



The Hidden Half

Bringing postnatal mental illness out of hiding

Methodology

In March 2017, NCT commissioned a survey from Survation, a member of the British Polling Council, which asked about women's experience of the six week postnatal check. This included questions about the length of their six week postnatal check, if their GP asked about any emotional or mental health issues and if they felt that they were able to disclose any concerns they had about their emotional wellbeing.

The survey was conducted via an online panel. Invitations to complete surveys were sent out to a nationally representative sample of the target population. Differential response rates taken from different demographic groups were taken into account. In total, 1,012 women with children aged two years old or younger from across the UK responded.

We also held two small focus groups, of GPs and mothers with lived experience of mental illness respectively, to hear about their experiences, some of which are reported or quoted here. We were separately given comments from some other GPs who came to us through an online forum.

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Dr Abigail Easter, Senior Research Fellow, King's College London, Institute of Psychiatry, Psychology and Neuroscience

Professor Louise M Howard, NIHR Research Professor, King's College London.

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About NCT

NCT is the UK's largest charity for parents, and we exist to support parents through the first 1,000 days, to have the best possible experience of pregnancy, birth and early parenthood. We do this by sharing knowledge, creating networks that result in vital friendships and using our voice to change public policy and attitudes for good. Since 1956, we have supported millions of women and parents through birth and early parenthood whilst also securing major advances in professional practice and public policy.

Our campaigning achievements include pressing to allow fathers into the delivery room; the labelling and then banning of Bisphenol A in baby bottles; reducing unnecessary interventions during childbirth; influencing the Equality Act in Britain and the Breastfeeding etc. (Scotland) Act 2005 to protect women breastfeeding in public.

We work on perinatal mental health by providing information through our courses and web-based information and are piloting a peer support project funded by the Department of Health, Parents in Mind, offering direct support to parents experiencing mental health problems. NCT is a member of the Maternal Mental Health Alliance (MMHA), a coalition of professional and patient organisations, committed to improving the mental health of women and children in pregnancy and the first postnatal year. In 2013, NCT and Netmums conducted research into mothers' experience of the six week check, including the way GPs asked about mental health.¹

¹ Mind the Gap: Perinatal mental health service provision. NCT (2015) https://www.nct.org.uk/sites/default/files/related_documents/328-NCT-mindTheGap-shortReport-loRes.pdf



Executive summary

Hidden half

The challenges of caring for a new baby are hard enough to tackle when you are emotionally strong. Doing so when your emotional reserves are depleted is even harder.

Our research shows that around half of new mothers' mental health problems don't get picked up by a health professional. This “hidden half” struggle on alone, often afraid to reach out for help or unaware that it is available.

Some women feel they have to hide their problems because they see them as a sign of failure or out of fear of having their baby taken away. Some are dismissed by health professionals who see their problems as the “baby blues” – a temporary period of sadness that rarely lasts more than about two weeks after the birth.

Critical time

If left untreated, the mental illness that these women experience – depression, anxiety, obsessive compulsive disorder or postpartum psychosis – can affect their ability to cope and their relationships within and outside the family, as well as the extent to which they are able to bond with their baby, with potentially serious implications for their child later on. ***95% of the women we surveyed who had experienced a mental health problem said it had had an impact on their ability to cope or to look after their children or on their family relationships.***

Some of these mental health problems can, if left untreated, escalate into more severe mental illness and every year around 20 expectant or new mothers take their own lives. Sadly, suicide is the leading cause of direct maternal deaths occurring within a year after the end of pregnancy in the UK.²

Avoidable harm

But so much of the suffering which mothers experience – not to mention the wider family – is avoidable. Women experiencing maternal mental health illness can be successfully treated and supported in a range of ways. ***Four-fifths (82%) of the women surveyed who received treatment for mental health problems said that it helped.*** This is testament to the excellent work that GPs and specialist services do in this area. It also demonstrates the enormous potential there is to make a difference to more mothers suffering from mental illness and their families if mental health problems are consistently picked up.

“ PND is still one of the highest taboo illnesses we have in this country ”

Mother of four, Staffordshire

² Knight M, Nair M, Tuffnell D, Kenyon S, Shakespeare J, Brocklehurst P, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care - Surveillance of maternal deaths in the UK 2012-14 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-14. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2016.

Getting the right treatment or support early, whether that is ongoing support from a GP, counselling, a peer support group or medication can have an enormous impact on a mother's health and ability to manage the challenges that a new baby brings. These interventions can make the difference between a woman coping well and being able to enjoy becoming a new mother or sliding into serious mental ill-health.

When maternal mental illness and emotional problems are left untreated, it is not only the mother and her family who pay the price. The economic costs of maternal mental illness have been estimated at £8 billion per annual cohort of births, largely comprising costs to health and social services, both for the mother but also later impacts to child health.³

The six week check – a missed opportunity

Around six weeks after they have given birth, most new mothers see their GP for a postnatal check-up. Official guidance (NICE Clinical Guideline CG37) encourages doctors to enquire about the mother's emotional wellbeing and this is an ideal opportunity for a GP to spot any mental health problems that are developing.⁴

While a pregnant woman has many healthcare appointments before the birth of her baby, the six week check may be the last routine appointment she has with a health professional with checks on her, as opposed to the baby. Given many new mothers' reluctance to actively seek help for mental health problems, if they are not picked up at the six week check, there is a significant chance of them remaining undiagnosed.

Some women get an excellent six week check, demonstrating the potential that it offers. If the doctor has the time to talk to the woman about how she is coping, problems can be identified and treatment, support or monitoring can be offered and follow up arranged, as appropriate. But our research shows that this is often not the case. ***A fifth of women questioned in our survey said they were not asked about their emotional or mental wellbeing at this appointment.***

GPs are increasingly under overwhelming pressures and are having to fill gaps in specialist services, health visiting and social care, without extra funding. Doctors do not receive any payment specifically for doing the mother's six week check and fitting in a full appointment for this is becoming harder. ***Our survey found that for two-thirds of new mothers, this check-up is squeezed in with checks on the baby, leaving little time to focus on the mother; a third of the women questioned had an estimated 3 minutes or less for their maternal check.***

“ This appointment very much focused on the child and not me ”

Mother of two, West Midlands

Encouraging a mother to talk about how she feels and is coping is not something that can be done in a couple of minutes. Open, supportive questioning and taking the time to listen and read between the lines is vital to spotting the signs of a developing mental health problem.

