



Perinatal mental health

Introduction

Mental health problems occurring during pregnancy or in the first postpartum year are referred to as perinatal. Problems may start at this time and or may be pre-existing conditions that may relapse or recur and may range from anxiety to severe mental illness, including psychosis.

Some women are more at risk than others, and at different times. Childbirth is associated with an increased risk of recurrence for people with a history of bipolar disorder or severe depressive disorder, which may occur when a pregnant woman stops taking medication. People with a previous history of other severe mental health problems such as schizophrenia can experience a deterioration of their disorder either during pregnancy or after childbirth.

Post-partum psychosis (acute, severe mental illness after childbirth), which has a range of possible symptoms including mania and delusions, is most likely to occur in the days and weeks following childbirth, and presents as a psychiatric emergency. Whilst women with a history of Bipolar disorder are more at risk, post-partum psychosis can occur in those with no previous psychiatric history.

Mild or moderate depression and anxiety are as likely to occur during pregnancy as after childbirth, but can escalate to severe non-psychotic depression in the weeks immediately following childbirth.

Problems during pregnancy

NICE figures indicate that depression and anxiety are the most common mental health problems during pregnancy, with around 12% of women experiencing depression and 13% experiencing anxiety at some point; many women will experience both¹. Serious mental illness is estimated to occur only in 2 in every 1000 pregnancies².

Psychiatric disorder is the cause of 15% of all maternal deaths in pregnancy and six months postpartum since 1997². The Confidential Enquiry into Maternal Deaths³ reports that there has been no significant reduction in maternal suicides (in pregnancy and within 6 months postnatally) in the last 20 years. They also note that the majority of women who die from suicide during pregnancy or postnatally have a past history of serious mental health problems.

Perinatal Mental Health – Problems occurring up to 1 year after childbirth

It has been estimated that as many as 50% of women become emotional or express 'baby-blues' after delivery². However this is short-lived with recovery.

- Depression and anxiety affect 15-20% of women in the first year after childbirth¹
- Severe depressive illness affects around 3% of women²
- PTSD affects around 3% of maternities and 6% of women who had an emergency caesarean section²
- Post-partum psychosis (also called puerperal psychosis) is rare and occurs in 1-2 per 1000 women giving birth¹

Post-partum psychosis is different from severe non-psychotic post-natal depression, though both may present as an emergency and both may require inpatient care because of the risk to both



mother and baby. Post-partum psychosis – a medical emergency - is a severe episode of illness with varied and rapidly-changing symptoms which may include mania, depression, hallucinations and delusions. Women with (or suspected of having) this condition require emergency specialist care. Symptoms of post-natal depression are like those seen in depression generally (for example feeling tearful for no apparent reason, and having disturbed sleep), but may include feeling hostile or indifferent to the baby.

Impact upon the child and family

Mental disorders during pregnancy and the postnatal period can have serious consequences for the health and wellbeing of a mother and her baby, as well as her partner and other family members, if not identified and treated.

Severe depressive illness is associated with increased rates of obstetric complications, including pre-term deliveries, suicide attempts and post-natal specialist care for infants.

Women with schizophrenia and bipolar illness have higher rates of suicides and exacerbation associated with pregnancy ⁴.

Psychotic illness during pregnancy is associated with poorer outcomes for the child including higher rates of pre-term delivery and neuro-developmental disorder.

Problems in the mother–baby relationship in the first year after childbirth may increase maternal mental health problems and are associated with a range of problems for the baby, including delayed cognitive and emotional development

There is good evidence that post-natal depression is a risk factor for impairment in infant development, with these deficits persisting to at least school age ⁵.

