Falling through the gaps:
perinatal mental health and general practice

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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 a 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,
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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 poor mental health 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.

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