The six week check offers a powerful opportunity to address the problem of the “hidden half”. Enabling GPs to give every mother a full appointment for the maternal check would ensure that mental health problems are consistently picked up so that these women don't slip through the net.

An appointment with a supportive GP can be the first step towards recovery from a mental health problem. Let's make that a reality for all new mothers experiencing mental illness, not just half.

³ Bauer, A., Parsonage, M., Knapp, M., Lemmi, V., & Adelaja, B. (2014). Costs of perinatal mental health problems.

⁴ National Institute for Health and Care Excellence Clinical guideline [CG37] Postnatal care up to 8 weeks after birth Published date: July 2006. Last updated: February 2015 <https://www.nice.org.uk/guidance/cg37/>

Key findings and recommendations

A few simple measures would help to solve the problem of the “hidden half”.

These measures would help to ensure that postnatal mental illness gets identified before it escalates and ensure that women get the help they need early on.

Recommendation 1: Fund the six week maternal postnatal check so that GPs have the time to give every new mother a full appointment for the maternal check

This recommendation is based on our findings that:

- **A third (31%) of women said their six week check was rushed**
- **A third (31%) of women’s maternal six week checks were estimated to last 3 minutes or less.**

Currently, GPs have to fit the maternal six week check into their routine workload and there is no special funding for it, in contrast to the baby check. GP workloads have increased substantially in recent years and in over-worked surgeries the maternal check inevitably gets compressed and it becomes harder for doctors to have an unhurried discussion of the mother’s emotional and mental health.

“ I think the time slot given for the postnatal checks is too short and you are rushed and made to feel a burden ”

Mother of two, Kent

GPs report that receiving a designated payment for the six week check would allow them to plan services in a way that makes it possible to give every woman a full appointment just for the maternal six week check, in addition to any appointment for baby checks. Even with a shortage of GPs, they might be able to employ a new (suitably trained) member of the practice team specifically to perform these checks. This could be shared amongst a collective of surgeries.

This should be new money, not funds reallocated from other services. We estimate the cost of this as approximately £20 million per annum – a drop in the ocean compared with the national economic cost of maternal mental illness of more than £8 billion for each annual cohort of births and the annual primary care budget of about £8 billion per annum.⁵

⁵ https://www.england.nhs.uk/wp-content/uploads/2015/12/04.PB_17.12.15-Allocations.pdf

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Recommendation 2: Improve guidance to GPs on best practice around maternal mental health, specifying (a) a separate appointment for the maternal six week check and (b) best methods of encouraging disclosure of maternal mental health problems

a) Separate appointment

This is based on our research finding that:

- **Nearly two-thirds (60%) of women reported that their six week check appointment was focused mainly or equally on the baby**

Guidance from NICE and other relevant bodies should make clear that the mother should get a full appointment dedicated to her mental and physical health. It is only by ring-fencing the time needed to do the maternal check, rather than including the maternal check in the same appointment as the baby check, that we can ensure new mothers get the time they deserve.

A requirement in the GP contract for all new mothers to get a separate appointment for the six week check and to be asked about their mental health would make a big difference by emphasising the importance of this check and the need to allow time for it, as well as the importance of enquiring about mental wellbeing.

“ It becomes very baby focussed.
The whole drive is for checking baby ”

GP, Coventry & Warwickshire

b) Methods of questioning

This is based on our findings that:

- **Half of the women who had an emotional or mental health problem that they wanted to discuss at the six week check, didn't feel able to**
- **Nearly a third (28%) of the women who didn't feel able to talk about a mental health problem at the six week check said it was because the health professional didn't seem interested and 15% said it was because they didn't think the health professional would be sympathetic.**

GP guidance should expressly encourage GPs to use questions that open up a conversation and help the woman feel comfortable about disclosing, as well as enabling the health professional to listen out for any alarm bells which indicate a possible emotional problem. This is needed because the difficulties many new mothers have in disclosing emotional problems and the stigma surrounding this issue mean that health professionals need to use skilled questioning to encourage disclosure.



“ The simple question, asked at the right time, is so valuable and something that has really altered my practice ”

GP, Chelmsford

Guidance should also encourage GPs to discuss wellbeing early on in the appointment, so that it can be covered in an unhurried and supportive way in which women are more likely to feel comfortable disclosing any mental health concerns they may have. It also means, where a mental health issue is uncovered in this early questioning, the doctor still has the time left in the appointment for a full conversation that draws out the woman about how she is feeling.

Recommendation 3: NHS bodies should support and invest in initiatives to facilitate and further develop GP education in the area of maternal mental health through a range of media

This is based on the following findings:

- **A fifth (22%) of mothers were not asked about mental health at their six week check at all**
- **60% of mothers who said there was an emotional problem they didn't feel able to discuss at the six week check cited feeling embarrassed, ashamed or worried that the health professional would think they were not capable of looking after the baby.**

The survey findings demonstrate that new mothers are prone to feelings of self-doubt, guilt, shame and fear of judgement. GP training therefore needs to take this in to account in terms of the style of questioning. It is important to reassure mothers that there is help available but not to normalise or dismiss their problems as insignificant.

Many GPs are well-informed about maternal mental illness and the stigma that women can feel but not all are. When GPs see new mothers immediately after the birth, it is important that they understand the difference between very short term “baby blues” that will resolve on its own and a mental health problem that requires additional support or treatment, and to make a follow-up appointment to clarify this if the woman is seen in the first ten days after birth.

The Royal College of General Practitioners (RCGP) and Royal College of Psychiatrists have recently made great strides in improving the resources available to doctors and are developing new imaginative training tools⁶. We applaud these excellent initiatives and would like to see government supporting them with funds and resources to make them more accessible to doctors.

“ I felt that the six week check was a tick box exercise only and was more of an inconvenience ”

Mother of two, Tyne and Wear

⁶ <http://www.rcgp.org.uk/clinical-and-research/toolkits/perinatal-mental-health-toolkit.aspx>

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A third of the mothers had an estimated 3 minutes or less for their maternal six week check

Nearly two-thirds of mothers reported that their six week check appointment was focused mainly or equally on the baby

A fifth of mothers were not asked about mental health at their six week check at all

Half of the mothers who had an emotional or mental health problem that they wanted to discuss at the six week check, didn't feel able to

Two-thirds of mothers who had an emotional problem they didn't disclose, said they were embarrassed, ashamed or worried the health professional would think they weren't capable of looking after the baby

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The problem

Around half of all new mothers suffer from emotional or mental health problems

Women are more vulnerable to developing mental health problems in the period around birth than at other times in their lives.^{7,8} **50% of the women we surveyed reported that they experienced mental health or emotional difficulties at some time during pregnancy or in the year after birth.**

Although postnatal depression is the most widely known maternal mental health problem, there are a range of other conditions that can affect women during pregnancy and/or postnatally, including anxiety, eating disorders, obsessive-compulsive disorder, post-traumatic stress disorder, and postpartum psychosis (see table below). Exact numbers of women with perinatal maternal mental health problems are unknown, due to problems around identification but our survey indicates that about half of all new mothers experience mental health problems of some kind during pregnancy or within the first year after birth.

