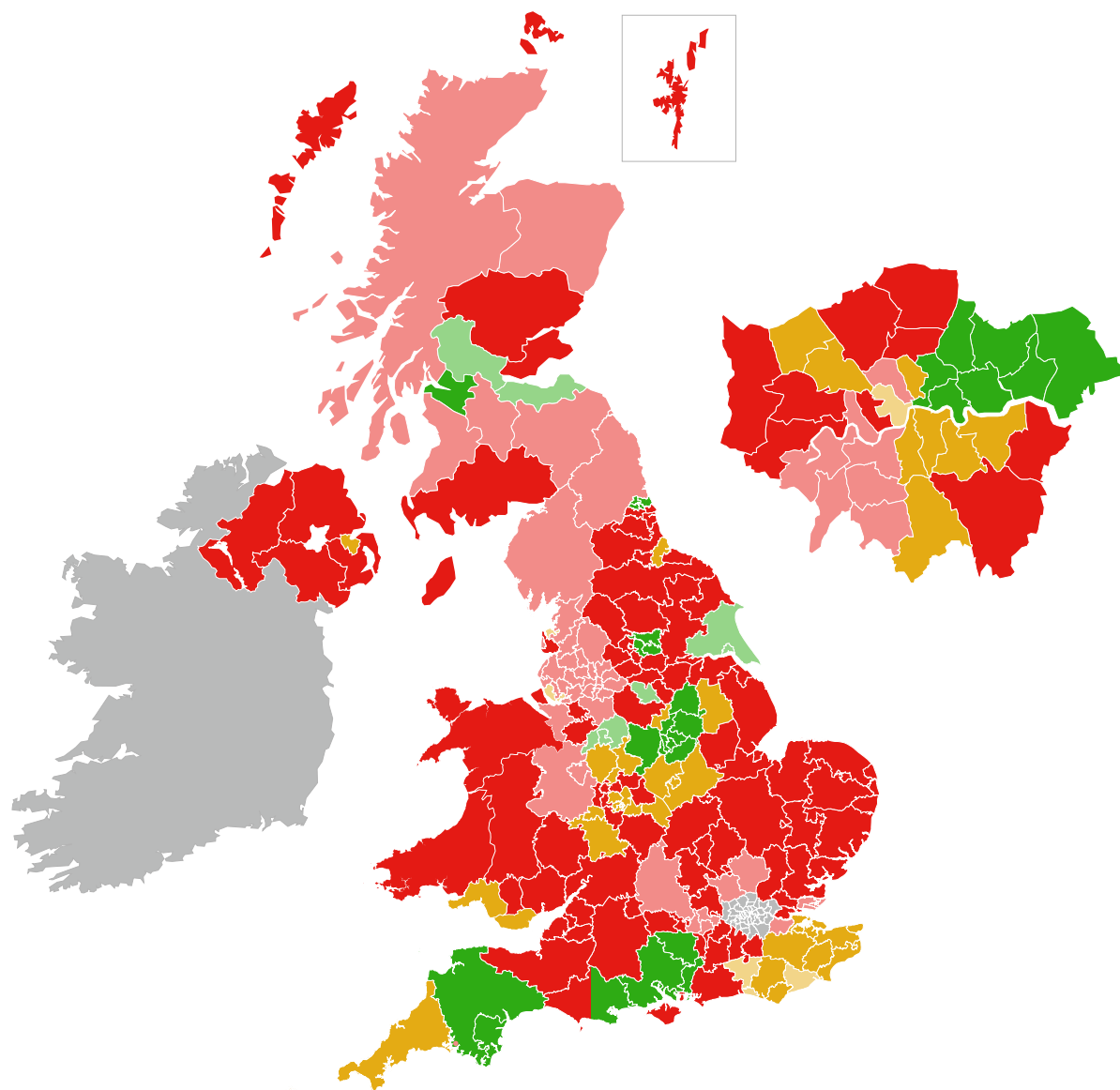
- Identifying mothers with poor mental health drawing on their knowledge of a mother's general wellbeing and psychiatric history, even if they are currently well
- Their ability to liaise with primary and specialist mental health services
- Being able to deliver primary care treatment and provide basic information on the risks and benefits of general and psychotropic medication during pregnancy and when breastfeeding
- Their ongoing contact with mothers and families providing continuity of care for mothers and infants (SIGN, 2012; NICE, 2014)







On the other hand, GP involvement in maternity care has incrementally declined over the last decade. Disengagement from maternity care began with changes in the GP contract and in 'out of hours' care arrangements and has been further affected by policy developments placing greater responsibilities on midwives and health visitors for antenatal and postnatal care and co-locating many midwives and health visitors in children's centres rather than in GP surgeries (NICE, 2008; Smith *et al.*, 2010; NHS England, 2014). Although co-location with children's centres aims to promote closer working across early years, health and preschool educational settings, unintended consequences have been greater fragmentation and potentially reduced continuity of care between GPs, midwives, and health visitors during this perinatal period (Chew-Graham *et al.*, 2008).

GP disengagement from perinatal care is important because it potentially de-skills them (risking inappropriate decision making). It may also jeopardise effective and speedy communication and coordination of care for mothers with poor mental health who are at risk of suicide (Centre for Maternal and Child Health Enquiries, 2011).

Effective detection and management of perinatal mental illness relies on the coordination of a wide variety of primary and secondary care services, including midwives, health visitors, facilitated self-help, IAPT teams, community mental health services, general practitioners, pharmacists, obstetricians and psychiatrists, with other community agencies, such as voluntary organisations, child and adolescent mental health teams and social services, providing further support (SIGN, 2012; NICE, 2014).

A care plan should be developed in partnership with women and other services. It should be coordinated with clarity about the roles of all those involved in providing support and follow-up and with a named person identified with responsibility for coordinating the care plan (NICE, 2014).



LEVEL	COLOUR	CRITERIA
5		Specialised perinatal community team that meets Perinatal Quality Network Standards Type 1 <a href="http://www.rcpsych.ac.uk/pdf/Perinatal%20Community%20Standards%201st%20edition.pdf">http://www.rcpsych.ac.uk/pdf/Perinatal%20Community%20Standards%201st%20edition.pdf</a>
4		Specialised perinatal community team that meets Joint Commissioning Panel criteria <a href="http://www.rcpsych.ac.uk/pdf/perinata_web.pdf">http://www.rcpsych.ac.uk/pdf/perinata_web.pdf</a>
3		Perinatal community service operating throughout working hours with at least a specialist perinatal psychiatrist with dedicated time AND specialist perinatal mental health nurse with dedicated time, with access to a perinatal psychiatrist throughout working hours
2		Specialist perinatal psychiatrist AND specialist perinatal nurse with dedicated time
1		Specialist perinatal psychiatrist or specialist perinatal nurse with dedicated time only
0		No provision

**Disclaimer** Levels of provision in this map have been assessed using the best information available to us from local experts but have not been independently verified. Please contact [info@everyonesbusiness.org.uk](mailto:info@everyonesbusiness.org.uk) if you suspect any inaccuracy or know of recent developments that may alter the level of provision level in any area listed here.

The Joint Commissioning Panel for Mental Health (2012) identified a range of expectations for local commissioners of particular relevance to GPs. These included:

- The development of an integrated perinatal mental health care pathway covering all levels of service provision and severity of disorder with active sign-up of all those involved in perinatal care
- That all those providing perinatal care (primary, secondary, tertiary, voluntary sector and CAMHS) should be actively signing up to and participating in a locally developed perinatal strategy
- Development of community perinatal specialist teams forming a central and coordinating part of local provision with good links to high quality mother and baby units
- Maternity services routinely informing GPs about pregnancy and requesting relevant further information relating to a mothers' mental health and wellbeing
- That GPs should receive additional training in perinatal mental health
- That GPs are specifically familiarised with the local perinatal mental health Integrated Care Pathway (ICP).
- Pharmacological responses should not be the first response during this period of time for common mental health problems. Prescribing should involve detailed risk/benefit discussion and assessment with women (and if appropriate with partners and families).
- For those with severe mental health problems, NICE provides guidance on prescribing by condition. For mothers with pre-existing illnesses, risk/benefit discussions on prescribing with women should start pre conception. For women wishing to breastfeed, GPs should discuss treatment options that enable women to do this. Further advice on prescribing for mothers with severe mental illness should be sought from specialist perinatal mental services.
- Specialist community perinatal services should be commissioned in each area providing consultation to local practitioners, coordinating local activity/networks, delivering directly to mothers with the highest needs and with robust links into local Mother and Baby Units.
- Access to treatment and talking therapies should be prompt because of the potential effect of an untreated mental health problem on the fetus or baby.
- Treatment options should be agreed collaboratively with women and summarised in a written care plan shared routinely with the women, their partner and family if appropriate as well as with other professionals.
- There is less known on effective interventions for preventing the development of depression and anxiety

NICE guidance (2014) and SIGN guidelines (2012) identify a broad range of effective and promising treatments for women affected by mild to severe mental health problems during the perinatal mental period. The following overarching messages emerge from guidance:

- For mild to severe common mental health problems: a range of 'stepped psychological therapies should be the primary response ranging from facilitated self-help to high intensity psychological interventions provided by practitioners such as specialist clinical psychologists who understand the risks and complexities of severe presentations within the perinatal context.



### 3. Identification of mental health problems

The biggest barrier to providing better support to women experiencing poor mental health in the perinatal period is low identification of need. The evidence we reviewed pointed to a number of barriers to identification and some things that facilitate it. Many of the themes in the responses of both women and GPs echo findings of previous studies in this area (Shakespeare *et al.*, 2003; Edge, 2009; Russell *et al.*, 2013). Taken together, they point to multiple drivers preventing disclosure of common perinatal mental health problems leading many women to ‘suffer in silence’.

