City Research Online

City St George's, University of London

Citation: Ayers, S. & Shakespeare, J. (2015). Should perinatal mental health be everyone's business?. Primary Health Care Research and Development, 16(4), pp. 323-325. doi: 10.1017/s1463423615000298

This is the accepted version of the paper.

This version of the publication may differ from the final published version. To cite this item please consult the publisher's version.

Permanent repository link: https://openaccess.city.ac.uk/id/eprint/13691/

Link to published version: https://doi.org/10.1017/s1463423615000298

Copyright and Reuse: Copyright and Moral Rights remain with the author(s) and/or copyright holders. Copies of full items can be used for personal research or study, educational, or not-for-profit purposes without prior permission or charge, unless otherwise indicated, provided that the authors, title and full bibliographic details are credited, a hyperlink and/or URL is given for the original metadata page and the content is not changed in any way. For full details of reuse please refer to City Research Online policy.

City Research Online: http://openaccess.city.ac.uk/ publications@citystgeorges.ac.uk

Editorial for Primary Health Care Research and Development

Should perinatal mental health be everyone's business?

Susan Ayers[1] and Judy Shakespeare[2]

[1] Centre for Maternal and Child Health Research, City University London, London, UK

[2] Royal College of General Practitioners, London, UK

Word count: 1770 words

*Corresponding author: Susan Ayers

Centre for Maternal and Child Health Research, School of Health Sciences, City University London, Northampton Square, London, EC1V 0HB, UK. Telephone +44 (0)207 040 5834; Facsimile: +44 (0)207 040 5808; E-mail: Susan.Ayers@city.ac.uk

Although pregnancy and birth are a positive time for most women, between 10 and 20% of women suffer from mental health problems during this time. Mental health problems can arise in pregnancy or after birth and most commonly consist of anxiety, depression, post-traumatic stress disorder following a difficult birth and stress-related conditions such as adjustment disorder. Severe postnatal mental illness, such as puerperal psychosis, is less common but is one of the leading indirect causes of maternal death (MBRRACE, 2014). In the UK there has been increased awareness of the importance of perinatal mental health in recent years, which has prompted a demand for change in prioritisation and health services. In this editorial we consider some of the factors that contributed to this and the challenges we face if we are to implement change in primary care. In doing so, we do not provide an exhaustive list but focus on contributors that may be useful to consider. We also outline the argument for why perinatal mental health should be everyone's business.

A significant factor in increasing awareness of perinatal mental health in the UK was the formation of the Maternal Mental Health Alliance (MMHA). This has over 60 member organisations, including many associated with primary health care such as the Royal College of General Practice, Institute of Health Visiting, Royal College of Midwives, and NHS England. In 2014 the MMHA launched a campaign for perinatal mental health entitled 'Everyone's Business' which included a map of perinatal mental health services produced by the Royal College of Psychiatrists. This showed significant variation in services across the UK and that services are limited, with 40% of the UK having no specialist perinatal mental health provision (www.everyonesbusiness.org.uk). Where services do exist they ranged from one specialist mental health nurse or psychiatrist to complete specialist perinatal community teams and inpatient mother and baby units. However, full specialist community perinatal services are rare. This and other factors mean that approximately half of women with perinatal mental health problems are not identified or treated despite regular contact with maternity services (Baur, Parsonage, Knapp, Iemmi & Adelaja, 2014).

So why should perinatal mental health be everyone's business? The arguments for this are compelling. There is now substantial evidence that maternal mental health problems are associated with a variety of adverse outcomes for women and children. The impact on women and children varies according to the timing (pre- and/or postnatal) and type of mental illness, and there are still gaps in our knowledge but overall the evidence is convincing. In this issue Peter Cooper and colleagues outline the evidence that postnatal depression is associated with a poorer relationship between the mother and baby, and consequently with poor child development. Anxiety and PTSD in pregnancy are associated with increased risk of preterm birth (Ding, Wu, Xu, Zhu, Jia, Zhang, Huang, Zhu, Hao & Tao, 2014). For example, a study of 2,654 women in the USA found those with PTSD in pregnancy had a 2.5 greater risk of preterm birth (Yonkers, Smith, Forray, Epperson Costello, Lin, Belanger et al., 2014). There is also evidence that anxiety in pregnancy has an impact on the developing fetus. Studies of stress, anxiety and depression in pregnancy show these are associated with altered patterns of fetal behaviour and heart rate responses (Kinsella & Monk, 2009). Postnatal follow-up shows infants of women who are anxious are more likely to show fearful or anxious behaviour and more at risk of poor development and adverse outcomes such as ADHD (Talge, Neal &

Glover, 2007). Stress hormones and epigenetic mechanisms are thought to underlie the effect of women's emotional state in pregnancy on the developing baby (Wadhwa, 2005).