50%
had mental
health or
emotional
difficulties

Prevalence of perinatal mental health problems*		
	Rate per number of births	Estimated number of women affected in England
Postpartum psychosis	0.2%	1,329
Chronic serious mental illness	0.2%	1,329
Severe depressive illness	3%	19,932
PTSD	3%	19,932
Mild to moderate depressive illness and anxiety	13%	83,050
Adjustment disorders and distress	23%	149,490

*There may be some women who experience more than one of these conditions.

Figures are estimated using prevalence rates produced by the Joint Commissioning Panel for Mental Health, Guidance For Commissioners of Perinatal Mental Health Services (2012) (<http://www.jcpmh.info/wp-content/uploads/jcpmh-perinatal-guide.pdf>) and ONS data on live births in England in 2015 (<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/livebirths/datasets/birthsummarytables>)

⁷ Jones I et al. Bipolar disorder, affective psychosis, and schizophrenia in pregnancy and the post-partum period. *The Lancet* 2014; 384 (9956): 1789–1799.

⁸ Pawluski, J. L., Lonstein, J. S., & Fleming, A. S. (2017). The Neurobiology of Postpartum Anxiety and Depression. *Trends in Neurosciences*.

Hidden half

Although maternal mental health is talked about much more now than it was in the past, around half of maternal mental health problems still go unidentified^{9,10}. **Of our survey respondents who had suffered from emotional or mental health problems, nearly half (42%) said that their difficulties were not identified by a doctor or other health professional.**

“Many women feel scared to admit they are struggling because you don’t want anyone thinking you’re incapable or a bad mother”

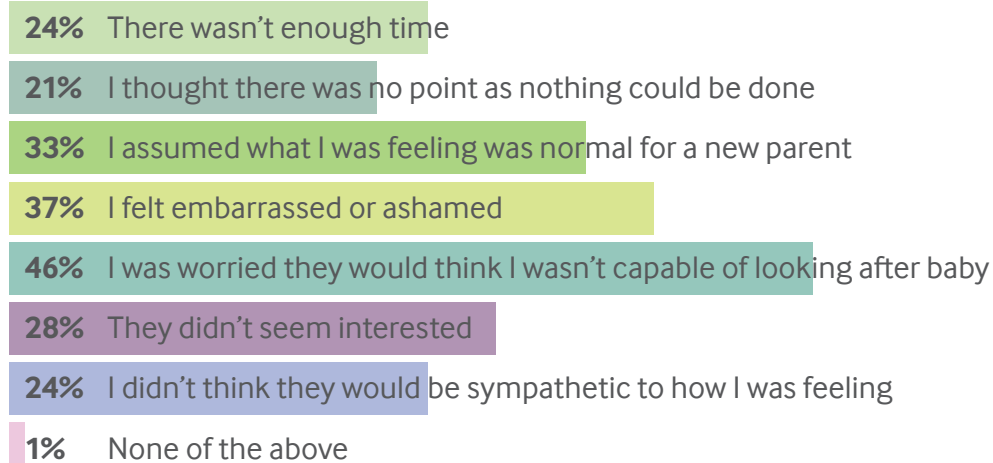
Mother of a two year-old, London

The reasons for this are:

1. Women do not always feel able to seek help

Half of the women who had an emotional or mental health problem that they wanted to discuss at the six week check, didn’t feel able to. When asked why, 60% of these mothers said the reason was due to embarrassment, shame or fear that the doctor would think they weren’t capable of looking after the baby.

Why didn’t you feel able to talk about the emotional or mental health problems that you wanted to? (tick all that apply)



These findings echo similar reasons cited for not disclosing, highlighted in the 2013 Boots Family Trust report, Perinatal Mental Health: Experiences of Women and Health Professionals.¹²

⁹ Bick, D. & Howard, L. (2010) When should women be screened for postnatal depression? Expert Rev. Neurother. 10(2), 151–154

¹⁰ Ramsay, R., 1993. Postnatal depression. The Lancet, 342(8883), p.1358.

¹¹ Percentages will not equal 100 as women could select multiple options

¹² Alliance, Boots Family Trust. Perinatal Mental Health: Experiences of Women and Health Professionals. Boots Family Trust, London (2013).



22%
were not
asked about
emotional
wellbeing

2. Women are not always asked about their emotional wellbeing

A fifth (22%) of women in our survey said that they were not asked about their emotional wellbeing in their six week postnatal check. If women are not given the opportunity to talk about how they are feeling, the stigma means that many will not voluntarily open up.

Which of the following statements best matches your experiences of your 6 week check?

69% I was asked about my emotional or mental health

22% I was not asked about my emotional or mental health

9% Can't remember

From our conversations with mothers who have experienced perinatal mental illness, we hear often that they fear social services becoming involved and that the baby might be taken away or that they would be labelled as being an unfit mother. Sometimes the language associated with safeguarding procedures exacerbate this fear. For example, women report having been labelled "at risk" but the risk isn't specified. While the label might be intended to ensure that the mother gets extra support, it is often perceived as indicating that they are a risk to their baby or themselves. Finding non-stigmatising language to be used in this context could be instrumental in encouraging women to disclose.

In "Women's Voices" a recent report by RCOG (2017), women also reported feeling that in postnatal checks healthcare professionals often focused on the health of the baby, and that they assumed that, as long as the baby was fine, the mother would be too.¹³

“The focus was mostly on the baby and was very thorough but I was only asked a few questions”

Mother of a 1 year-old baby, Scotland

Some women are less likely to be asked about their mental health than others; a recent study found that women from ethnic minorities, those who lived in more deprived areas and those who had received less education, were less likely to be asked about their mental health postnatally.¹⁴ These are often the women who most need support and treatment.