#### Lack of contact with patients

Fewer than a quarter of GPs responding to the RCGP survey had responsibility for ongoing contact with patients on their caseload while just over two thirds of GPs said they worked as part of a GP team acknowledging that this had implications for their ability to see the same women on a regular basis. This trend in working practices may well have implications for building relationships with women and limits opportunities to develop necessary trust for disclosure (Chew-Graham *et al.*, 2008). Establishing trusting relationships with women from some BME communities was regarded as particularly important, as some women were perceived to be especially averse to health surveillance (Edge, 2009).

A few GPs also referred in qualitative comments to their increasing distance from antenatal care due to organisational changes placing some midwives and health visitors outside practice surgeries:

*I feel my role has been marginalised since joint working with health visitors has effectively stopped.* (GP, survey respondent)

#### GP knowledge, awareness and confidence

GP survey respondents were largely divided in how confident they felt about detecting whether a woman had previous or existing mental illness; just over half said that they were confident and just under half said that they were unsure or not confident that they would know. Most relied on historic GP records to support identification recognising that good team-working and reliable note taking on the part of primary and secondary care colleagues was critical for identification and effective treatment. A few GPs said that information sharing did not work as well as it could.

Although commissioning guidance stresses the importance of systematic training for GPs on perinatal mental illness (JCPMH, 2012), responses also highlighted wide differences in GP access to such training:

- Just under half said they received no specific training in this field of work;
- Of those who had received training, just under a quarter had accessed it as part of core specialist training for general practice;
- Just over a third developed knowledge through personal study.

In qualitative responses, a minority of GPs noted that ‘lived experience’ or increased training had noticeably altered their effectiveness in identifying women with such difficulties:

*It is quite recent that after a workshop I became more aware of this and since then I have diagnosed about 5-7 ladies and looked after them including referral to perinatal mental health service in our area. I try to review them myself to keep the continuity of care.* (GP survey respondent)

*Tragically it is only because of my own personal experience of severe postnatal depression 8 years ago and my struggle to find help and treatment (eventually by paying privately to see a Perinatal Psychiatrist and*

*subsequent reading of NICE guidelines, personal reading etc) has the perinatal mental health of my patients become a priority for me... I am very sensitive to this in my patients and have a high pick up rate and aim to provide excellent multidisciplinary care for patient and her baby/family. (GP survey respondent)*

Promising improvements have also been noted in health professionals' perinatal mental health knowledge, confidence, sensitivity, skills, detection rates and quality of response in research studies following the delivery of training (Elliott *et al.*, 2001; Appleby *et al.*, 2003).

Finally, many GPs said they had insufficient resources to support informed discussion on perinatal mental illness with women. For example:

- GPs were divided on whether they had sufficient information to support women who may be taking medication for their mental health during pregnancy, after giving birth and when planning pregnancies.
- Almost all GPs said that they did not use any literature to support discussions with women around mental health and wellbeing during this perinatal period (despite the fact that this is considered important for effective practice) (JCPMH, 2012). The same number also felt having better practical guides available for women would be helpful.
- A third felt that cultural or translation issues could undermine their effectiveness when dealing with women experiencing perinatal mental illness.

In terms of the priority of perinatal mental health problems in their day to day work:

- just over a quarter of GPs felt that it was a high priority
- just under half thought it was 'on the agenda'
- and a further quarter felt either that they were faced with too many competing issues or had too little capacity to prioritise this issue

## Time pressures on GPs

GPs also highlighted many pressures in their day to day practice affecting their ability to effectively support women with perinatal mental health difficulties including:

- 1 in 5 identifying competing priorities as a barrier to providing good quality care
- a third feeling that they had nowhere to refer women presenting with needs
- and half identifying restricted time during consultations as the greatest barrier to providing better support.

Time pressures affecting GPs were also mentioned by women as a barrier to disclosure, help seeking and getting the help they needed:

*I did go to my GP once and broke down uncontrollably but he said I have run out of time; you are obviously depressed and must come back which of course I never did and they never contacted me. It has never been mentioned since. (Mother, survey respondent)*

Time pressures are noted to act as a disincentive to disclosure and identification in previous studies focusing on broader primary care perinatal mental health providers (Shakespeare *et al.*, 2003; Seehusen *et al.*, 2005; Russell *et al.*, 2013).

Taken together, findings suggested variability in GP knowledge, confidence, team working, continuity of contact with mothers, linkage with other primary care practitioners and access to resources on perinatal mental health issues. Activity and knowledge were often reliant on personal interest, enthusiasm or experience rather than being based on systematic approaches or professional development.



## GPs' capacity to identify perinatal mental health problems

### » Key findings

GP survey responses revealed significant variability in:

- training in perinatal mental health
- confidence levels when dealing with women
- continuity of care for women within practices
- access to resources to support women effectively.

Time limitations were also seen significantly to undermine capacity to encourage disclosure.

### » Recommendations

- The Government and NHS England should take action to reduce pressure on general practice to allow longer consultations to be offered to women at risk of or with perinatal mental health problems.
- Health Education England (HEE) should work with the RCGP Clinical Champion to support specific perinatal mental health training provision for qualified GPs
- Local Education and Training Boards and Deaneries should develop curriculum competences relating to perinatal mental health through their GP training programme and these competencies should be assessed by workplace-based training and Membership of the Royal College of General Practitioners (MRCGP) assessments.

## Inconsistencies and discontinuities in the system

Both women and GPs raised inconsistencies and discontinuities as a barrier to identification and to securing appropriate help. The women surveyed by Tommy's in 2013 pointed to a 'hit and miss', inconsistent and non-proactive system which stacked the odds against disclosure, seeking help and effective identification and treatment.

Overall, comments suggested an unpredictable, geographically variable and unreliable system of perinatal mental health care populated by a broad range of primary care professionals all of whom had variable levels of awareness, interest, linkage with each other, knowledge and skills. These inconsistencies are well documented in other sources (Hogg, 2013; Edge, 2009; Rowan *et al.*, 2010; MMHA, 2014).

Some women and GPs described benefitting from close team work approaches supporting mothers' mental health:

*The health visitor and GP [...] were brilliant I just wish I had spoken to them earlier instead of pretending I was ok. (Mother, survey respondent)*

*My GP and HV were much more approachable and caring. I felt I could talk to them and I did so for the first time about my concerns [...] when my baby was 6 weeks, they kept an eye on me and offered support if I needed it. When after 4 months things got worse they were there for me straight away. (Mother, survey respondent).*

*[We have a] brilliant midwife who runs antenatal clinics in the surgery. This [facilitates]...good communication between midwife and GP, excellent team work and good continuity of care. All mothers-to-be with perinatal mental health issues are identified during [the] booking appointment with [the] midwife – [then the] form [is] faxed to [the] local secondary care team to add to records. (GP, survey respondent)*

Indeed, women tended to talk most positively about perinatal mental health care and recovery when they had benefited from what felt like a well-functioning, compassionate and integrated network of primary (and sometimes secondary) care:

*[I] received immediate help from both my GP and health visitor who comes over every couple of weeks to talk things through. The service I have received is fantastic and I owe them a great deal.* (Mother, survey respondent)

However, others revealed negative or unreliable experiences of care suggesting a generally chaotic, capricious and ‘hit and miss’ system:

*I became more and more depressed and I denied it for months until I finally realised I needed to get help and went to my GP on the advice of the sure start midwife. The doctor was great but referred me to the mental health practitioners who were not at all friendly. But I have recently been through a phase where I have been very depressed again but feel too ashamed to seek help and dread being referred to the same unhelpful person.* (Mother, survey respondent)

*Midwives don't really have the time to discuss your feelings and when you do they just tell you to see the GP. The health visitor and GP were far more helpful.* (Mother, survey respondent)

One mother described a lack of real accountability for or meaningful engagement with her care and needs summing up her experience of her health visitor as being similar to being bounced off ‘a human trampoline’:

*99.9% of [her] activity was to give me a leaflet or suggest I contact someone else - the GP/Midwife/Hospital. She acted like a human trampoline...any query/question was ‘bounced’ to someone else.* (Mother, survey respondent)

Furthermore, the quality and consistency of responses not only varied from profession to profession, they often varied within the same professional group:

*No one showed any interest until I hit breaking point. My health visitor brushed me off and didn't listen. My GP was useless but finally saw a different one, who did listen, but it took 10 weeks.* (Mother, survey respondent)

*I struggled through her first year suffering from depression and anxiety that was undiagnosed despite visits to health visitor and GP to discuss my feelings. I was told as I was breast feeding there was nothing that could be done until I stopped. I managed until her first birthday and then reached rock bottom and went to a different GP who was amazing and really offered me and my partner the support and help that we needed.* (Mother, survey respondent)

Both mothers and GPs also made references to postcode inconsistencies in responses and in the range of care available.

*My first Health visitor was one in a million, I cannot sing her praises highly enough; she listened to me but was also straight with me. However, I moved across the country after the breakdown of my marriage and my new health visitor treated me like scum. The relationship broke down completely and I stopped attending clinic (never followed up).* (Mother, survey respondent)

*We are lucky to have fairly easily accessible clinics locally, but I know from personal experience that these are definitely not available nationwide. In [the] distant past [we had one] attached to our practice - which was when we did have a working postnatal depression protocol.* (GP, survey respondent)

And many mothers talked of a lack of continuity, follow-up, overarching review and accountability for women’s ongoing care (making sure that referrals are successful, ongoing review if concerns have been raised or identified etc).