The economic argument is also compelling. A recent economic analysis estimated the cost to the UK society of not treating perinatal mental health problems is £8.1 billion per annual cohort of women giving birth. The majority of this cost (72%) was attributable to long term adverse consequences for the child. The direct cost to national health and social services was estimated as £1.2 billion. In contrast, the cost of providing perinatal mental health services to the standard specified by national guidelines is £0.28 billion (Baur et al 2014). From a public health perspective a strategy for preventing perinatal mental health problems and treating them effectively has the potential to prevent significant long-term burden of ill-health and problems in children. Evidence based guidelines are available that outline effective treatments for the mother (NICE 2014; SIGN 2012).

Politically, members of parliament have been critical in highlighting perinatal mental health as a national priority. An all-party parliamentary group (APPG) with representatives from all main political parties has looked at how to optimise the health of women and children from conception to age 2. This group made recommendations about the need to prioritise perinatal mental health and ensure services are available for women and families in their manifesto *1001 Critical Days* (2013) and later inquiry report *Building Great Britons* (2015). The UK government subsequently allocated £75 million to perinatal mental health in the 2015 budget.

A variety of factors also enable women with perinatal mental health problems to have influence. Social media enables women with perinatal mental health problems to lobby politicians and healthcare organisations directly. For example, Kathryn Grant who blogs about her experiences (www.bumpsandgrind.blogspot.co.uk) and Rosey Wren who runs a twitter support group (@PNDandme). Families of women who have died from perinatal mental illness are also active such as Lucie Holland's petition on behalf of her sister Emma; and Chris Bingley's campaign on behalf of his wife Joanna (www.joebingleymemorialfoundation.org.uk). Social media helps people join forces with each other and relevant organisations to raise awareness and become a frequent and powerful reminder of the need for services. At the same time it has become increasingly common for funders of health research in the UK to specify that research projects should involve members of the public and patients in all aspects of research - from setting the research question to conducting the study.

The evidence base, economic argument, political and social drivers have therefore combined to increase awareness in the UK of the importance of women's perinatal mental health and provide impetus for change. However, implementing change is complex and there are barriers. Primary care in the UK has a potential conflict of interest, as primary care practitioners act as commissioners of specialist services and they also provide a service for women in their practices. If they do not understand the importance of perinatal mental health for their patients they are unlikely to see the need for a specialist service. This is also a time of financial constraints to developing new services, although some new resources have been

made available. A key barrier in the UK is that perinatal mental health is not yet prioritised at a local level, with only 3% of clinical commissioning groups having a strategy for perinatal mental health (APPG, 2015). There is also little universal agreement on which types of services or pathways should be implemented, how they should be funded, structured or organised. This has led to different initiatives being implemented by public, private or third sector organisations; often with little evidence they are effective (Fontein-Kuipers, Nieuwenhuijze, Ausems, Bude & de Vries, 2014). Various recommendations for the types of services and the way they should be structured have been put forward (e.g. Royal College of Psychiatrists, 2001; APPG, 2015) but again evidence for the effectiveness of different approaches is limited (Glover, 2014).

Professional organisations are working to address this. The Royal College of General Practitioners made perinatal mental health a clinical priority with the aim of developing and implementing a strategy for perinatal mental health in primary care. The Institute of Health Visiting has trained perinatal mental health champions across the UK to raise awareness and expertise in nationwide public health services. A report commissioned by the Royal College of General Practitioners entitled *Falling Through the Gaps* identified a number of patient, physician and organisational barriers to identification and treatment of perinatal mental health problems (Khan, 2015). The biggest barrier was lack of identification of women with problems. Other barriers included lack of training for general practitioners (GPs) on perinatal mental health, GPs not feeling confident about managing perinatal mental health problems, time pressure, stigma preventing women asking for help, and women feeling dismissed or overly reassured by GPs when they did ask for help. When perinatal mental health problems were identified the treatment most commonly provided was pharmacotherapy, which may partly reflect the lack of specialist services for practitioners to refer onto (Khan, 2015). Research evidence on diagnosis and treatment of perinatal mental health problems in primary care is notably sparse and focuses almost entirely on postnatal depression. As primary care practitioners are often the first line of care for women with perinatal mental health problems more research is needed on how to effectively identify and treat women with perinatal mental health problems in this context.