¹³ Royal College of Obstetricians and Gynaecologists (RCOG) Maternal Mental Health – Women's Voices. February 2017

¹⁴ Redshaw, M., & Henderson, J. (2016). Who is actually asked about their mental health in pregnancy and the postnatal period? Findings from a national survey. BMC Psychiatry, 16(1), 322.

“ I felt that the six week check was a tick box exercise only ”

Mother of two, Tyne and Wear

3. Even if mothers are asked, it is not always done in a way that makes it easy to disclose mental health problems

Our findings demonstrate that new mothers are very vulnerable to feelings of self-doubt, shame and fear of judgement. Becoming a mother is a huge life change and there is a lot of pressure on them to step up to their new role and responsibilities, often leaving them fearful of admitting to difficulties. This, combined with the stigma that still surrounds mental illness and fears that their baby may be taken away from them, can make new mothers especially reluctant to disclose mental health problems, so it can take sensitive and supportive questioning to make them feel comfortable enough to disclose a problem.

The style of questioning adopted is therefore critical in this context. The kind of closed questions that might elicit disclosure of physical problems will often not work if adopted with a new mother's emotional difficulties. Closed questions like “Are you OK?” or “Are you coping?” can close down the conversation and make it hard for women to disclose problems.

Additionally, health professionals are sometimes over-reliant on screening tools as the main way of enquiring about a woman's mental health without having a general conversation beforehand. These tools, used on their own do not invite an open discussion. Although they may be relevant later on, GPs have told us that starting with them can lead to women closing down rather than opening up.

Similarly, the 2015 Falling through the Gaps study by the Centre for Mental Health reported:

“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.”¹⁵

Although the assessment questions may be relevant later on in the conversation, GPs have advised us that starting with the assessment questions to begin with can lead to women closing down rather than opening up. This was mentioned in The 2013 Boots Family Trust report:

“Some health professionals expressed their concerns that too many vulnerable mothers were ‘missed’ when using the Whooley questions as the first part of a mental health assessment, especially those that had mental health problems other than depression.”¹⁶

Additionally, the assessment questions are only designed to assess depression and anxiety and are not usually helpful in identifying other problems, like OCD, eating disorders and psychosis. Furthermore, another study suggested that using such screening tools may mean that some depressed patients are missed, raising concerns that their use may not even be helpful in the detection of depression.¹⁷

¹⁵ Khan, L. (2015). Falling through the gaps: perinatal mental health and general practice. Centre for Mental Health. Page 26

¹⁶ Boots Family Trust. “Perinatal Mental Health: Experiences of Women and Health Professionals.” Boots Family Trust, London (2013). P11

¹⁷ Mitchell AJ, Coyne JC. Do ultra-short screening instruments accurately detect depression in primary care? A pooled analysis and meta-analysis of 22 studies. Br. J. Gen. Pract. 57, 144–151 (2007)

79%
said the
maternal six
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the same
appointment
as baby checks

NICE, which is responsible for setting out healthcare best practice, alerts clinicians to the need to be non-judgemental and supportive but the wording of the guidance on methods of questioning in its Clinical Guideline CG192 “Antenatal and Postnatal Mental Health” is problematic in the way it refers to use of standardised questions (known as the Whooley-2 and the GAD-2 assessment scales) to identify possible depression or anxiety.¹⁸ Although the guidance leaves the use of these questions in the clinician’s discretion and states that they should be asked within a general discussion, anecdotally, we hear that health professionals sometimes resort to them quickly, rather than first having a general discussion. It has been suggested that the wording of the NICE guidance encourages an over-dependence on rigid questions that can be perceived as tick-boxing by patients.

“Some professionals just ask are you coping, are you OK? And think that is all they need to ask but this is a very closed question and too easy for a woman just to say yes when she could be crying out for someone to notice her or help her”

Mother of two, West Midlands

4. Pressures on GPs mean that they do not always have time for an unhurried, supportive conversation

Our research found that ***a quarter of the women who did not feel able to talk about their emotional or mental health problems said that this was because there was not enough time. In 79% of all cases surveyed, the woman’s maternal six-week check was covered alongside the baby checks and not given an appointment of its own. In a third of cases, the time spent on the maternal check was estimated to be 3 minutes or less.***

These findings echo those of a recent survey of mothers with lived experience of mental health problems carried out by the Royal College of Obstetricians and Gynaecologists (RCOG).¹⁹ Women said that they didn’t feel that they had had enough time with healthcare professionals to discuss their mental health, or that appointments had been rushed. Many women commented that they felt this had been due to an overstretched service, not because the healthcare professional did not care:

¹⁸ Recommendation 1.5.4. Antenatal and postnatal mental health: clinical management and service guidance Clinical guideline [CG192] Published date: December 2014

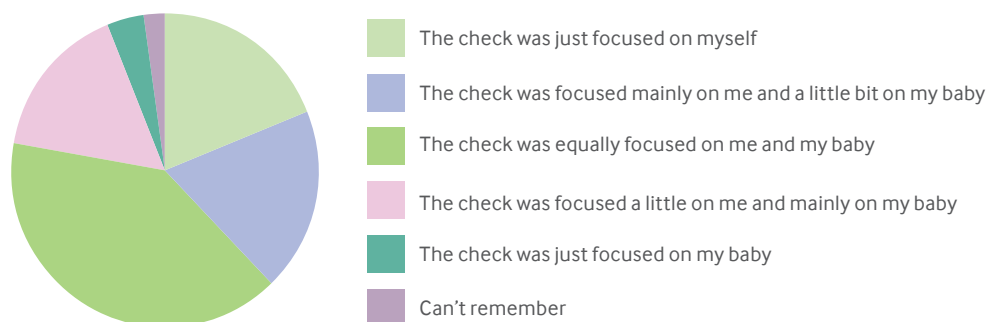
“There were lots of women praising specific healthcare professionals who they felt that without them they would not have got the support they needed. Many had built up trusting relationships over time with healthcare professionals who then fought for them to get support. Others just found someone who listened and encouraged them to open up. Some women with existing mental health conditions felt supported throughout their pregnancy and birth by professionals who understood them.”¹⁴

Doctors reported to us that they feel extremely frustrated about the lack of time available to explore women’s wellbeing supportively. They want to be able to conduct a maternal six week check without rushing but lack of GP time and a significantly increased workload means that sometimes they are forced to rush these conversations.