Finally, only 1 in 10 GPs thought they had good quality perinatal services in their local area and two thirds had ‘some’ but felt that they were ‘not good enough’. These postcode variations have been well documented in previous publications highlighting shortcomings in current systems of perinatal care (Bauer *et al.*, 2014; MMHA, 2014).

## Inconsistencies and discontinuities

### » Key findings

Women described inconsistencies:

- in the way they were dealt with by different GPs in the same practice.
- in knowledge and responses from different primary and secondary care practitioners
- in services from geographical area to area

Some women also described discontinuities in treatment – with occasionally poor tracking of their progress and follow-up after problems were identified.

Lack of consistency and poor responses hampered disclosure and help seeking and women were most positive about their care when surrounded by a team of consistent and supportive practitioners.

### » Implications

CCGs should ensure that inconsistencies are minimised through:

- Facilitating and resourcing a strongly led Integrated Care Pathway (ICP) in every locality with a well-supported and trained network of local practitioners. To be well attended practitioners need to have time ring-fenced within busy schedules to attend.
- Commissioning specialist community perinatal mental health services who can coordinate local activity and provide coaching/training/resources to support greater consistency in local areas.
- Commissioning should routinely be informed by the experiences of local mothers

### » Recommendation

NHS England and Clinical Commissioning Groups should urgently address postcode inconsistencies in the availability of community specialist perinatal mental health teams/ consultants and good quality ICPs to support women facing or with perinatal mental illness.

## The six-week maternal postnatal check

Nearly all GPs said they routinely asked mothers about their mental health during the 6-week post natal check and just over half felt that this was, in their experience, the best opportunity to bring up the issue. Accompanying qualitative comments suggested that for some GPs every contact (sometimes from preconception if planning with a woman with a previous history of poor mental health) was considered an important opportunity to raise mental health and emotional wellbeing as an issue. However, recent changes in the organisation of perinatal care (particularly reduced GP co-location with midwives and health visitors in some areas)

and more unreliable communication and information sharing was seen sometimes to limit GP involvement in earlier identification and support:

*[It is important to identify women] at any opportunity - the midwife sees patients during their pregnancy, so we may not see the patient until after she has delivered, unless there are problems with her mental health. (GP, survey respondent)*

*[I now have] much less opportunity [to identify women]. [I] used to do joint clinics with [the] health visitor [but these have] now stopped so communication with other*

*healthcare professionals [is] poor. I feel I am seeing fewer patients with post-natal depression which cannot be correct.* (GP, survey respondent)

Given that most GPs saw the 6-week check as a key point of contact with new mothers, this appointment could be seen as an important chance actively to review both a mothers' wellbeing and the effectiveness of care so far received. Indeed, a recent online survey confirmed that almost half of women felt that the 6-week check was rushed and not sufficiently thorough or consistent in its focus with just under a quarter saying that they put on a brave face and nearly a third of women saying that they wanted to talk about emotional issues as an intrinsic part of this post natal check (NCT & Netmums, 2014).

## Women's knowledge about mental health and mental illness

Like GPs, women felt they lacked adequate information during pregnancy and new motherhood about perinatal mental health problems and particularly on:

- the risk factors predisposing women to poor mental health
- the importance of seeking early help
- who might most effectively help them
- what works (lack of faith in the effectiveness of treatment dissuaded many women from seeking help despite their distress)
- what successful recovery feels and looks like

Many women described being unprepared when their mental health began to deteriorate and described feeling frightened, overwhelmed, and confused about their worsening wellbeing during what was already a period of significant transition and adaptation to new motherhood.

*I'd not realised you could get antenatal depression.* (Mother, survey respondent)

They found it difficult to differentiate between 'normal' feelings, behaviours and tiredness and those symptoms meriting treatment and support.

## The six-week check

### » Key finding

The 6-8 week check currently represents a very important safety net and potential opportunity to pick up poor perinatal mental health for mothers who have been missed before this check.

### » Implication

The RCGP clinical lead should lead work to explore existing evidence for what might most effectively be focused on to support mother, baby and the family during this check.

*I thought it was normal so I didn't say anything.* (Mother, survey respondent)

Many were reluctant to waste practitioners' time or 'make a fuss':

Mothers' narratives suggested that GPs faced similar challenges differentiating between normal adjustment to parenthood and reactions more indicative of poor mental health.

Previous analysis of quantitative data from the Tommy's survey (Russell *et al.*, 2013) highlighted worrying discrepancies between health professionals' and women's perceptions of the frequency with which perinatal mental health problems were raised routinely by healthcare contacts. It may be that women and professionals use a different language to talk about mental health, that discussions are too subtle or that women are too distressed to log these interactions.

This inconsistency requires further investigation but suggests that health professionals cannot assume that previous discussions have either been heard or fruitful and that there is a need to exploit every primary and community care opportunity to make space each time for explicit compassionate interest in women's (and their new families') wellbeing. New NICE guidance suggests using explicit questions about mental health to facilitate this (2014).

## Stigma and lack of acceptance

Some women knew very quickly that they were unwell (Russell *et al.*, 2013) but acknowledged ‘just [not] wanting to talk about it’ or accept their illness. Some women described primary care practitioners sharing this lack of acceptance of their deteriorating wellbeing:

*It felt like they wanted a reason for the way I was feeling and didn't really accept that I was just losing grip on my mental health. Feeling low is not enough.* (Mother, survey respondent)

Many more women talked of a great sense of shame, embarrassment and failure at being perceived as ‘not coping’.

One woman also talked of facing an attitude of ‘pull yourself together’ from her family which prompted her to hide her distress. This shame often led women actively to avoid confiding in professionals, families and friends.

*I did not want to accept that I was not well, and didn't want my partner to feel I was weak.* (Mother, survey respondent)

*[I] did not want them to know there was something wrong, and also felt guilty about how I felt.* (Mother, survey respondent)

40% of GPs survey respondents also said women’s reluctance to talk about their wellbeing was a major barrier to identification.

Although needing to ‘be strong and get on with it’ was a driver for non-disclosure among women generally responding to the Tommy’s survey, is also known to be a particular barrier to disclosure among African Caribbean women experiencing perinatal mental health difficulties (Edge, 2009).

Women’s comments also suggested that clumsy use of language or unintended stigmatising responses from GPs or other health professionals often increased resistance to disclose and seeking help if women felt ashamed or had high needs to be seen as ‘coping’.

## Women’s fears of separation from their baby

A particular barrier to disclosure among mothers was fear of separation from their infant if they were seen not to be coping. Some mothers described being disproportionately frightened of this prospect despite the fact that this is an extremely rare event:

*[I] was terrified my baby would be taken away from me.* (Mother, survey respondent)

*I didn't want anyone to know how I was feeling as I thought they might think I was one of those ladies who might hurt their baby, which never crossed my mind I just felt... hopeless.* (Mother, survey respondent)

*I just want to run away and leave the baby with his dad. I haven't told my GP this; I'm scared they will call social services take my baby or put me in hospital. I don't want to be separated from my children but when I'm down I'm really down and I hate it. I hate it so much that I scratch myself with scissors, not to kill myself just repeated surface scratches to help relieve the pain I feel inside. I get headaches and I just don't feel like I'm worth being around anyone.* (Mother, survey respondent)

## Masking distress

Another striking theme was the energy invested by many women in masking their distress, ‘paint[ing] this face on for the outside world’ and hiding their true feelings:

*I found it easy to ‘cover up’ the fact that I was suffering from depression by acting when I was out and also I lied on my ‘Maternal Mood Score’ questionnaire.* (Mother, survey respondent)

Indeed, previous analysis of Tommy’s survey data identified around half of women admitting to being somewhat untruthful when asked about their mental health and wellbeing with just under a third making active efforts to hide their illness. In fact, fewer than 1 in 5 were honest about their feelings (Russell *et al.*, 2013).



## Faith in effective treatments

A few women who recognised their declining mental health said that they had not approached GPs or primary care practitioners for help as they did not have faith that there were effective or acceptable treatments that could make a difference to their situation.

Some said it would have been helpful to talk through more options and to have real life examples of how a range of different mothers had managed and moved on from their challenges during this and subsequent periods of poor mental health.

## Online help, disclosure and support

Responses analysed as part of this study were drawn from a group of women who had already sought online resources on the Netmums website. A small number of women said that online chat rooms, stories and responses had made them feel worse. However, the majority of mothers were very positive about the process of anonymous disclosure and support received through this virtual community which appeared to make them feel less isolated in their experiences, less stigmatised and encouraged disclosure of difficulties for some.

*Posting on the internet was the only way I could really articulate how I was feeling because when I tried to talk face to face with anybody I always broke down in tears. The replies were incredibly kind and helpful. Knowing that I wasn't alone or "wrong" to feel like I did was my first step towards recovery. (Mother, survey respondent).*

The potentially positive and supportive role played by social media in providing information, in helping mothers make sense of what they were experiencing and in offering a vision (from mothers who had recovered) of hopefulness and how things might get better was repeated by women during qualitative interviews during interviews.

## Women's barriers to disclosure – knowledge, stigma and lack of hope

### » Key finding

Women gave a range of explanations for their lack of disclosure of perinatal mental health problems – mainly linked to lack of awareness, stigma and fear and pessimism about the likelihood of recovery.