Births in Suffolk

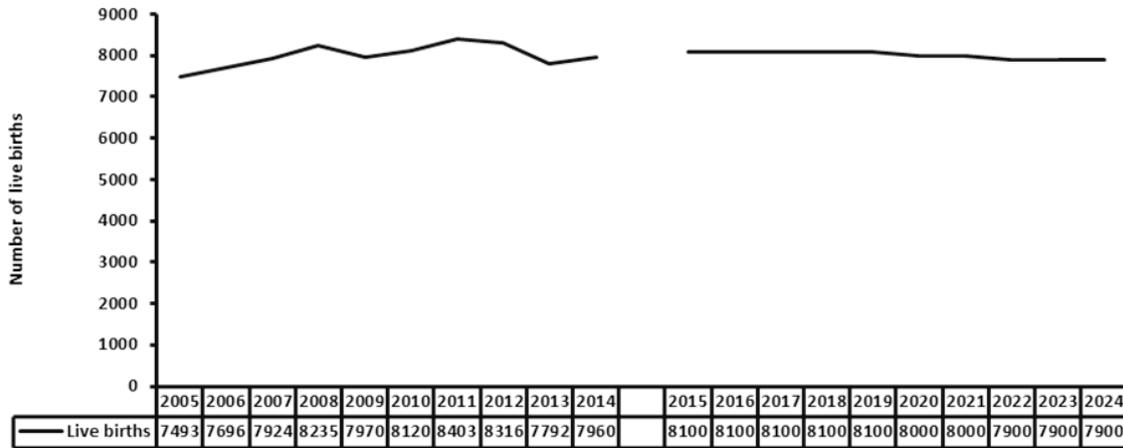
Information on pregnancy and births is collected in several ways:

- Number of pregnancies or conceptions (which would count multiple births as one pregnancy)
- Numbers of maternities (which would exclude terminations and miscarriages)
- Numbers of live births (which would exclude miscarriages and stillbirths and include multiple births)

Numbers for Suffolk County residents

In 2014 there were 9357 pregnancies in women living in Suffolk County of which there 7857 maternities and 7960 live births (ONS). The largest number was in Ipswich, where there were 1866 live births in 2014. The chart below shows estimated trends in live births until 2024. These estimates should be treated with caution (ONS).

Observed numbers of live births 2005-14
 Projected numbers of live births 2015-24
 Residents of Suffolk County



Migration

Trends in births are affected by migration in addition to local fertility rates. Net migration is the difference between people leaving and entering an area (both internally and internationally). It is possible that migration will include women who will be of child-bearing age. This could lead to increased or reduced demand. Net increases in migration can lead to increased variability in cultural and language needs. ONS figures suggest there was a net outward migration of women of child-bearing age (15-49) in 2014.

Ethnicity of mother

Ethnicity can influence how women access services. For example, there may be cultural issues that influence how readily pregnant women and new mothers access services, and language barriers to overcome. The 2011 Census shows that 4.7% of Suffolk’s residents were from an ethnic group other than white, but there is considerable variation within Suffolk, and this proportion rises to 11% of the population in Ipswich.

Deprivation

Evidence suggests there are differences in access to healthcare services and treatment of conditions by levels of deprivation. The following table shows the proportion of births (live and stillbirths) in deprived households (relative to each-other) in Suffolk in 2014. It shows that more births occur in households which are more deprived than in households which are better off.



Deprivation quintile	Number of births	% Distribution of births
1 (most deprived)	1951	24.4%
2	1778	22.2%
3	1558	19.5%
4	1354	16.9%
5 (least deprived)	1352	16.9%
Suffolk	7993	100%

Data sources: Office of National Statistics 2014 (Public Health Birth File); English Indices of Deprivation 2015.

How common are perinatal mental health problems in Suffolk?

Estimates can be made for Suffolk based on numbers of maternities and evidence from research.

The table below gives estimated numbers of cases of perinatal psychiatric disorders in Suffolk County, based on the number of maternities in Suffolk County in 2014. The figures give an estimate for the level of need for mental health support and can be used in planning and reviewing services.

	Number of cases per 1000 maternities*/pregnancies**	Estimated number in Suffolk County per year (rounded)
Post-partum psychosis	1-2	9-16*
Chronic serious mental illness	2	18**
Severe postnatal depression	30	236*
Mild-moderate depression and/or anxiety +	150-200	1400-1871**
PTSD	30-60	236-471*

Source JCPMH and NICE†

Access to care and existing pathways

The first antenatal, or 'booking', appointment is very complex and detailed and includes review of pre-existing conditions which may affect the health of the pregnancy. The midwife also assigns the patient to a standard, intermediate or complex pathway and tariff. Patients with a history of mental health problems are assigned to the intermediate tariff and should be offered support through appropriate pathways. Data for Suffolk (excluding Waveney) in 2015-16 shows the majority of women (62%) are assigned to the standard antenatal pathway.