“ Services are absolutely pushed to the limit ”
 Mother of a one-year old, Lancashire

This echoes the findings of the 2015 Falling Through The Gaps report, which found that one of the key barriers to identification of mental health problems by GPs was time pressure, as reported both by GPs and women.²⁰

Was it a single appointment just focused on you or did the professional also do some checks on the baby in the same appointment?



¹⁹ Royal College of Obstetricians and Gynaecologists (RCOG) Maternal Mental Health – Women’s Voices. February 2017

²⁰ Khan, L. (2015). Falling through the gaps: perinatal mental health and general practice. Centre for Mental Health.

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health
professional
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interested

5. Some women feel they are not taken seriously or not treated sympathetically

More than a quarter (28%) of women surveyed who did not disclose an emotional or mental health problem in their six week check said that this was because the health professional did not seem interested. Almost a quarter (24%) said that they did not disclose because they did not think the health professional would be sympathetic to how they were feeling.

Women experiencing fatigue, low mood or other symptoms of mental illness, are more prone to experience negativity or indifference in the way the professional asks about emotional wellbeing, and can be sensitive to tone of voice or style of communication, gesture, body language or facial expression. Women can easily interpret efficiency for lack of sympathy, so tone of voice and style of questioning become very important. Health professionals need to be very careful about the manner and language they adopt, so that they reassure the mother and make her feel comfortable about talking about her emotional state.

“Other than a tick box ‘are you ok?’
there’s not much time to explore”

Trainee GP, East London

Occasionally, doctors can misunderstand women’s symptoms and shut down conversations prematurely. In the RCOG Women’s Voices report (2017)²¹, some women reported that their feelings were not taken seriously, and that they were told it was ‘normal’ to feel down after having a baby. They felt like they had been shut down and this stopped them feeling comfortable about continuing the conversation. In the same report, women talked about some health professionals being judgmental and dismissive of attempts to communicate emotional distress.

This experience of lack of sympathy is multifactorial. Time pressures in general practice mean that appointments can feel rushed. All GPs have training in mental health and perinatal mental health is now part of the curriculum for the postgraduate GP exams. However, it may be that a GP is not familiar with some of the signs and symptoms of perinatal mental health problems and the treatments available. Reliance upon tick-box screening tools can also sometimes mean cases are missed. Finally, GPs may sometimes be nervous of discussions about mental health if they are unconfident about treatment options available. Changing treatment pathways can also mean that it is hard for GPs to stay up to date with specialist referral options in their area, which can include community and third sector services as well as NHS psychiatric services.

The RCGP have developed excellent learning tools and are developing new training programmes. We look forward to working with them to develop more resources and to help disseminate them and we urge other bodies to support these valuable initiatives.

²¹ Royal College of Obstetricians and Gynaecologists (RCOG) Maternal Mental Health – Women’s Voices. February 2017

95%
said their
mental health
problem had
an impact

Why the hidden half matters

If maternal mental health problems go unidentified and untreated, the problems that these women experience can escalate to severe mental illness and can, in a small number of cases, lead to suicide. Even in less severe cases, maternal mental illness can have a significant impact on women’s relationships within and outside the family, as well as the extent to which they are able to bond with their baby - with potentially serious implications for their child later on. **95% of the women we surveyed who had experienced a mental health problem said it had had an impact on their ability to cope or to look after their children or on their family relationships.**

1. Impact on mothers

Maternal mental illness can have a long-term impact on women: around 30% of women diagnosed with postnatal depression still have depression beyond the first year after childbirth and a significant proportion of women who experience perinatal depression and/or anxiety will develop recurrent long-term mental health problems.²²

Maternal mental illness can also have an impact on a woman’s relationship with her partner, which may in turn have an effect on the child. Of the women we surveyed who had experienced a mental health problem, a third reported that it had had a great impact on their relationship with their partner.

If mild or moderate mental health problems are not treated early they can worsen and develop into severe mental illness.

Occasionally, a severe case can involve risk of harm to the mother herself or to her baby. In the UK, suicide is the leading cause of direct maternal deaths occurring during pregnancy or within a year after the birth.²³

<i>If you have had any emotional or mental health difficulties, how do you feel that this has affected each of the following?</i>			
	No impact	Small impact	Great impact
Your own ability to cope with everyday life	15%	53%	32%
Bonding with your baby	56%	35%	9%
Your relationship with any other children	60%	30%	10%
Your relationship with your partner	16%	51%	32%
Your ability to look after your child(ren) in the way you wanted	41%	46%	13%

²² Howard, L.M., Molyneaux, E., Dennis, C.L., Rochat, T., Stein, A. and Milgrom, J., 2014. Non-psychotic mental disorders in the perinatal period. The Lancet, 384(9956), pp.1775-1788.

²³ Knight M, Tuffnell D, Kenyon S, Shakespeare J, Gray R, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers’ Care - Surveillance of maternal deaths in the UK 2011-13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2015.

2. Impact on children

Maternal mental illness can have implications for the emotional, behavioural and cognitive development of the child.^{24,25} It can interfere with the ability of a mother to bond with her baby and almost half of women in our survey who experienced emotional or mental health problems said that these had had an impact on their ability to bond with their baby.

Maternal mental illness can threaten a child's attachment security and insecure or disorganized attachment styles have been linked to increased risk of poor outcomes later in life.²⁶ Research studies have shown that insecure attachment is higher in children whose mothers suffer from mental illnesses such as depression.²⁷

The quality of moment-to-moment interactions between parent and child, which is increasingly being recognised as a marker of positive infant mental health, can also be negatively impacted by maternal mental illness, particularly on how responsive a mother is able to be towards her baby.²⁸

There may also be longer-term impacts for children whose parents suffer with perinatal mental illness. For example, studies have shown links to poorer intellectual outcomes²⁹, increased likelihood of involvement in the criminal justice system³⁰ and offspring adolescent depression³¹.

It is important to note that not every child of a mother with mental health problems will experience these outcomes but they may be more vulnerable to these risks.³²

3. Impact on society

Research commissioned by the Maternal Mental Health Alliance on the economic cost of perinatal mental illness suggests that each annual cohort of births in the UK is associated with a cost of £8.1 billion, two-thirds of which is related to infant and childhood morbidity and mortality.³³ The average cost to society of one case of perinatal depression is estimated at £74,000.