### » Implications

- Women need reassurance that it is extremely unlikely that their child will be removed in the event of deteriorating poor mental health
- Women should be encouraged to develop a 'wellbeing plan' as a routine part of antenatal support (a tool developed by Netmums and Tommy's has recently been endorsed as a resource for inclusion in NICE guidance - see [www.tommys.org/file/Wellbeingplan.pdf](http://www.tommys.org/file/Wellbeingplan.pdf)). This wellbeing tool should be regularly reviewed with women during the perinatal period.
- Women with perinatal mental health problems (and those routinely in contact with them) need access to credible recovery stories illustrating how good quality assistance can make a difference to their recovery and to their relationships with their infant and families.

### » Recommendation

The Government should commission targeted work to reduce stigma among women with perinatal mental health difficulties.

## The contribution of partners

Both the literature and women's comments highlight the important part played by partners during this perinatal period (Ericksen *et al.*, 2005; Hogg, 2013). Many partners described in this survey were instrumental in picking up early signs of escalating poor mental health sometimes advocating persistently to get women the help they needed:

*I was encouraged by my partner to tell my health visitor how I felt, which made me cry explaining it all to her, but she was so lovely and understanding, she suggested I talk to my GP, which I did. (Mother, survey respondent)*

*My partner made me realise I had to get better for the sake of our family. (Mother, survey respondent)*

*Eventually my husband was so concerned for my health he was phoning my GP every day and got her to get the health visitor to come and see me. (Mother, survey respondent)*

Partners and families could also be an important part of the network of support helping mothers recover:

*I stopped taking these tablets and used the support of my family and partner more when talking about things which were getting me down. (Mother, survey respondent)*

*When I do feel low, I will talk to my partner and he always helps me thro[ugh] it. (Mother, survey respondent)*

In a small number of instances, partners were described as contributing to women's poor mental health due to lack of support or in a very small minority of instances through abusive relationships:

*My husband realised that part of the problem was that I felt he wasn't supporting me and he started to support me a lot better. (Mother, survey respondent)*

*I felt I had no support from my partner and he was contributing to my low mood and anxiety. We have now split up 3 months after my second daughter was born. I was only able to get the strength and confidence to break with him from the support I received from health visitor, counsellor and GP. (Mother, survey respondent)*

Some women's comments suggested that partners had been ill-prepared for women's escalating mental health problems, were confused and affected themselves and had to go through their own process of trying to work out what was going on. One interviewee felt frustrated that health practitioners had not shared fears about her greater predisposition to poor mental health after a traumatic birth with her or her partner. She felt that her partner had a sense that things were not right but was ill equipped to take appropriate and swift action when her mental health deteriorated.

In a minority of instances, as highlighted in other studies (Goodman, 2004; Hogg, 2013), partners were noted to develop their own mental health problems during this transitional period to new parenthood:

*My partner tried to support me [the] best he [could]... but it was dragging him down too. (Mother, survey respondent)*

Discussions with GPs revealed concerns that some women needed a safe and confidential space away from family members to discuss and consider other issues contributing to their poor mental health and wellbeing. Understandably (given patient confidentiality concerns), the majority of GPs said they only engaged with partners if a woman was happy to have her partner attend. However, survey responses also indicated that a very small number of GPs systematically and explicitly encouraged women to choose whether they brought along their partner relying instead on women's own assertiveness in arranging a partner's attendance.



## Partners

### » Key findings

- Partners are key informants and sometimes important sources of support when a woman's health begins to deteriorate at this time. They are also at risk themselves.
- There is some indication from GP responses that partners could be more routinely and explicitly involved during consultations and contact during perinatal months.
- But explicit invitation would need to be balanced against the need in a minority of instances to provide women with a safe space should their mental health be affected by an abusive or controlling relationship.

### » Implications

Better quality information should be available for partners (and possibly where appropriate wider family members) to help promote women's mental health, facilitate early disclosure and mobilise support when maternal wellbeing deteriorates. There is also a need to monitor and intervene early if a partner's mental health worsens during this critical period of transition.

GPs should implement NICE guidance (2014) encouraging health practitioners to:

- involve the woman and, if she agrees, her partner, family or carer, in all decisions about her care and the care of her baby.
- take into account and, if appropriate, assess and address the needs of partners, families and carers that might affect a woman with a mental health problem in pregnancy and the postnatal period. These include the welfare of the baby and other dependent children, as well as partners, the wider family or carers.

## A reactive system

Overall, women described a predominantly rushed, reactive and unreliable system of identification and support which often led them to fall through the gaps in this system of care. Some women remained under the radar throughout this perinatal period and sometimes even during subsequent pregnancies when problems reoccurred:

*There was never any talk about anxiety AT ALL with midwives, doctors or health visitors. I went years not knowing what was truly wrong with me. (Mother, survey respondent)*

Other women were only picked up through their own or their partner's persistence or through chance encounters with an informed or compassionate professional:

*I saw four different health visitors. Eventually once I'd sought help from my GP, she immediately rang the lead health visitor for our area and demanded that she see me urgently. I then saw her consistently which helped no end. (Mother, survey respondent)*

For many this lack of proactivity in the system was frustrating since, when ill, they often lacked sufficient emotional resources and energy to actively seek out help or persist in the face of dismissal and knock backs:

*GPs and health visitors need to listen really carefully to new mums and act on what they hear because for me certainly at that stage I was too exhausted to take any positive action - I would have been too exhausted to ring a counselling service even if I had realised how much I needed that kind of support. (Mother, survey respondent)*

Both GPs and women described a number of different aspects of the lack of proactivity in the system:

- A preoccupation with physical rather than mental health and with the baby rather than with the mother
- A tendency to overlook mothers' actively raising concerns about their wellbeing when parents were perceived as being 'lower risk'. These parents sometimes described concerns being dismissed.

- An absence of primary care interest in and review of women's continuing progress after the initial weeks of birth. A number of women mentioned becoming aware of problems after postnatal checks had ceased and when there was no further routine follow up:

*My depression did not really set in until after the regular health visitor checks. There is little or no opportunity to raise it at baby weigh-in sessions.* (Mother, survey respondent)

Perhaps most worrying is the lack of monitoring of maternal perinatal mental health and infant wellbeing reported by mothers after postnatal contact ceases. After the 6-8 week check, the Healthy Child Programme offers vaccination appointments for infants between months 2 and 4 months via Practice Nurses. In 2012, plans were explored for a 3-4 month mother and infant check focusing on both mother and infant's physical and mental wellbeing. However, this check is not mentioned in the current Health Visitor national specification (NHS England, 2014) and data collection focuses on the 12 month check suggesting a risk that, other than immunisation visits, no tracking could take place between 8 weeks and a year. Prevalence studies indicate that perinatal mental health difficulties continue to emerge and affect mothers throughout the first year of a baby's life potentially undermining the mother infant relationship (Gavin *et al.*, 2005). Furthermore, for all the reasons explored in this study so far, some women only realised the need for action after the 8 week point.

## A reactive system

### » Key findings

- Practice nurses should be supported in compassionate enquiry relating to maternal wellbeing at vaccination visits.
- Research evidence suggests that women continue to develop mental health difficulties throughout the first year of their child's life; furthermore, some women responding to this survey said that they only became aware of deteriorating mental health or felt able to disclose difficulties after routine contact with health professionals had ceased (usually around 2 months after giving birth). Mental health problems continued to affect mothers (and potentially some infants) throughout the first year of birth requiring ongoing vigilance and effective intervention.

### » Recommendation

The Department of Health should ensure that there are more systematic opportunities to focus on the mental health and wellbeing of mother and infant before a child's first birthday. This may include improved focus on mother and infant wellbeing by health visitors and practice nurses during the second half of the first year following birth.

## 4. Disclosure of difficulties

Once a woman has asked for help and need has been identified, the way GPs and other professionals respond is then crucial to ensure women get appropriate treatment and support.

### How women seek help from their GPs

Despite many barriers to disclosing and seeking help, women's qualitative comments suggested that GPs remained an important port of call for women who may have a treatable common mental health problem. For example:

- Just under half of women reported that their GP had been responsible for confirming their mental illness (higher than for any other health professional).
- Many women described routine referral by health visitors and midwives to GPs for confirmation of their illness (a referral system which it must be noted often felt frustrating, prolonging their distress and sometimes raising anxiety as they faced the prospect of yet another difficult conversation).

*I saw several health visitors and had to chase one to come and see me. The only helpful thing they did was to get me an early appointment with the GP. Someone who felt unable to push for help like I did may not have got any help. (Mother, survey respondent)*

- Many women also described approaching GPs themselves. Sometimes this was with somatic complaints or concerns about their baby or sometimes when they were at 'breaking point' and had finally built up the courage to do something about their situation. Often mothers talked of approaching GPs if they were no longer in the first few months following child birth and when routine contact with midwives and health visitors had ceased.

- Finally, many women talked of approaching GPs early and decisively if they had previously been diagnosed with and treated for perinatal mental health problems - either to plan management of a further pregnancy or if they became aware of reoccurring symptoms:

*My first pregnancy, I saw in excess of 10 different midwives. None of whom seemed interested in my mental health; I passed all of the paper tests. It took me a long time to realise I was actually depressed. With my second baby I knew the signs straight away so took myself to the GP and they've been great ever since. (Mother, survey respondent)*

### How GPs screen for distress

The GP survey suggested that three quarters of GPs relied on clinical discussion with women as their main method of identification of perinatal mental health difficulties. Just under a third used the Edinburgh Postnatal Depression Scale (EPDS) tool as part of that clinical assessment and around a quarter used the EPDS on its own. There were mixed views from mothers and from GPs about the effectiveness of 'tick box' approaches used in isolation. Some women balked at a tick box approach, preferring a compassionate, concerned but proactive conversation.