Each antenatal contact is a further opportunity for midwives, and other health professionals, to assess whether there are any mental health problems.

All pregnant women should access maternity services for a full health and social care assessment by 12 weeks and 6 days of their pregnancy.



Current perinatal mental health pathways in Suffolk

Currently there are no specific services or protocols in place for perinatal mental health in Suffolk, although a pilot has taken place in West Suffolk. All the generic mental health services would provide support through existing pathways.

GP services provide support for less severe mental health problems and the [Suffolk Wellbeing Service](#) provides psychological interventions. Health visitors and midwives refer to the relevant services for support. There are no specifications in place regarding specific thresholds or timing of assessments for pregnant or postnatal women.

Health visitors use the Edinburgh Postnatal Depression Score (EPDS) where applicable. Suffolk GPs use the Patient Health Questionnaire PHQ-9 for depression and the Generalised Anxiety Disorder scale (GAD7) for anxiety. There is not as yet a systematic process for identifying mental health problems at 'booking' although there are many instances of this happening and referrals continue.

What should perinatal mental health services look like?

Identifying mental health problems during pregnancy and post-partum

There are a number of opportunities for identifying mental health problems during pregnancy. National guidelines¹² are clear about how problems can be identified and managed. These guidelines have implications for both maternity and mental health services.⁶

All communications between professionals concerned with the care of a pregnant or post-natal woman should include reference to any known (past or present) mental health problem, and professionals should be aware that the range and prevalence of mental health problems in pregnancy and post-partum are under-recognised. However, health professionals should recognise that women may be reluctant to disclose mental health problems because of stigma or fears about the implications.

Two steps to take at first contact (often called 'booking') with maternity services

1. At booking appointment and during the early post-natal period, staff should ask two questions that may identify depression and two that may identify anxiety (the GAD-2):

During the past month, have you often been bothered by feeling down, depressed or hopeless?

During the past month, have you often been bothered by having little interest or pleasure in doing things?

If the answer to either of these is yes, the midwife/health visitor or other professional should consider asking further questions using either the Edinburgh Postnatal Depression Scale (EPDS) or the PHQ-9, with referral to GP or secondary mental health services as appropriate. Similar action should be taken if the woman scores above 3 on the GAD-2.



N.B. Guidance suggests these questions should be repeated later in and after the pregnancy by any professionals in contact with the woman, to help identify those women at higher risk postnatally and to encourage disclosure of any difficulties.

2. The midwife or other health professional should ask the woman about any past or current severe mental illness and/or treatment in secondary mental health services. They should also ask about any history of severe perinatal mental illness in the woman's mother, daughter or sister.

Treatment for women identified during pregnancy or postnatally with a mental health problem

- Pregnant women identified (for example at booking) as having a past or current severe mental health problem should be referred to secondary mental health services for assessment and treatment.
- Women referred during pregnancy or postnatally should receive assessment within 2 weeks of referral and psychological interventions within 1 month of the initial assessment.
- Women with symptoms suggesting post-partum psychosis should be referred to secondary mental health services (perinatal when possible) and receive assessment within 4 hours.
- Recommendations for treating depression, anxiety and other mental health problems (including severe mental health problems) during pregnancy are set out in ¹ [NICE Guidance 192 Section 8](#). They include the use of facilitated self-help for women with sub-threshold depression or anxiety, when to offer psychological interventions, and pro-active management of women with a previous history of severe depression.
- Guidance for mental health commissioners emphasises that pregnant women with moderate non-psychotic disorder may not meet the usual thresholds for adult services but should have a lower threshold of access because of the risk of serious disorder developing and the potential impact of this on both mother and baby.

Women at particular risk

- In addition to pro-active management and integrated care for women with previous or current mental health problems, services should be particularly mindful of the risk of mental health problems in women who have had a traumatic birth, who have had a miscarriage, still-birth or neo-natal death. Women should be offered support and advice.
- Women with PTSD following a traumatic birth should be offered high-intensity psychological interventions (trauma-focused CBT or EYMD) in line with NICE Guidance CG26 ⁷. However, they should NOT be offered single session 'reliving the experience' psychological interventions.