²⁴ Center on the Developing Child at Harvard University (2009). Maternal Depression Can Undermine the Development of Young Children: Working Paper 8

²⁵ Murray L. The impact of postnatal depression on infant development. *J Child Psychol Psychiatry*. 1992;33(3):543-561

²⁶ Fearon, R.P., Bakermans-Kranenburg, M.J., Van IJzendoorn, M.H., Lapsley, A.M. and Roisman, G.I., 2010. The significance of insecure attachment and disorganization in the development of children's externalizing behavior: a meta-analytic study. *Child development*, 81(2), pp.435-456.

²⁷ Manning, C. & Gregoire, A. (2008). Effects of Parent Illness on Children. *Psychiatry* 8:1.

²⁸ Beck CT. The effects of postpartum depression on maternal-infant interaction: a meta-analysis. *Nurs Res*. 1995;44(5):298-304

²⁹ Hay, D.F., Pawlby, S., Sharp, D., Asten, P., Mills, A. and Kumar, R., 2001. Intellectual problems shown by 11-year-old children whose mothers had postnatal depression. *Journal of Child Psychology and Psychiatry*, 42(7), pp.871-889.

³⁰ Hay, D.F., Pawlby, S., Angold, A., Harold, G.T. and Sharp, D., 2003. Pathways to violence in the children of mothers who were depressed postpartum. *Developmental psychology*, 39(6), p.1083.

³¹ Pawlby, S., Hay, D.F., Sharp, D., Waters, C.S. and O'Keane, V., 2009. Antenatal depression predicts depression in adolescent offspring: prospective longitudinal community-based study. *Journal of affective disorders*, 113(3), pp.236-243.

³² Stein, A., Pearson, R.M., Goodman, S.H., Rapa, E., Rahman, A., McCallum, M., Howard, L.M. and Pariante, C.M., 2014. Effects of perinatal mental disorders on the fetus and child. *The Lancet*, 384(9956), pp.1800-1819.

³³ Bauer, A., Parsonage, M., Knapp, M., Lemmi, V. and Adelaja, B., 2014. Costs of perinatal mental health problems.

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The solution

In order to prevent the potential harm that maternal mental health problems can cause to women, families and society, there needs to be better and earlier identification of maternal mental health problems. To do this, we are calling for the following:

Recommendation 1: Fund the six week maternal postnatal check so that GPs have the time to give every new mother a full appointment for the maternal check

Recommendation 2: Improve guidance to GPs on best practice around maternal mental health, specifying (a) a separate appointment for the maternal six week check and (b) specifying best methods of encouraging disclosure of maternal mental health problems

Recommendation 3: NHS bodies should support and invest in initiatives to facilitate and further develop GP education in the area of maternal mental health through a range of media

Early identification of mental health problems can improve outcomes

The good news is that maternal mental health illness can be successfully treated. *Four-fifths (82%) of the women we surveyed who received treatment for mental health problems said that it helped.*

Did treatment help?

82% Yes

19% No

82%
said that
treatment
helped

GPs and specialist services provide a range of treatments, the vast majority of cases being managed directly by the GP themselves through regular monitoring and sometimes medication. Specialist services like peer support, counselling, infant services, mother-and-baby residential units and other psychiatric services are still severely stretched and GPs report long delays, even in the most severe cases. However, when they are available, these services can be hugely effective.

Getting the right treatment early on can have a significant impact on outcomes. If maternal mental health problems are spotted and treated early, this can prevent problems from escalating and in some cases can even prevent suicide. NSPCC's Prevention in Mind report, notes that:

*"The onset and escalation of symptoms of mental illness can often be prevented through proper management of a woman's condition, avoidance of environmental risk factors and triggers such as stress or sleeplessness, and making prompt and informed choices about medication. This is why it is critically important to identify women who are at risk and ensure they get timely and appropriate support"*³⁴

Improvements in care which may have made a difference to outcome were noted in almost half of the 124 cases of women who died related to psychiatric causes between 2012-14.³⁵ Better identification of escalating symptoms and treatment could have prevented some of these deaths:

The 2015 MBRRACE report in to cause of maternal death showed that some women who went on to die from mental health related causes were identified as having symptoms of 'anxiety' at first presentation:

*"Their presentation in the early postpartum period with a newly emergent significant change in mental state should have alerted staff caring for them to the presence of more severe illness."*³⁶

The importance of the GP's role

Although all health professionals who meet a woman on her journey through pregnancy and childbirth have an important role to play, GPs play a particularly significant role in the postnatal period. They see women soon after the birth, when adjustment to new circumstances can precipitate emotional difficulties, and they have an ongoing relationship with the mother, her baby and her family.

³⁴ Hogg, S., 2013. Prevention in mind. NSPCC. Page 3.

³⁵ Knight, M., Kenyon, S., Brocklehurst, P., Neilson, J., Shakespeare, J. and Kurinczuk, J.J.E., 2014. Saving Lives, Improving Mothers' Care Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-2012.

³⁶ Knight M, Tuffnell D, Kenyon S, Shakespeare J, Gray R, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care - Surveillance of maternal deaths in the UK 2011-13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2015. Page 30

GPs are also usually the first port of call once mental health problems are identified and they can play a key role in a woman's recovery, be it through referral to other specialist services or through management by monitoring or medication. They are often best placed to monitor and manage mental health problems because of their ongoing relationship with a woman. Indeed, in *Women's Voices*, the 2017 RCOG survey of women with lived experience of mental health problems, over half said they did or would feel comfortable talking to a GP.³⁷

Furthermore, in a study looking at GPs' beliefs and practices around maternal mental illness, the majority of GPs felt responsible for diagnosing and treating postnatal depression.³⁸

The six week check – a missed opportunity

At 6-8 weeks after they have given birth, new mothers conventionally see their GP for a postnatal check-up and this is widely known as the six week check. It is often done alongside baby checks, which also have to be done at this time.

Official guidance from NICE Clinical guideline CG37, "Postnatal Care"³⁹, encourages doctors to do this check and to enquire about the mother's emotional wellbeing at this appointment and this is a good opportunity for a GP to identify any mental health problems that are developing. Over a quarter of women who had experienced perinatal mental health problems recognised that they were unwell within six weeks of the birth and many more may have had symptoms that were not recognised at that stage but, with the right kind of questioning, GPs are in a position to recognise and offer support even where the woman does not.⁴⁰

NICE guidance recommends the following best practice:

- **The NICE clinical guideline on Antenatal and Postnatal Mental Health [CG192] (1) states:**

"At all contacts after the first contact with primary care or the booking visit, the health visitor, and other healthcare professionals who have regular contact with a woman in pregnancy and the postnatal period (first year after birth), should consider:

- o asking the 2 depression identification questions and the GAD 2 (see recommendation 1.5.4) as part of a general discussion about her mental health and wellbeing and
- o using the EPDS or the PHQ 9 as part of monitoring. [new 2014]"

It also highlights women's reluctance to disclose mental health problems due to stigma.