*Only my health visitor asked me about my feelings, specifically postnatal depression and it was clearly a 'tick-box' exercise, I wouldn't have felt comfortable discussing my feelings with her - everything she said sounded like it came straight out of a text book. (Mother, survey respondent)*

But for a few women, it was clear that using screening tools had been an effective and positive method of identifying difficulties faced:

*I realised I was first ill the day I had my second baby and spoke to the midwife/nurse on shift on the maternity ward but she dismissed my feelings, however my community midwife noticed I wasn't right and on the 28th day she asked me to complete the Edinburgh scale test which I scored high in and she referred me to my GP. (Mother, survey respondent)*

However, there was general discomfort at filling out screening forms when there was 'no privacy' and therefore discussing results in antenatal groups.

*The health visitor I see is in a group so you are surrounded by other parents cooing over their children. There was no privacy and I felt so guilty about being so miserable. If there was more of a private setting with my health visitor perhaps I would have spoken out. (Mother, survey respondent)*

When GPs were asked about language used with new mothers to encourage disclosure or discussion, most GPs began with open questions asking about:

- a mother's general adjustment to motherhood – whether they were enjoying their time with their baby
- how they were sleeping and to what extent it was getting them down
- whether they felt supported

Some GPs also stressed the importance of asking non-judgemental but direct questions about a mother's mental health and wellbeing. For example:

- how were they feeling?
- how was their mood?
- whether they were feeling their normal self and generally looking forward to things or had any worries or anxieties.

Once again, some GPs talked of routinely asking questions about how mothers were 'coping'; as noted earlier, an over emphasis on 'coping' can be counterproductive to disclosure for some women.

Most GPs said they used everyday language and avoided jargon and also stressed the importance of the way that such interactions were managed, talking about the need for gentle questioning, empathy, a non-judgemental approach and being reassuring. Some GPs also talked about the importance of picking up on nonverbal cues and sometimes even on babies' responses.

A small number of women described how during 'knife edge' moments of vulnerability, proactive and compassionate questions could promote disclosure.

## Screening

Both GPs and women had mixed reactions to the use of screening tools as the primary means of identifying perinatal mental health difficulties. Most GPs preferred clinical discussions to open up a dialogue. However, broader findings from this analysis pointed to:

- some GPs feeling unconfident about this area of practice
- a reticence on the part of some GPs to open up dialogue about and respond to distress
- unhelpful inconsistencies in language which hampered disclosure.

## Women's experiences of disclosing to their GPs

For some women, GPs were perceived as caring and 'valuable'. They often acted as a critical safety net in this unreliable system of perinatal care:

*My midwife was cold towards me. My GP was the best and got me back on the right path.*  
(Mother, survey respondent)

*I was lucky in that I had a reasonable relationship with my GP otherwise it would have been very easy for me and the baby to drop through the gaps in the system.*  
(Mother, survey respondent)

When their circumstances worsened and they reached 'breaking point', many women turned to GPs or described the emotional 'floodgates' being opened by a kind word enquiring about their wellbeing.

*[I] was finally diagnosed with depression when he was 8 months old. All the questions at my 6 week check I put a brave face on, said I was coping, when actually, that was far from the truth. It was only when I thought I was going insane that I went to the doctors and it all came pouring out. I was put on fluoxetine.*  
(Mother, survey respondent)

And a striking message from women's experiences and recovery stories was that if a woman contemplated raising fears with her GP or health professional about her wellbeing, it often took significant courage and frequently by this time things were approaching crisis point:

*I did tell them I had no confidence, [that I was] very unsure [...]. They reassured me it was normal [...] but I did not feel normal. [...] I did not know how ill I was until I broke down at [the] doctors; after I could not stop crying for days.* (Mother, survey respondent)

*I soon fell into a deep depression and got so low that I considered suicide while pregnant with my unborn child. It was purely the fact that I couldn't leave my daughter that made me phone the doctor and admit I was very ill.*  
(Mother, survey respondent)

This study suggests that voluntary disclosure by women should always be seen as a 'red flag' moment requiring further active and compassionate investigation. Yet, many GPs seemed to miss these key opportunities even when women proactively volunteered concerns about their mental health:

*At the six week check the GP asked if I felt low and I told her I felt dreadful and she just said "every mum feels that – it's normal". I really believe that support in those early months might have changed my life, and my child's life for the better. I asked for help and felt unheard.* (Mother, survey respondent)

*I have spoken to my doctor about being depressed and not feeling up to doing every-day things but he just prescribed me some iron tablets! Ever since that happened I'm struggling to find the confidence to reach out for help again... I thought it would get better but it hasn't, it seems to be lingering on and getting worse.* (Mother, survey respondent)

*My GP at the time was a very unsympathetic man who does not believe in mental ill-health problems and was VERY dismissive [...]. I was in the GP's office countless times over the next 4 years and was often in tears with anxiety about my son and not ONCE did he ever ask me if I was alright, He simply said it was in my head and I needed to deal with it.*  
(Mother, survey respondent)

And one GP, who herself suffered from poor perinatal mental health, offered an interesting perspective of her own consultation with her GP during which she felt too quickly reassured:

*My personal experience of seeing my own GP with mental distress in postnatal period, was of being interrupted and reassured, before having had a chance to reveal the extent of my distress and thoughts of self-harm. I was fine in the long run but most likely would have benefitted from some help in the short term.* (Mother, survey respondent)



Taking GPs' and women's comments together, it was clear that a fine balance was required between reassuring women about their feelings whilst at the same time avoiding dismissal of their experiences. As noted in other studies being told that 'everyone feels like that' only seemed to exacerbate mothers' feelings of distress and failure (Shakespeare *et al.*, 2003).

Conversely, for a few women, alarmist reactions from GP's to their mental health problems were also experienced as unhelpful, counterproductive and punitive:

*I started to self-harm and when I finally went to see my GP, she threatened to section me if I didn't promise to stop cutting myself - she went to pick up the phone whilst I was in her consulting room. It was a very frightening time and it made me even more wary of finding help. (Mother, survey respondent)*

In summary, although women said they wanted reassurance, the reassurance often revolved around feeling listened to, being treated compassionately and being reassured that treatment was available and that what they were experiencing could be manageable or 'fixable'.

## Womens' experiences of disclosing distress to GPs

### » Key findings

- If a woman voluntarily discloses concerns about her wellbeing to GPs, this should be seen as a 'red flag' moment and should always prompt further investigation.
- Women's comments suggested that by this time they were likely to be approaching crisis point. GPs' responses at the point of disclosure are critical.

### » Implications

- GPs should avoid dismissive responses or overly minimising what women were experiencing but equally should avoid being alarmist.
- GPs should take what women say seriously, reassure them that there is effective help that has a good record of helping their recovery, provide examples of how women have moved forward and work with the mother to risk benefit assess and plan the best way forward using a range of local resources considered helpful by women to their recovery.

## 5. Interventions

The third major hurdle to improving mental health for women during the perinatal period is the availability of effective treatment and support. The surveys shed light on what treatment is offered and how it is experienced by women and their GPs.

GPs responding to the RCGP survey favoured a range of solutions to improve the quality of care for mothers affected by perinatal mental health difficulties:

- Two thirds wanted better quality information to support conversations with mothers presenting with perinatal mental health problems about the broad range of options available. Mothers also echoed this desire for more information.
- Just under half wanted more reliable referral pathways or access to a colleague with specialist training for advice.
- Over half wanted better or more accessible training materials or opportunities.

### Women's experiences of GP treatment offers

Many women described their experiences of accessing GPs for treatment – sometimes after a number of failed attempts to secure help from other primary care sources. The range of options they were offered tended to be narrow.

The majority of women described GP responses being strongly reliant on prescribing – a trend also documented in another study noting that 70% of mothers said they were given antidepressants compared with around 40% being offered Cognitive Behavioural Therapy (4Children, 2011).

Like women interviewed during the 4Children surveys and the development of NICE guidelines, the women in Tommy's 2013 survey held mixed views on the helpfulness of prescribing as a response. For some, medication helped them 'ride' what felt like a transient but high risk period of turbulent mental health:

*After 6 weeks of [feeling like] this I realised I needed help for myself for my son. I wanted to be happy again because I knew that with a bit of help I could be. My doctor diagnosed post-natal depression and prescribed me antidepressants. After a couple of weeks it felt like a shadow had been lifted. I really started to enjoy motherhood. (Mother, survey respondent)*

*I experienced dreadful insomnia and was getting 1-2 hours of sleep a night. I felt totally awful. I owe my sanity to an understanding GP and antidepressants and sleeping tablets. The anti-panics have been amazing - but essential, if I forget a pill, I quickly become anxious. Very pleased with help but had no idea I was ill. (Mother, survey respondent)*

*Taking the anti-depressants just allows me to feel more balanced and not stress when the kids are crying or I'm feeling pressured to get jobs done at home. Not being given a timeframe to come off the tablets by the doctor has helped. I feel so much more in control being on them. (Mother, survey respondent)*

For many, however, options presented by GPs were too narrow, were not explored in partnership and GPs were seen as too hasty to prescribe:

*The pills made me feel dead instead of very angry so I stopped taking them and never went back to the Doctor as I didn't want to be just stuck on pills again. No counselling therapy was ever mentioned or offered. (Mother, survey respondent)*

Many women talked of the importance of broader holistic, practical and psycho social support:

*I have never had any support other than from my GP. Even when she diagnosed me with severe post natal depression I was given no additional support (other than medication) and not visited or contacted by any other person. (Mother, survey respondent)*



Many GPs responding to the RCGP survey acknowledged a lack of trust in local referral pathways. One GP interviewee (who had experienced perinatal mental health problems herself) observed that when faced with unreliable care pathways and lengthy waits to access other treatment, prescribing at least provided GPs with reassurance that women would not be left without support for immediate distress. On the other hand, women's comments clearly outlined how in many instances broader alternatives to prescribing had not been explored:

*My first GP just put me on anti-depressants which I hated. It's only now 6 years after my son was born that I've finally got myself referred to a psychiatrist and am finally getting some help. (Mother, survey respondent)*

And for some, time pressures were considered to influence GP prescribing practices:

*GPs think tablets get you out of their surgery quickly, they don't look for long term solutions it's too much effort. (Mother, survey respondent)*

As noted in other studies (Chew-Graham *et al.*, 2008; Hogg, 2013), an over reliance on prescribing and a lack of faith in treatment was seen to dissuade some mothers from approaching GPs for help:

*[I] don't want drugs, so [it's] pointless going to a GP, plus [I] don't want to talk to someone I don't know who probably can't help. (Mother, survey respondent)*

A few women stated that they had been 'refused' medication by GPs due to their pregnancy and breast feeding. In these circumstances, there was no mention of any risk/benefit conversation taking place. Neither were women generally offered any other form of support in the absence of this treatment.

