

Practical implications for primary care of the NICE guideline CG192 Antenatal and postnatal mental health

This document highlights the recommendations relevant to GPs from NICE CG192 Antenatal and Postnatal Mental Health. It has been developed to raise awareness and support implementation of the NICE guideline in primary care. ***This resource is not RCGP guidance; it is an implementation tool and should be used alongside the published [NICE guidance](#).***



GPs are expected to take NICE recommendations fully into account when exercising their clinical judgement. However, in no circumstances does guidance override their responsibility to make decisions appropriate to the circumstances of each individual, in consultation with the individual and/or their guardian or carer. Clinical guidelines are based on the best available evidence and are there to help healthcare professionals in their work, but they do not replace their knowledge and skills.

10 questions a GP should ask themselves (and their team)

1. Why is perinatal mental health important?

Perinatal mental health illness is common. Between 10% and 20% of women will develop a mental illness during pregnancy or within the first year after having a baby. They are also one of the major causes of maternal death (from suicide).

Most women will have mild to moderate illness, including depression, anxiety and PTSD, but some will have severe depression, PTSD or pre-existing serious illness like schizophrenia or bipolar disorder or they may develop postpartum psychosis with no previous history.

Some women will have drug and alcohol problems.

The consequences include immense distress for women and their families. The first two years of a baby's life are the building blocks of their long-term social and emotional development. There is a marked variation in the [availability of specialist perinatal services](#) across the UK. The huge economic impact of untreated perinatal depression, anxiety and psychosis carries a total long-term [cost](#) to society of about £8.1 billion for each one-year cohort of births in the UK, with two-thirds of the cost being linked to short and long term problems for the child.

90% of women diagnosed with perinatal mental health illness are cared for in primary care.

Treatment is effective and there are clear [guidelines](#) for care.

Intervening early reduces the impact of the disorders on the mother, her child and family.

2. As a GP could I improve detection?

Reasons for poor detection

Only about half of cases of perinatal mental health illness are detected and only about half of these are treated. So there is clear room for improvement.

Maternal factors for poor detection

Stigma
Putting on a brave face
Fear of being thought a 'bad mother'
Fear the baby may be taken away
Not knowing what is 'normal'
Not knowing if treatment will help

GP factors for poor detection

Not asking
Time constraints
Lack of training or confidence
Lack of access to specialist service
Normalising or dismissing symptoms

As a GP what could I do?

- Be proactive.
- Ask open and interested questions about how she is finding being a mother, even if she is smiling!
- Ask every time you see her; don't assume someone else has asked.
- Consider asking [the 2-question depression test and GAD-2](#) (please go to the bullet points in recommendation 1.5.4).
- Consider using the [wellbeing plan](#) to recognise, support disclosure and engage with women.
- Respond to 'cues' (e.g. poor eye contact, tears, not sleeping when baby sleeps, reporting feeling overwhelmed).
- Remain vigilant throughout the first year following birth.

Recognise the exceptional opportunity of the 6-8 week maternal postnatal examination

This may be the only time you, as a GP, see a mother in the entire pregnancy and postnatal period. Consider asking about possible mental health illness BEFORE focusing on the physical tasks. Consider doing the mother's postnatal at a different time from the baby check.

Disclosure is a 'red flag'. It's so difficult for a woman to raise this with a GP; if she says she has a problem, assume she does. Do not dismiss her.

3. Do I think about involving her partner?

Make it clear that her partner is welcome to come to her appointments, if she wants. They can help with detection if they know what to look out for and offer practical and emotional support.

But: Make sure you see her by herself on at least one occasion as she will not be able to tell you about problems with her relationship if her partner is present (women with perinatal mental illness are three times as likely as other women to be suffering from domestic violence).

Remember the partner could also be ill: around 10% of partners have depression, anxiety or other mental health illness and they may also need treatment.



4. How should I care for women with a history of serious mental health disorders?

Women with a history of severe mental illness, such as bipolar disorder, schizoaffective disorder or severe depression need specialist care, preferably by a specialist perinatal psychiatrist during pregnancy and the postnatal period.

Bipolar women (1-2% of the population) have a risk of developing postpartum psychosis of around one in four, or one in two if they have had a previous episode of postpartum psychosis.

Bipolar disorder is a 'red flag'. The woman, her family, her midwife and obstetrician all need to know her level of risk so that it can be managed and reduced.

The psychiatrist should work closely with the midwifery and obstetric teams, and you, the GP, to make a plan for her postnatal care, when she is at highest risk of relapse. Her medication pre-

conception, during pregnancy and after delivery should be the responsibility of the psychiatrist NOT you, as the GP.