- **The NICE clinical guideline on Postnatal Care [CG37] states that:**

"At each postnatal contact, women should be asked about their emotional wellbeing, what family and social support they have and their usual coping strategies for dealing with day-to-day matters. Women and their families/partners should be encouraged to tell their healthcare professional about any changes in mood, emotional state and behaviour that are outside of the woman's normal pattern."

- The NICE clinical guideline on Postnatal care recommends a maternal check at 6-8 weeks after birth:

"At the end of the postnatal period, the coordinating healthcare professional should ensure that the woman's physical, emotional and social wellbeing is reviewed. Screening and medical history should also be taken into account."

(1)National Institute for Health and Clinical Excellence (NICE) *Antenatal and postnatal mental health: clinical management and service guidance*. Clinical guideline [CG192] Published date: December 2014. Last updated: June 2015.

(2)National Institute for Health and Clinical Excellence (NICE) *Postnatal care up to 8 weeks after birth*. Clinical guideline [CG37] Published date: July 2006 Last updated: February 2015

³⁷ Royal College of Obstetricians and Gynaecologists (RCOG) Maternal Mental Health – Women's Voices. February 2017

³⁸ Leiferman JA, Dauber SE, Heisler K, Paulson JF. Primary care physicians' beliefs and practice toward maternal depression. *J Womens Health*. 2008;17(7):1143-1150

³⁹ National Institute for Health and Clinical Excellence (NICE) Postnatal care up to 8 weeks after birth. Clinical guideline [CG37] Published date: July 2006 Last updated: February 2015

⁴⁰ Alliance, Boots Family Trust. "Perinatal Mental Health: Experiences of Women and Health Professionals." Boots Family Trust, London (2013).

Many women get an excellent six week check. If the doctor has the time to talk supportively with the mother about how she is coping, problems can be identified and treatment, support or monitoring can be offered, as appropriate.

Indeed, one of the key findings of the Falling Through The Gaps report was that:

“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.”⁴¹

So, an effective six week postnatal check is potentially a powerful tool in identifying maternal mental illness early on and preventing mild and moderate problems developing into more severe ones

Making sure that GPs are able to encourage a woman to talk about her feelings and can identify a mental health problem even if the woman herself does not, at this six-week point, can significantly reduce the damage caused to mothers, children and families and reduce costs down the line.

We have seen in Chapter 1 that disclosing an emotional problem is hard to do at the best of times – doing so under pressure in a rushed appointment is not always realistic – as our research shows.

Overstretched GPs find themselves forced to rush the conversation on emotional wellbeing, so that women don't feel comfortable disclosing. The key to solving this is to help doctors to have time for an unhurried and supportive conversation, as well as providing resources to help them to encourage disclosure and to read between the lines when women talk about how they feel, if they don't explicitly disclose that they are worried about their mental health.

Our research found that many women don't get time for an unrushed and supportive conversation and only a third of new mothers got an appointment that was focussed mainly on them, rather than on the baby. For the other two-thirds, the maternal check was added in with baby checks which were the main or equal focus of the appointment. A third of women in our survey had an estimated 3 minutes or less for their maternal check, as the baby and maternal check were covered in one appointment.

When questioning about emotional wellbeing is rushed, it can end up becoming a tick-box exercise. Encouraging a mother to talk about how she feels and is coping is not something that can be done in a couple of minutes. Open, supportive questioning and having time to listen is vital to spotting the signs of a developing mental health problem and pressures on GP practice mean that doctors increasingly don't have that time.

Additionally, improving resources and access to training so that GPs can spot the signs of mental illness would help bring all services up to the standards of the best. The Royal Colleges (especially the Royal College of General Practitioners and the Royal College of Psychiatrists) have made great strides in the last few years and have produced excellent resources for GPs. They need to be supported and assisted in these initiatives by all of those working in this area.

⁴¹ Khan, L. (2015). Falling through the gaps: perinatal mental health and general practice. Centre for Mental Health. Page 19

Why is designated funding needed for the six week check?

Cuts in health and social care services mean that GPs are left filling the gaps. As a result, the maternal six week check is being squeezed and identification of maternal mental problems has suffered. The guidance, training and funding available for this vital weapon in doctors' armoury needs to be firmed up to enable doctors to make the most of the opportunity it offers to save money and pain down the line.

“ We have stopped 6 week checks as we don't have the funding or the staff but it has made me feel very uncomfortable and I'm not sure it is the right thing to do ”

GP, London

Doctors report that specialist perinatal mental health services are being rationed even for severe mental illness, leaving them to safeguard patients and manage treatment alone, at least while patients wait for referrals, which can sometimes take months.

Currently GPs have to fit the maternal six week check into their routine workload. In overworked surgeries, the maternal check inevitably gets compressed and any discussion of the mother's mental health can sometimes be perfunctory or missed altogether. Some GP surgeries do not offer a six week check at all.

Funding GP surgeries for every six week check they do will enable them to plan their workload and staffing so that they have the time to give new mothers a full and unrushed appointment for the maternal check and make a consistently good maternal six week check possible. Even with a shortage of GPs, designated funding would enable practices or collectives of surgeries to employ a doctor with a special interest or another suitably trained health professional specifically to perform postnatal checks.

We estimate the cost of this to be in the region of £20 million for England (based on an estimate of about £30 per check for the approximately 660,000 women giving birth each year). This is a drop in the ocean relative to the damage caused by maternal mental illness and to the cost of other services, some of which would be saved by identifying maternal mental health problems early.

“ It's even more important in a time of care fragmenting that we look at definitive mum-only checks ”

GP, East Kent

Why a separate appointment for the maternal check?

Two thirds of women we surveyed said that their six week check was mostly or equally focused on their baby. It is only by ring-fencing the time needed to do the maternal check, by giving mothers an appointment focused on them, separate from baby checks, that we can ensure new mothers get the time they need.

Guidance from NICE and other relevant bodies should also make clear that the mother should get a full appointment dedicated to her own mental and physical health and this should be specified in the GP contract, so that it is consistently implemented.

“ I think it needs to be completely decoupled from the baby check ”
GP, Coventry and Warwickshire

Why specify open supportive questioning early on in the appointment?