## Improving Access to Psychological Therapies (IAPT)

After prescribing, the second most commonly mentioned treatment raised by women in this 2013 survey was referral for 'counselling' or for psychological therapies. Descriptions were often unclear concerning the exact type of counselling/therapy being accessed although some women mentioned cognitive behavioural approaches or condition-specific interventions such as Cognitive Analytical Treatment. Some women found interventions easy to access:

*The love of my life left when I was 12 weeks pregnant, without the baby inside me I would have given up. I ate for my baby that was all. I came home from work and couldn't stop crying, called my doctor and they told me to come straight in. Within 24 hours I was seeing a health visitor and had counselling booked. (Mother, survey respondent)*

*I now have a diagnosis (since my first child was born) of complex PTSD and anxiety disorder, and have had help from my GP to find more specialist psychotherapy. (Mother, survey respondent)*

Others experienced lengthy and frustrating waiting periods for therapy which once again echo findings from previous research (4Children, 2011). What they describe runs counter to NICE guidance highlighting the importance of prompt responses both to meet the needs of women with perinatal mental health difficulties and minimise the impact on infant wellbeing and development:

*My doctor has referred me for counselling but I'm on a waiting list. (Mother, survey respondent)*

*I didn't sleep for 11 days prior to labour. Doctors at hospital would not help, GPs tried to give me Temazepam. I suffered hallucinations and panic attacks and now post pregnancy I am terrified of it happening again and after 7 months I'm still waiting for cognitive behavioural therapy. (Mother, survey respondent)*

*I knew on the day of the birth, after a traumatic birth, that post-natal depression was possibly going to be a problem (I had history of depression but had been well for many years). But despite being clear about being ill, there was a long waiting list for talking therapy and insistence on drugs instead. (Mother, survey respondent)*

Some women decided to pay for private help as a result of these delays:

*My GP was very understanding and I went to a therapist every week (private: the NHS waiting list [...] meant I would have had to wait till months after the birth!). (Mother, survey respondent)*

Some women also described having to be persistent to access therapeutic help

*[By a mother whose first GP had prescribed medication] I went back to a different GP, got a referral to a psychiatrist and have been referred for talking therapies. I feel much more balanced now as I feel like I'm being taken seriously not just hushed up with medication. My son's behaviour is improving now I have more control and I feel that hopefully someday soon I will come out of this a better person. (Mother, survey respondent)*

Many women found therapy helpful if accessed promptly:

*They referred me for cognitive behavioural therapy and it transformed my life. Gave me confidence back and my life back. (Mother, survey respondent)*

*I had counselling which was great and she suggested that I didn't realise I loved my babies. She suggested that I was just overwhelmed and exhausted and I needed to make time for myself. It started with just a basic, "go to the shop, buy a magazine, make a brew and read the magazine in peace. (Mother, survey respondent)*

But there were also a few who found talking therapies unhelpful:

*All the post-natal depression [counsellor] had to say was I think you [have]...depression and need a good hug. Why don't you see if you can get some help! (Mother, survey respondent)*

For a small minority, accessing therapy with an infant was described as logistically challenging without the availability of crèche facilities:

*My husband's company gave him time off every Monday morning so that I could leave my daughter with him to attend counselling sessions. I was given coping strategies and these have served me well throughout my life so far. I still use them from time to time. I feel that once you have suffered like this, depression is always sitting on your shoulder but if you are given the right tools to deal with it then life can continue generally in a 'normal way'. (Mother, survey respondent)*

## The perinatal virtual primary care team

Women appeared most positive about the care they received when it felt bespoke, integrated and when it was experienced as wrapping around their needs. For some, multifaceted care packages were put in place after disclosure to health professionals and following diagnosis by GPs. In a very small number of instances, women described being linked up with children's centres, voluntary sector providers and other support services (although references to broader support were relatively rare):

*I had really good support from my GP, but did not get the right, positive support from one of the health visitors which I found very upsetting. I did utilise services such as local children's centres and also Homestart which have been wonderful. (Mother, survey respondent)*

*Received help from [my] local post-natal depression support organisation. (Mother, survey respondent)*

Findings pointed once again to inconsistencies, this time in the extent to which overarching accountability and continuity of care existed for those diagnosed with poor mental health. For some women, follow-up was explicitly encouraged or organised:

*I saw my GP in the end as my anxiety was causing sleeplessness and bad eating habits and nervous indigestion. I went to a peer support post-natal depression group who talked about ways to cope. [My] GP recommended that I come back and speak to him if things get bad and we could look at other methods of managing my worries. Though I wasn't officially diagnosed with anything, I found the referral to the support group and his advice very re-assuring.* (Mother, survey respondent)

For others it was left for mothers to arrange and for some there was no follow up at all.

*I was visited at home by a very nice and aware health visitor who I never saw again as she was never at the doctors during the baby clinic. She diligently put the post-natal depression questionnaire in front of me during one check-up but despite a borderline score nothing was put into my or the baby's notes and nothing was ever followed up.* (Mother, survey respondent)

## Specialist perinatal services and availability of services and pathways

Nearly half of GPs responding to the RCGP survey reported not trusting the quality of local referral routes with over a third of survey respondents feeling that the greatest barrier to providing women with effective support was a lack of reliable pathways in their local area. Specifically, GPs said:

*Specialist care is patchy, and the waiting times are unacceptable.* (GP survey respondent)

*Services are too stretched and referrals are refused.* (GP survey respondent)

*I have or have had several patients who have experienced post-natal mental health problems. Our local service is purely antenatal, and for those under consultant care, which to me seems to miss when these problems often develop. The local priority feels low. We have a specialist psychologist within our psychology department - but no access to her as GPs.* (GP survey respondent)

Some GPs (particularly locums) said they struggled to keep up with local care pathways in different sites without easy access to a clear and well promoted local Integrated Care Pathways (ICP). Another GP, leading on perinatal issues in her local area highlighted the challenge of maintaining sufficient leadership and priority for this area of work and also sustaining resources for the maintenance of the ICP which invariably became no-one's responsibility and an 'afterthought'.

The Tommy's survey specifically sought responses from women with common mental health problems and therefore the majority of those responding (although not all) did not have severe mental health difficulties warranting intervention by specialist perinatal services. However, a very small number of women responding to the Tommy survey made reference to accessing specialist mental health services:

*I had long term depression and self-harmed from the age of 16. I got pregnant at 20 years old [and] had to come off my anti-depressants. I was ok for 3 months but then my mood rapidly dipped. I took an overdose during my pregnancy as I was so depressed. I received no help for this just an A&E on-call psychiatrist interview, no follow up. My midwife was helpful though. I had a traumatic labour and had no bond at all with my child. The health visitor came at least 3 times a week for a long period of time. She was very supportive. I had a [psychiatric] evaluation and they diagnosed a personality disorder and said I would be prone to postnatal depression. I was on and off medication for a year, counselling did not help nor cognitive behavioural therapy, but cognitive analytical therapy with a psychologist helped me to cope for a while, I even went back to work.* (Mother, survey respondent)

*After being on an increased dose of anti-depressants I did not get any more help and I attempted suicide. After this I had regular visits from the crisis team which really helped to talk about how I was feeling. (Mother, survey respondent)*

A few women specifically mentioned accessing community specialist perinatal mental health services. However, even when these services existed in local areas, referral did not appear straightforward with some women struggling to get access until they had slipped significantly into crisis:

*My other half gave up his job as I couldn't cope alone. After 10 weeks I went to the GP who prescribed anti-depressants, but with no advice or comment. Two days later I had a massive panic attack and collapsed. My other half called the paramedics who didn't want to take me to hospital so recommended I saw an emergency doctor for a sedative. [The emergency doctor] told me [I was]... supposed to be happy when I'd had a baby! The next day I saw a different GP who was much better. He listened and referred me to the perinatal department at the hospital. A perinatal psychiatric nurse visited me the following week and he was amazing. He instantly upped my dosage and he just knew what to say. (Mother, survey respondent)*

*I pushed very hard to see a specialist mental health midwife -[...] pushed extremely hard. [A] lot of chasing and complaining for some counselling. Getting anti-depressants from the GP, was extremely easy. (Mother, survey respondent)*