In conclusion, this is an exciting time for perinatal mental health in the UK because of the increased momentum for change. However, we still have a long way to go in terms of effecting change. We need to be careful that we are not implementing change without evidence such change is effective. Research is needed on how to improve the identification and treatment of women with perinatal mental health problems in primary care and other services. It is important that policy makers, commissioners, researchers, clinicians and women and families who have experienced perinatal mental illness continue to work together to ensure appropriate and effective care pathways and services are provided.

References

All-Party Parliamentary Group for Conception to Age 2 (2015). Building Great Britons. http://www.1001criticaldays.co.uk/buildinggreatbritonsreport.pdf

All-Party Parliamentary Group for Conception to Age 2 (2013). The 1001 Critical Days: the importance of the conception to age two period. http://www.1001criticaldays.co.uk/UserFiles/files/1001_days_jan28_15_final.pdf

Bauer A, Parsonage M, Knapp M, Iemmi V & Adelaja B. (2014). Costs of Perinatal Mental Health Problems. The costs of perinatal mental health problems. London: Centre for Mental Health.

Ding XX, Wu YL, Xu SJ, Zhu RP, Jia XM, Zhang SF, Huang K, Zhu P, Hao JH, Tao FB. (2014). Maternal anxiety during pregnancy and adverse birth outcomes: a systematic review and meta-analysis of prospective cohort studies. Journal of Affective Disorders, 159:103-110.

Fontein-Kuipers YJ, Nieuwenhuijze MJ, Ausems M, Bude L & de Vries R. (2014). Antenatal interventions to reduce maternal distress: a systematic review and meta-analysis of randomised trials. British Journal of Obstetrics and Gynaecology, 121, 389 – 397.

Glover V. (2014). Maternal depression, anxiety and stress during pregnancy and child outcome; what needs to be done. Best Practice and Research Clinical Obstetrics and Gynaecology, 28(1):25-35.

Khan L. (2015). Falling through the gaps: Perinatal mental health and general practice. Royal College of General Practitioners and Centre for Mental Health. London.

Kinsella MT, Monk C. (2009). Impact of maternal stress, depression and anxiety on fetal neurobehavioral development. Clinical Obstetrics and Gynecology, 52(3), 425-440.

Knight M, Kenyon S, Brocklehurst P, Neilson J, Shakespeare J, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care - Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–12. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2014.

National Institute for Clinical Excellence (2014). Antenatal and postnatal mental health: clinical management and service guidance (CG192). Available at: http://www.nice.org.uk/guidance/cg192/evidence/cg192-antenatal-and-postnatal-mental-health-full-guideline3

Royal College of Psychiatrists (2001). CR88. Perinatal Mental Health Services. Recommendations for Provision of Services for Childbearing Women. Royal College of Psychiatrists. London.

Scottish Intercollegiate Guidelines Network (SIGN) **(2012)**. Management of perinatal mood disorders. Edinburgh: SIGN; 2012. (SIGN publication no. 127). Available from:

http://www.sign.ac.uk/guidelines/fulltext/127/

Talge NM, Neal C, Glover V. (2007). Antenatal maternal stress and long-term effects on child neurodevelopment: how and why? Journal of Child Psychology and Psychiatry, 48(3-4):245-261.

Yonkers KA, Smith MV, Forray A, Epperson CN, Costello D, Lin H, Belanger K. (2014). Pregnant women with posttraumatic stress disorder and risk of preterm birth. JAMA Psychiatry, 71(8):897-904. doi: 10.1001/jamapsychiatry.2014.558.

Wadhwa PD. (2005). Psychoneuroendocrine processes in human pregnancy influence fetal development and health. Psychoneuroendocrinology, 30(8):724-43.