GP Perinatal Tips

Below is a summary of guidance that has been provided by Dr Stephanie de Giorgio, GP lead Perinatal Mental health, Kent & Medway and NHSE

1. Recognise the most common perinatal mental health disorders

Women can present in many ways, for example, with symptoms of depression, anxiety (which is possibly more common than depression antenatally[3]), insomnia, obsessive compulsive disorder, PTSD and Birth Trauma. The timing, severity, and pervasiveness of these symptoms will help to distinguish what is related to normal pregnancy or postnatal worries, and what is pathological.

2. Know which women are most at risk

All women are at risk of perinatal mental illness, but some are at increased risk, including:

- women with (or with a family history of) bipolar disorder or schizophrenia
- women with previous perinatal mental illness
- women experiencing domestic abuse, social isolation, or unplanned pregnancy.

Women with bipolar disorder and previous significant perinatal mental illness should be referred antenatally, even if well, to ensure a good plan can be put in place.[2,4] Ideally, all women of reproductive age with mental health problems should be counselled on what to do if they become pregnant, and to seek advice pre-conceptually or early in pregnancy—in the same way as would be done for a woman with diabetes or epilepsy.

Although not in the remit of this article, remember that men can experience perinatal mental health problems and are at increased risk if their partner has been diagnosed with a perinatal mental illness.[1,4]

3. Be aware of societal expectations

Don’t presume that the patient and her partner are enjoying the experience of parenthood when you meet them, and avoid normalising problems a woman may be having through statements such as ‘all new mothers are tired’.

The difficulties and realities of parenthood are often not discussed openly, and women may be reluctant to admit that they are finding things hard. This may be especially true of women from cultures where mental health problems are not discussed. Multigenerational living, migration status, and maternal isolation in the home may also increase the risk of perinatal mental health problems.[5,6]

4. Remember that appearances can be deceptive

Most mothers will attempt to hide their distress at postnatal appointments for fear of judgment or having their baby taken away[1]. Make-up, a beautifully dressed baby, and a smiling mother do not mean that a woman is not experiencing significant mental health problems.

5. Ask the right questions

Use every contact with a woman during pregnancy and post-natally to find out how she is managing.[1] Although screening and detection tools (such as the Edinburgh Postnatal Depression Scale, Whooley Questions, and the 7-item Generalized Anxiety Disorder scale) can be used as an aid to diagnosis,[4,7] women report that the best way of finding out how they are doing is for GPs to ask the right questions, provide reassurance that they are being taken seriously, and really listen to the answers.[1] Perhaps consider asking:

- 'How are you finding being a mum (again)?'
- 'Tell me about the birth.'

Asking both of these questions, focusing entirely on the mother and her verbal and non-verbal responses (such as pauses, looking away, and becoming tearful)[8] encourages disclosure and facilitates the start of a therapeutic relationship.

Where postnatal checks are still offered,[1] invite the mother to come to an appointment by herself separate to the baby check, use the tools and questions above, and look to see whether she comes alone or with her partner. A partner attending can be a sign of a supportive relationship, but as the incidence of domestic abuse increases during pregnancy, it is important to be sure that their presence isn't due to controlling behaviour.[1,8]

6. Always act on red flags

Bipolar disorder is a red flag.[8]

A woman disclosing that she thinks she has postnatal or antenatal mental health symptoms is a red flag and her concerns must be taken seriously.[8]

Likewise, a partner disclosing fears about his or her partner's mental health in the antenatal or postnatal period must be acted upon.

7. Be alert to postpartum psychosis

Postpartum psychosis is a psychiatric emergency. It comes on rapidly in the first hours to 2 weeks post-partum, with psychotic features of delusions, hallucinations, and mania, often focused on the baby. Mothers presenting with these features need to be seen by secondary care mental health services (preferably a specialist

perinatal mental health service) within 4 hours.[7] Not all areas have specialist perinatal psychiatry services, so the on-call psychiatric team for the area or the emergency department may be necessary if specialist services are not available. Although postpartum psychosis is more common in women with a history of bipolar disorder, 50% of women who experience postpartum psychosis have no history that suggests they are at high risk of developing it.[9]

If you think a woman has PP, do not leave her alone unless with a trusted family member or friend and ensure safe transport to hospital, which may necessitate an ambulance. These women can deteriorate extremely quickly.