A very small number of women mentioned multi-faceted packages of care being mobilised involving medication, peer support groups, practical help, psychological therapy, children's centre support, voluntary sector support, self-help strategies and sometimes with primary care workers coordinating these packages and monitoring progress:

*I was encouraged by my partner to tell my health visitor how I felt and she suggested I talk to my GP, which I did and in time was prescribed anti-depressants. She also recommended getting in touch with my local Home Start charity, which designated a lady to us who came out whenever we needed her to, to either help me with the baby or come out with us. This worked for me along with regular visits and talks with my health visitor, in time I decided I needed to do something to help myself which is how I came to do the Netmums cognitive behavioural therapy course. (Mother, survey respondent)*

*Counselling and therapy helped, [as did] various medication. [I went to an] amazing parenting/anger management course – [it is] all [...] like little building blocks building me back up! (Mother, survey respondent)*

*I actually went to my GP and asked for help. The GP was great and referred me for cognitive behavioural therapy as well as suggesting I try hypnotherapy to deal with the traumatic experiences I'd suffered and the affects they were having on my anxiety - which I did. I also took anti-depressants for about a year to help me along. The Health Visitor team came to visit me at least once a week to make sure I was okay. I also became a member of the gym, and the exercise honestly helped a lot! It was a long and hard process to get better but at least I'm able to enjoy life and my family again, having learnt an awful lot about myself and people around me along the way! (Mother, survey respondent)*

## **Mother and baby interventions**

Many mothers responding to the survey felt strongly that their relationship with their child had remained largely unaffected by their mental health crisis (although mothers may of course have found it difficult to volunteer concerns):

*I was always delighted with my baby though, it was never a case of not bonding, just being totally isolated from friends and family and having a really bad birth experience. (Mother, survey respondent)*



However, some mothers expressed concern at ongoing emotional numbness and poor bonding with their infant and sometimes felt able to identify differences in the quality of attachment with their new infant compared to other children. This was an ongoing source of guilt, anguish and anxiety for mothers:

*Counselling and anti-depressants have helped ease the guilt that I felt about not bonding with my baby girl but 5 years on it still hurts and I do over compensate with her. The birth of my second daughter was totally different and I bonded immediately with her which then lead to a [resurfacing]... of feelings from [my] first daughter's birth and new guilt which again my lovely GPs helped with – [with] anti-depressants and counselling. (Mother, survey respondent)*

*I will always worry about the effect that may have had or may [not] have on him in the future. (Mother, survey respondent)*

There is increasingly promising evidence of the effectiveness and cost effectiveness of parent-infant interventions (JCPMH, 2012; Bauer *et al.*, 2014; SIGN, 2012; NICE, 2014; Gray, 2013) and their importance as part of an overall perinatal mental health strategy in local areas.

However, provision remains highly variable and findings from this analysis suggested little evidence of a broader 'Think Family, Think Parent, Think Child' (SCIE, 2009) approach with appropriate referral into local parent-infant provision where extra help is needed. This is unfortunate since there is growing evidence of the potential damage caused if early mother and child interaction is undermined (Shonkoff & Garner, 2012). Furthermore, the majority of the costs of perinatal mental health problems relate to the impact on children's later mental health and emotional wellbeing. Women distressed about their relationship with their infant appeared unaware of mother and infant interventions and neither GPs nor mothers made reference to them.

The Government's Healthy Child Programme outlines a range of stepped-care interventions supporting parent-infant relationships and infant wellbeing (ranging from supporting attachment and, for those with higher level concerns, referral to specialist services for attachment orientated or parent-infant psychotherapeutic interventions). However there are few systematic opportunities for health practitioners to track mother/infant wellbeing during the first year of birth. Routine contact largely ceases after the 4 month vaccination by practice nurses – and these visits primarily focus on the physical health of the child.

Neither has there been significant focus so far on the need to support practice nurse awareness of mother and infant wellbeing during routine perinatal contact.

All factors pointed to a general tendency to overlook mother and baby wellbeing and the quality of parent-infant relationships following early post-natal checks despite the fact that many women were aware of ongoing concerns, felt anguished and ashamed that they felt this detachment with their baby. Some mothers and GPs also felt that there was an over emphasis on physical health during early checks rather than infant wellbeing.

## Interventions

### » Key findings

- Despite good evidence for the effectiveness of psychological therapies for common mental health problems and some other conditions, GPs were much more likely to prescribe medication.
- Referral to Improving Access to Psychological Therapies (IAPT) services often involved lengthy delays which run counter to advice in guidance and to the need for urgent action during these critical perinatal years to prevent dual damage to mother and baby's wellbeing.
- GPs generally lacked trust in the system of referral to other services which may encourage them to be over reliant on medication (which they generally control).
- There was little evidence of most GPs linking women up with broader packages of support available in the community and most importantly little mention of bridging women to mother and baby interventions.

### » Recommendations

- Consistent with NICE Guidance (2014), clinical commissioning groups 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 foetal/infant mental health. Waiting times should be routinely measured for this target group. GPs will also need to be made aware of fast tracking systems.
- Clinical commissioning groups should ensure that there is adequate commissioning of parent-infant interventions and that these are well publicised to GP practices, to mothers and integrated within ICPs.

## 6. Conclusions

This study sought to triangulate findings from a series of sources to better understand the experiences of women affected by perinatal mental health difficulties particularly with a view to understanding the role played by GPs in supporting disclosure and identification and women's, infants' and partners' care.

The study has some limitations. The GP sample involved a very small (43 people) self-selecting group either with an interest in or a curiosity for this work and who are unlikely to be representative of the broader GP population. These GP responses were then triangulated with a much larger group of women responding to surveys a year apart. The women's survey was also targeted at those women with common mental health problems such as depression and anxiety rather than broader severe mental illness such as bipolar disorder or psychosis (although a very small number of women did describe suffering from such illnesses). Furthermore, the surveys did not cover the mental health problems of women and families tragically bereaved by stillbirth and neonatal death. Finally, it relies mainly on analysis of qualitative findings.

Despite these limitations, findings raise concerns about missed opportunities to improve identification of women and infants affected by poor perinatal mental health as well as ongoing concerns about inconsistencies and discontinuities in care for women, infants and families affected by poor perinatal mental health. This is worrying in light of increasing evidence not only of the damage caused by poor perinatal mental health to mothers, infants and families but also because of mounting evidence about the cost implications of poor identification and poor quality treatment.

Both GPs and women raised questions about time pressures in the system affecting the likelihood of women's disclosure as well as a lack of parity of attention to mental health compared to physical wellbeing during the perinatal period. GPs generally varied in their levels of confidence and in their knowledge of this area of work with some not trusting local care pathways. Women were also divided in experiences of care with as many reporting unsatisfactory experiences as effective and compassionate mental health care. Variability in the quality, consistency and continuity of care mirror findings emerging from the work of the Maternal Mental Health Alliance everyone's business campaign in 2014 which pointed to a postcode lottery of care for mothers, infants and their families (MMHA, 2014). Variability continues to persist despite the existence since 2007 of clear guidance from NICE guidance which has recently been updated presenting a fresh opportunity to drive and improve effective practice.

In terms of disclosure, help-seeking and identification, findings pointed to a conspiracy of silence with women often feeling ashamed and frightened or reluctant to disclose and GPs sometimes feeling unconfident, poorly supported or ill-equipped to open up a dialogue and respond promptly or adequately to women's distress. Findings also pointed to a generally reactive rather than proactive system – a system sometimes requiring dogged persistence on the part of women to be heard or to get help. This lack of proactive attention to mental health was all the more unfortunate since women said they often lacked energy and tenacity to seek treatment when unwell.

When considering findings in the context of broader literature and guidance, some clarity begins to emerge both about the role GPs can play as commissioners – ensuring the availability of well-integrated and high quality care - and as family practitioners, supporting better outcomes for mothers, children and families across a life course.



A large proportion of perinatal mental health problems emerge during pregnancy and the longer identification is delayed, the longer exposure a foetus or infant has to potentially damaging experiences. It was clear that midwives and health visitors (rather than GPs) now play a key role at these earliest opportunities for detection of perinatal mental health difficulties. However, the location of these practitioners outside GP practices and the transfer of health visitor funding to Local Authority Commissioners in 2015 has in some instances undermined collaborative working with GP practices and led to GPs feeling de-skilled in this area of work.

In their role as CCG commissioners, however, GPs have responsibility for commissioning and maintaining an effective, well promoted perinatal mental health integrated care pathway, commissioning recommended specialist community perinatal services and supporting a local perinatal network. This network should aim to improve practitioner knowledge and glue multiagency activity together minimising inconsistencies and discontinuities in the system. It should also seek to align commissioning activity with commissioning for infant/children's mental health to ensure availability of good quality interventions focused on the mother/baby relationship.

Findings from this study suggest that poor identification, unreliable referral pathways and poor follow up sometimes resulted in women approaching GPs (and occasionally emergency services) in crisis with GPs either acting at this point as critical safety nets for a system not working well at earlier stages or alternatively being yet another missed opportunity to identify and intervene effectively with vulnerable women and their infants. Furthermore, GPs are one of the few practitioners with a life course and inter-generational responsibility for their patients.

Late detection, poor quality treatment and poor attention to the mother and baby relationship potentially stores up problems, demand and costs with GPs needing to pick up the pieces of ineffective care at later stages. Lack of investment in improving detection and in providing a more proactive, consistent and better quality start for new mothers and infants is short-sighted, being associated with longstanding safeguarding risks for mothers, long term risks for children's emotional development and sizeable future societal expenditure.