By discussing emotional and mental health early on in the appointment, it can be covered in an unhurried and supportive way. In some cases, the discussion on wellbeing can be relatively quick and the doctor can move on quickly to physical checks but where a mental health problem is uncovered in this early questioning, the doctor has the opportunity to prioritise the conversation about mental health and can make use of the time available for an unhurried conversation that draws out the women about how she is feeling. If necessary, another appointment can be made if there isn't time to complete all checks, as long as they aren't urgent.

Guidance should advise GPs to prioritise a general discussion on mental wellbeing before being drawn into physical screening, so as to make sure that emotional problems are not overlooked, as can happen if it is tackled last.

The importance of open non-judgmental questioning is demonstrated by one of the findings of the Falling Through The Gaps study:

“A small number of women described how during ‘knife edge’ moments of vulnerability, proactive and compassionate questions could promote disclosure.”⁴²

⁴² Khan, L. (2015). Falling through the gaps: perinatal mental health and general practice. Centre for Mental Health. Page 26

NICE and other bodies producing guidance should be clearer about the type and style of questioning appropriate for this early question, highlighting the need for a sympathetic manner and language which recognises the difficulties many new mothers have in disclosing emotional problems. This guidance should advise that health professionals should start with open questioning on wellbeing before using any assessment tools, like the Whooley-2 and GAD-2 questions, which can close down conversations and give an impression of tick-boxing.

The Whooley-2 and GAD-2 questions are screening tools for depression and anxiety respectively and are not designed to start an open conversation about mental health or to encourage disclosure. NICE guidance needs to be clearer that they should only be used within a general discussion, once the woman has been made to feel comfortable about talking about her emotional state.

Experienced GPs suggest that it is often helpful to start with a question such as “How are you finding being a mum?” or “How are you finding looking after the baby?” which tends to get a conversation started and creates a safe space for disclosure and the opportunity for the doctor to get a holistic view of the women’s emotional state.

It would be helpful if NICE would be clearer in guidance about the need to get a conversation going and to put the woman at ease. Inclusion in the guidance of examples of the sorts of questions that can work well at the beginning of a discussion to encourage disclosure, could be helpful to GPs and might counteract any impression that the Whooley-2 and GAD-2 questions are the right way to start. Additionally, NICE clinical guideline CG192⁴³ mentions stigma and reluctance to disclose but does not give any guidance about how clinicians should reflect this in their practice. Elaboration about questioning techniques or methods of reassurance which address this problem would be helpful, especially for GPs less experienced in this area.

“ I now always ask “How are you finding being a mum” and am amazed at how that helps them open up ”

GP, Lochcarron

The guidance should require a general discussion on emotional wellbeing before embarking on physical checks and could provide examples of the type of questions and language that can be helpful but it should not be prescriptive as the key is for the doctor to listen and respond to the woman.

Other issues that should be addressed in guidance include the language used when a woman is considered to be vulnerable in some way and avoiding use of the label “at risk” or “not coping” when it comes to new mothers, who perceive this as stigmatising and suggestive of her being a risk to her baby or judgemental about her ability to carry out her role as a mother. This ties into fears that social services might get involved and that the baby could be taken away and exacerbates feelings of shame or failure. A shift towards language denoting a need for additional support, rather than risk, would be helpful.

The issues raised here should lead to a commissioned full evidence review, including qualitative research and patient feedback, to develop evidence-based guidelines into the maternal postnatal examination. This would take some time to complete. In the meantime we believe there is sufficient evidence presented here to justify a change in official guidance.

⁴³ National Institute for Health and Clinical Excellence (NICE) Antenatal and postnatal mental health: clinical management and service guidance. Clinical guideline [CG192] Published date: December 2014. Last updated: June 2015.

Why should NHS bodies invest in more special training for GPs?

Our research found that 60% of mothers who said there was an emotional problem they didn't feel able to discuss at the six week check cited feeling embarrassed, ashamed or worried that the health professional would think they were not capable of looking after baby.

“ We need to acknowledge that detection and treatment of PMH is falling on the GPs. That is the reality. We want the tools to be able to do it better and stop pretending there are other people doing it when there aren't ”

GP, East London

Given that many new mothers experiencing mental health problems will not actively seek help, it is important that GPs are familiar with the symptoms of maternal mental illness and capable of spotting the subtle signs that something is not right.

Sometimes, health professionals do not fully understand the difference between very short term “baby blues” and a mental health problem that requires treatment. A key recommendation of a 2015 report carried out by the Centre for Mental Health (Falling through the Gaps) was that GPs should avoid minimising or being dismissive of women's experiences, as this can actually exacerbate mothers' feelings of distress and failure.⁴⁴ If a woman has taken the step of disclosing an emotional difficulty, there should be a presumption that she needs treatment or support and should not be dismissed.

One of the recommendations of the Falling Through the Gaps report was for improvements in training provision for GPs around perinatal mental health, with specific mention of Health Education England, RCGP and Local Education and Training Boards.⁴⁵

We would like to see government agencies (especially NHS bodies) getting behind training initiative with active support and investment to ensure all doctors receive accessible resources and training in this area, by, for example:

- Investing in the development and distribution of training resources using varied media (such as videos and online training modules) that can be easily accessed by GPs and fitted in around a heavy workload. This could include developing the existing resources already created by RCGP and others and helping to publicise and disseminate them.
- Funding GPs to learn specialist skills, for example by funding an optional specialist module as a fourth year of GP training and funding time off from practice to run or attend peer education and develop resources.
- Ensuring that maternal mental health is recognised as a topic in safeguarding training and that red flags and women's reluctance to disclose are addressed effectively in these courses.

⁴⁴ Khan, L. (2015). Falling through the gaps: perinatal mental health and general practice. Centre for Mental Health. Page 28

⁴⁵ Khan, L. (2015). Falling through the gaps: perinatal mental health and general practice. Centre for Mental Health. Page 16

“ PND is still one of the highest taboo illnesses we have in this country ”

Mother of four, Staffordshire

“ Many women feel scared to admit they are struggling because you don't want anyone thinking you're incapable or a bad mother ”

Mother of a two year-old, London

“ I felt that the six week check was a tick box exercise only ”

Mother of two, Tyne and Wear

“ This appointment very much focused on the child and not me ”

Mother of two, West Midlands

If you would like more information about this report or our survey questions, please email:

campaigns@nct.org.uk

For advice or signposting on pregnancy, birth and early parenthood, including emotional problems, contact:

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