Treatment for women with previous known mental health problems

- Care for women with a pre-existing mental health problem who are pregnant, or seeking to become pregnant, should be pro-active.
- Pregnant women should have a co-ordinated integrated care plan that clearly sets out who is responsible for doing what. It should clearly identify how information will be shared



between professionals, what interventions will be provided, and monitor progress (including timely delivery of interventions) against agreed actions and outcomes.

- Mental health professionals should be aware that there are changes to the risk/benefit ratios for the use of psychotropic medication (used to treat mental health problems) during pregnancy and post-partum, including risks to both mother and baby from suddenly stopping anti-depressants (particularly paroxetine and venlafaxine).
- Women with child-bearing potential should NOT be given valproate for acute or long-term treatment.
- Women should NOT be offered benzodiazepines when pregnant, or postnatally, except for short-term treatment of severe anxiety and agitation.
- Women should receive advice from a specialist (preferably a specialist peri-natal mental health service) if there is any uncertainty about the risks of medication.
- As soon as they are medically stable after childbirth, women with a past or present severe mental illness should have a review/assessment for adjusting/restarting psychotropic medication.
- Women with a history of mental health problems should be encouraged to breastfeed, subject to assessing the risks due to any medication, and providing this is the method that most suits her and her family.
- Mental health professionals should be aware of the possible onset of severe symptoms in pregnancy and (particularly for women with bi-polar disorder) in the immediate weeks post birth.
- NICE Guidance CG192 (sections 3 and 4) ¹ includes for further recommendations on the use of anti-psychotic or anti-convulsant drugs, or lithium, and on co-ordinated care, and on medications during breastfeeding.

Organisational and Staffing implications from the guidelines

- There should be a clinical network (including service users, commissioners and managers) for perinatal mental health which provides a specialist multi-disciplinary maternity mental health service, leads on local care pathways, training and support of maternity and mental health, and which ensures access to expert advice.
- Maternity, health visiting and mental health professionals should receive training on how pregnancy and childbirth may affect mental health conditions and vice versa, and on local pathways.
- Pregnant/breastfeeding women with mental health problems should have access to specialist advice regarding prescribing of psychotropic medication.
- There should be clear referral and management protocols in place for seeking specialist advice and service pathways with clearly delineated roles, skill-sets and responsibilities for delivering co-ordinated care.
- Women needing in-patient care for a mental health problem within 1 year of giving birth should be admitted to a specialist mother and baby unit unless there are clear reasons for not doing so.



- Pregnant women with mild/moderate mental illness should have access to psychological interventions or secondary mental health services at or below the usual threshold, because of the high risk that problems can escalate rapidly.

Conclusions

Care in Suffolk is not formally organised according to recommended models. Psychological interventions are available through the Suffolk Wellbeing Service. GPs provide care and there is specialist input available for more serious cases of puerperal psychosis and severe mental illness.

However, given the rural nature of the county, the relatively low birth rate, and the requirement for a rapid response to psychotic or very severe illness, current services may be better placed to respond quickly than a regional specialist team.

Perinatal mental health has been identified as a priority area in the Suffolk Sustainability and Transformation Plan, with actions yet to be defined. Learning and business case material to inform a business case is available from a pilot (now ended) that was carried out in West Suffolk (by West Suffolk Foundation Trust and NSFT). Commissioners should consider prioritising the development of a perinatal mental health pathway, based on existing services including referral pathways for professional and patients, and identifying clinical networks for support and training. Providers of maternity and mental health services should check if their services are compliant with NICE Guidance 192.

Commissioners have requested Wellbeing services to assess how many pregnant women are accessing services currently and to ensure waiting times are within recommended limits.

It is recommended that the commissioners request that the mental health trust (Norfolk and Suffolk Foundation Trust) and maternity services (West Suffolk, Ipswich and James Paget hospitals) and health visiting services establish clear pathways for referral and integrated care management. This should include assessment of the use of the Identification Questions and appropriate onward referral by maternity services, provision of staff training, and access to Wellbeing or specialist services within the defined time-frames.