8. Consider non-pharmacological treatments

For mild-to-moderate depression, NICE Clinical Guideline (CG) 192 recommends facilitated self-help;[7] however, it may also be very appropriate to initiate talking therapies at this level of illness to facilitate recovery as self-help can be hard for the patient to do if they are feeling unwell. Specialist and timely talking therapies can be difficult to access, so if women are showing significant symptoms or worsening quickly, it may be necessary to consider pharmacological therapy sooner rather than later.

Making use of peer support groups, both face-to-face and online, voluntary sector groups, and the patient's own network of social support should also be encouraged.[10]

9. Offer medication

Consider medication for those with moderate-to-severe depression or those presenting with mild depression or anxiety who have worsened significantly in previous pregnancies or at other times.[7]Using medication in pregnancy and post-natally can feel daunting for a non-experienced prescriber but can be life-saving and life-changing.

- Abrupt withdrawal causes problems. If a woman presents when newly pregnant on medication, do not stop the medication until specialist advice has been sought. It may be better not to stop it, as seven out of 10 women will relapse if medication is stopped[12] . Some women are being seen in specialist clinics who may not need to have been had their medication been continued by their GP.
- The potential risks to the foetus, such as congenital abnormalities and autism, are far from clear and must be balanced against the risk of not treating[13] The risks of not treating an unwell mother, in terms of harm to the fetus, are often greater than the risks of treating.
- Intention to breastfeed or current breastfeeding should be discussed. Breastfeeding is not a barrier to treatment but may influence the choice of medication used.

NICE CG192 recommends that the woman and her family are given information about pharmacological treatment that considers:[7]

- the potential benefits of psychological interventions and psychotropic medication
- the possible consequences of no treatment
- the possible harms associated with treatment
- what might happen if treatment is changed or stopped, particularly if psychotropic medication is stopped abruptly.

The following NICE CG192 framework is recommended when using psychotropic medication in pregnancy:[7]

- choose the drug with the lowest risk profile for the woman, foetus, 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, foetus, and baby may be dose-related), but note that sub-therapeutic doses may also expose the foetus to risks and not treat the mental health problem effectively
- use a single drug, if possible, in preference to two or more drugs.

The antidepressants most commonly prescribed by GPs are selective serotonin reuptake inhibitors, serotonin–norepinephrine reuptake inhibitors, and tricyclics. Sertraline, Citalopram and Fluoxetine are all commonly prescribed. All are **unlicensed** for use in pregnancy so it can be difficult to recommend which ones to use. For the unlicensed use of a medicine, the prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's *Good practice in prescribing and managing medicines and devices* for further information.[11]

10. Consider the psychological effects of pregnancy loss

Miscarriage and stillbirth are particular risk factors for perinatal mental health problems. Ensure that women who have been through pregnancy loss are sensitively asked about their mental health in a timely fashion. It is also important to consider their mental health if they go on to have a subsequent pregnancy.

Resources relating to treatment in pregnancy and breastfeeding

UK Teratology Information Service
The UK Teratology Information Service (UKTIS) provides a national service on all aspects of the toxicity of drugs and chemicals in pregnancy.

Best use of medicines in pregnancy (BUMPS)
Provides information for patients about drug use in the perinatal time.

LactMed
US-based website about medication in breastfeeding.

UK Drugs in Lactation Advisory Service (UKDILAS)
Provides evidence-based information on the use of drugs during the breastfeeding period.

The Breastfeeding Network
An independent source of support and information for breastfeeding women and others. Research regarding the relationship between breastfeeding and postnatal depression has failed to come to any definite conclusions[14]. Successful breastfeeding may be protective against developing postnatal depression, but failing to establish effective breastfeeding when a woman has intended to breastfeed may increase the risk of developing postnatal depression. It is important to keep this in mind when advising women on breast and formula feeding as it is a highly emotive topic and women need support with their choice of feeding method.
Mood stabilisers and antipsychotic medication are the realm of secondary and tertiary care prescribing for the perinatal period.[15]

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