## 7. Recommendations

These recommendations are not in order of priority.

### Government and arm's length bodies

- 1. The Government should commission a taskforce to examine how to ensure that NICE guidance on perinatal mental health is implemented in full during the next Parliament.**

There is good evidence of the importance of improving the quality of perinatal mental health care both to improve women's experiences, safety and outcomes, to promote children's futures and to reduce costs (Bauer *et al.*, 2014). Despite the existence of longstanding NICE guidance on what should be provided, there are persistent inconsistencies in current systems of care around the country (MMHA, 2014) and it cannot be assumed that new NICE guidance will automatically translate into improvements in practice.

Given the critical importance of getting practice right at this time, Government should consider what levers exist in the system to improve the consistency of commissioning and best practice around the country. By way of example, long standing difficulties in the provision of CAMHS services have resulted in a call for a review with nationally-led action.

- 2. The Government and NHS England should take action to reduce pressure on general practice to enable longer consultations to be offered to women at risk of or with perinatal mental health problems.**

Time pressures during contact with GPs prevented some mothers disclosing perinatal mental health problems and in the longer term risks storing up cost in the system later on through preventing early identification. The RCGP's 'Put Patients First' campaign has already highlighted time restrictions as a barrier to providing effective care.

- 3. The Government should commission targeted work to reduce stigma among women with perinatal mental health difficulties.**

There is a need for a targeted campaign to reduce stigma experienced by women with perinatal mental health difficulties. This should be a priority area of work for Time to Change linking with the MMHA Everyone's Business Campaign.

- 4. The Department of Health should ensure that there are more systematic opportunities to focus on the mental health and wellbeing of mother and infant before a child's first birthday. This may include improved focus on mother and infant wellbeing by health visitors and practice nurses during the second half of the first year following birth.**

Research evidence suggests that women continue to develop mental health difficulties throughout the first year; furthermore, many women responding to this survey said that they only became aware of deteriorating health or felt able to disclose difficulties after the routine contact with health professionals had ceased. Mental health problems continued to affect mothers (and potentially some infants) throughout the first year of birth requiring ongoing vigilance and effective intervention.

- 5. The Department of Health should identify opportunities to collect monitoring data to reinforce the importance of supporting mother and infant mental health and wellbeing.**

### Health Education England and Local Education and Training Boards

- 6. Health Education England (HEE) should work with the RCGP Clinical Champion to support specific perinatal mental health training provision for qualified GPs.**

**7. Local Education and Training Boards and Deaneries should develop curriculum competencies relating to perinatal mental health through their GP training programme and these competencies should be assessed by workplace-based training and Membership of the Royal College of General Practitioners (MRCGP) assessments.**

Improved training is considered a high priority to facilitate cultural and practitioner level change. The Government has increased the opportunities for extended (four year) training for GPs in line with the RCGP ‘Put Patients First’ campaign. Perinatal mental health is to be incorporated in the GP curriculum with a new high-level outcome that states ‘as a GP you should recognise the increased risk of mental health problems in the perinatal period and demonstrate how to assess and manage these appropriately’. This is a welcome development that now needs to be supported by the development of high quality training provision.

## NHS England and clinical commissioning groups

**8. NHS England and clinical commissioning groups 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 with perinatal mental illness.**

Investment in these services and networks represents good value in the short and longer term (Bauer *et al.*, 2014). A well-functioning perinatal network and ICP requires strong local leadership to establish and support a network, backed up by refresher multidisciplinary training as well as allocated resources for ongoing maintenance of the ICP. The ICP should include a broad range of potential providers supporting recovery (including midwives, health visitors, GPs, IAPT services, CAMHS or secondary care services, community specialist perinatal mental health teams and the voluntary sector). Most importantly, there is a need for the ICP to be easily accessible for busy clinicians/practitioners. Specialist perinatal mental health services should be commissioned to deliver services directly to those with complex needs,

to lead this ICP and associated network and to deliver consultation and training.

**9. Consistent with NICE Guidance (2014), clinical commissioning groups 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 foetal/infant mental health. Waiting times should be routinely measured for this target group. GPs will also need to be made aware of fast tracking systems.**

**10. Clinical commissioning groups should ensure that there is adequate commissioning of parent-infant interventions and that these are well-publicised to GP practices, to mothers and integrated within ICPs.**

## Research funders

**11. Research funding bodies should commission more studies in this area addressing some of the following questions:**

1. What systems and methods of working might help more effective perinatal mental health care coordination and team working at GP practice level? Such a study could counter potential risks of fragmentation of perinatal mental health care highlighted in this publication following the co-location of health visitors away from GP practices and in to children’s centres and the transfer of their funding to Local Authorities.
2. What factors underpin discrepancies between women’s and health practitioners’ different perceptions of the frequency with which wellbeing is raised in current antenatal and postnatal contacts? How might these discrepancies be minimised?

Tommy’s survey highlights a mismatch between the extent to which mothers felt wellbeing was raised by health practitioners during routine contact and the perceptions of health visitors. Mothers were much less likely to feel that they had been asked about their mental health and wellbeing.

## 8. Implications for the RCGP Clinical Champion for Perinatal Mental Health

Based on the findings of this report, and other evidence, the RCGP Perinatal Mental Health Clinical Champion will develop a three year prioritised work plan to improve GP management of perinatal mental health including establishing a methodology for evaluating the impact of this work plan.

Findings from this analysis suggest that there may be merit in exploring some of the following areas:

1. Given their decreased contact with mothers during the antenatal stage, most GPs saw the 6-week maternal check as their most realistic opportunity to identify perinatal mental health needs. **It will be vital to ensure that this check is evidence-led in terms of its content, that it involves parity of focus on mental health as well as physical health and that it sufficiently emphasises the mother's needs.**

**The RCGP Champion could complete developmental work (with Government Departments and other stakeholders exploring this area of practice) with a view to improving the quality of activity and support for perinatal mental health offered in this 6-week check.**

2. Many women in this study described experiencing high levels of stigma and fear which prevented identification. They also described feeling put off disclosing difficulties due to clumsy interactions concerning their mental health and emotional wellbeing with health practitioners and GPs or alternatively they felt dismissed when they felt 'brave enough' to volunteer difficulties.

**The RCGP Champion should consider developing an evidence-led communication tool to support GPs with compassionate enquiry and response to women and families affected by perinatal difficulties. This work could usefully link with other RCGP Champion activity, focusing on improving communication skills in other sensitive areas of general practice.**

3. GPs said they lacked critical resources to facilitate discussion with women about perinatal mental health (e.g. written materials, culturally adapted and sensitive materials, recovery stories etc). There is a range of developmental work currently taking place through the MMHA Everybody's Business Campaign and in the voluntary sector to improve resources available to mothers, infants and families affected by perinatal mental health difficulties. For example, this work includes the development of a universal Wellbeing Plan for mothers and families (endorsed by NICE), written materials for partners, a resource bank, recovery story DVDs and the creation of a range of other support materials for mothers, partners and families (including those targeted at BAME communities).

**The RCGP Champion should link closely with other stakeholders (including the voluntary sector as well as Royal Colleges) involved in this developmental work and consider methods of making a range of resources (including online materials) more widely accessible to GPs.**

4. **The RCGP Clinical Champion will work with NICE to develop a distillation of new NICE guidance for GPs. There would be value in developing guidance for GPs both as practitioners and also 'top tips' for GPs as commissioners.**

**5. The RCGP Clinical Champion should consider how other findings from this publication might best be incorporated into training and CPD or used to support GP practice. These include:**

- Alerting GPs to the fact that voluntary disclosure by a woman represents a ‘red-flag moment’.
- Improving awareness of the important role GPs can play as a safety net when the system isn’t working – and also of the benefits to GPs (as life course and family practitioners) of identifying poor perinatal mental health and disrupted maternal/infant relationships early.
- Ensuring greater explicit encouragement for partners (and where appropriate wider families) to be involved and adopting a more family-centred approach.
- GPs being aware of the emotional wellbeing of significant others and offer support if needed.
- GPs improving their vigilance for any impairment to parent-infant relationship resulting from maternal mental illness during routine contacts.
- The need for better pre-conception care and coordinated care with the establishment of a lead professional systems to improve accountability for womens’ and infants’ mental health needs.
- Exploring systems to improve team working and coordination of perinatal mental health support at GP practice level.

### Key resources for GPs

**The Maternal Mental Health Alliance’s everyone’s business campaign:**

<http://everyonesbusiness.org.uk/>

**NICE guidance 2014:**

<http://www.nice.org.uk/guidance/cg192>

**Summary of the Costs of perinatal mental health problems report:**

[http://www.centreformentalhealth.org.uk/pdfs/costs\\_of\\_perinatal\\_mh\\_summary.pdf](http://www.centreformentalhealth.org.uk/pdfs/costs_of_perinatal_mh_summary.pdf)

**RCGP website on perinatal mental health:**

<http://www.rcgp.org.uk/clinical-and-research/clinical-resources/perinatal-mental-health.aspx>

**GP survey:**

<https://www.surveymonkey.com/s/T7HP5CZ>

**Tommy’s & Netmums survey:**

<https://www.surveymonkey.com/s/GTRZ3WW>

**Tommy’s Wellbeing plan:**

<http://www.tommys.org/file/Wellbeingplan.pdf>

**Tommy’s website including resources on mental health and pregnancy:**

<http://www.tommys.org>



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## Falling through the gaps

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Centre for Mental Health

134-138 Borough High Street, London SE1 1LB

Tel 020 7827 8300

Fax 020 7827 8369

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