5. How urgent is treatment for postpartum psychosis?

Postpartum psychosis is a psychiatric emergency and a woman should be assessed and treated by a psychiatrist, preferably a specialist perinatal psychiatrist, within 4 hours.

Have you got the details of how to contact your local perinatal psychiatrist?

6. How is mild-moderate depression and/or anxiety treated?

Offer a range of treatment and give hope by explaining that treatment is effective. Identify one health professional as **the lead professional** who will develop a shared plan to co-ordinate her care with the woman and where appropriate her partner and family. The lead could be a health visitor, midwife or GP: it does not necessarily have to be you, as the GP.

Health visitors can play an important role screening and managing mild to moderate illness through a variety of low intensity therapeutic psychological interventions.

It is vital that HVs, GPs and others working with mother and family communicate with each other.

Ensure this plan is coordinated with other perinatal support.

Ask yourself/your team:

Am I aware of local support groups or national organisations that could also provide help?

Is there a local pathway and how can I access it?

This is an opportunity to gather these resources together so whole practice is aware of them.

There are 2 main types of treatment: psychological therapies and medication.

Self-help: accessing social mums/babies activities, post-natal exercise classes, online CBT (www.twoinmind.org/), or other on-line parenting support, such as [Netmums](#)

Psychological therapies: Rapid access to primary mental health (IAPT in England or CBT/talking therapies in Wales) is important. The NICE standard is assessment within 2 weeks and starting treatment within 4 weeks. In some areas there may be delays in accessing this help but support and regular follow up should be offered in the interim.

Medication: Before starting any treatment in pregnancy and the postnatal period, discuss with the woman the higher threshold for pharmacological interventions arising from the changing risk-benefit ratio for psychotropic medication at this time. When psychotropic medication is started in pregnancy and the postnatal period, consider seeking advice, preferably from a specialist in perinatal mental health, and:

- choose the drug with the lowest risk profile for the woman, fetus and baby, taking into account a woman's previous response to medication
- use the lowest effective dose (this is particularly important when the risks of adverse effects to the woman, fetus and baby may be dose related), but note that sub-therapeutic doses may also expose the fetus to risks and not treat the mental health problem effectively
- use a single drug, if possible, in preference to two or more drugs
- take into account that dosages may need to be adjusted in pregnancy.

A woman (and her family, if appropriate) need to be involved in making an informed decision.

With increasing severity of mental health problems and with current delays in accessing psychological therapies the balance may shift towards prescribing medication.

NICE recommendations on prescribing can easily be viewed via the pathway [here](#). Free information for GPs on drug use in pregnancy can be obtained from the [UK Teratology Information Service](#) (UKTIS).

If the woman fails to attend a booked appointment or make contact as expected, call her.

7. What should I consider when caring for women of childbearing potential who have new or existing mental health disorders?

Around 50% of pregnancies are unplanned, so preconception care of any woman who has the potential to become pregnant needs to be built into routine care.

If you are starting or reviewing a medication, such as an antidepressant, routinely raise the possible risks in pregnancy, ask about contraception and, if necessary, offer a special appointment to give information and make an individualised plan for any future pregnancy, planned or not.

8. If a woman is taking antidepressants and becomes pregnant should she stop immediately?

No. Stopping treatment suddenly may carry a high risk of relapse. There is time to make an [informed decision](#), taking into account the risk-benefit equation. If you are not confident as a GP to give this advice, seek help or refer.

9. Do I ever consider how the woman is interacting with her baby?



Perinatal mental illness can sometimes affect interaction and lead to longer term problems for the infant. Some mothers describe feeling numb and having worries about this. Look at attachment between the mother and infant and if you have concerns talk to mothers about any worries they have. Explain that simple interventions can improve attachment. Consider with the mother referral to your health visitor or infant mental health service for assessment. Early intervention helps (and it can also improve maternal mental health as well).

10. What should I do if there is a bereavement?

Stillbirth and neonatal death increase the risk of postnatal mental health illness for both parents. It is likely that they will find it difficult to ask you for help. You should call them and offer to visit at a time that suits them. The need for extra support will carry on, possibly for years and certainly during another pregnancy.

Other resources

[Everyone's business campaign](#)
[Netmums local contacts](#)

[Netmums website](#)
[RCGP perinatal mental health resources](#)

May 2015, Judy Shakespeare, Clinical Champion for Perinatal Mental Health, Review date: May 2017