Case Studies

1. Extracted from Oates and Cantwell³

“A woman died from violent causes some weeks after delivery. Throughout her normal pregnancy she became increasingly anxious and, by the end of pregnancy, had bizarre delusional beliefs about her health. At no point was psychiatric referral considered. Following delivery, her mental state deteriorated, and she self-presented to the Emergency Department agitated and expressing bizarre beliefs about her health. Her symptoms were clearly documented at her psychiatric assessment but a diagnosis was made of an anxiety state. The community mental health team to whom she was referred declined to accept her. She died shortly afterwards”.



2. A mother's blog post describing her experience of post-natal depression (shortened), from Mind <http://www.mind.org.uk/information-support/your-stories/dealing-with-postnatal-depression/#.VysWJv72apo>

"It took me three weeks to start to feel a real connection with my son. It all came to a head when I was briefly hospitalised due to an injury and then my mood spiralled out of control. It felt like I had been running on a treadmill going faster and faster, but then all of a sudden, I just couldn't keep up any more and fell off.

I could no longer accept how I felt as 'normal' so I finally asked for help. Hearing the doctor say she thought I had postnatal depression was initially a shock, but it started to make sense. If my story connects with your experience, please don't carry on beating yourself up about it. Please talk to someone. You are not alone."

Sources

1. CG192 NICE guideline 20151112 Antenatal and postnatal mental health: clinical management and service guidance. 2015;(June).
2. *Guidance for Commissioners of Perinatal Mental Health Services.*; 2012.
3. Cantwell R, Clutton-Brock T, Cooper G, et al. Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer: 2006-2008. The Eighth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom. *Bjog*. 2011;118 Suppl(March):1-203. doi:10.1111/j.1471-0528.2010.02847.x.
4. Thomas H V., Dalman C, David AS, Gentz J, Lewis G, Allebeck P. Obstetric complications and risk of schizophrenia: Effect of gender, age at diagnosis and maternal history of psychosis. *Br J Psychiatry*. 2001;179(NOV.):409-414. doi:10.1192/bjp.179.5.409.
5. Stein A, Pearson RM, Goodman SH, et al. Effects of perinatal mental disorders on the fetus and child. *Lancet*. 2014;384(9956):1800-1819. doi:10.1016/S0140-6736(14)61277-0.
6. 2016 N. *Improving Perinatal Mental Health Practice across Services Through Training, Pathways, Resources, Consultation, Champions and Passion – but without Extra money* No Title. <https://www.nice.org.uk/sharedlearning/improving-perinatal-mental-health-practice-across-services-through-training-pathways-resources-consultation-champions-and-passion-%E2%80%93-but-without-extra-money>.
7. NICE. Post-traumatic stress disorder (PTSD) (CG26). NICE. 2005. <http://www.nice.org.uk/CG26>.



Further information

Dealing with post-natal depression. Mind, the mental health charity.

<http://www.mind.org.uk/information-support/types-of-mental-health-problems/postnatal-depression/#.Vyszv72apo>

The Association for Post Natal illness (APNI) <http://apni.org/>

Post-natal Depression and Puerperal psychosis: information, support and help for sufferers and their partners <http://puerperalpsychosis.org.uk/>

NICE Quality Standard QS115 Antenatal and postnatal mental health. Published February 2016

<https://www.nice.org.uk/guidance/qs115>

Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK.

<https://www.npeu.ox.ac.uk/mbrace-uk/reports>

Role and job summary for specialist mental health midwives. In Mental Health Midwives: What they do and why they matter Maternal Mental Health Alliance/NSPCC/Royal College of Midwives.

<https://www.rcm.org.uk/sites/default/files/MMHA%20SMHMs%20Nov%202013.pdf>

Information leaflet: Sheffield perinatal mental health service. Available at <http://shsc.nhs.uk/wp-content/uploads/2015/10/Perinatal-service-leaflet-27-August-2015.pdf>

Good practice example from St Georges Hospital, London(2009)

<http://www.dppi.org.uk/journal/66/goodpractice2.php>