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Centre for Mental Health

Review of the National Childbirth Trust *Hidden Half* report and GP consultation

Executive summary

The National Childbirth Trust (NCT) report *The Hidden Half: bringing postnatal mental illness out of hiding* found that up to half of women experiencing mental health difficulties during pregnancy and in the year after did not have their needs recognised by health professionals. It called for GPs to be resourced to ensure they make use of the mandatory six-week check-up to enquire about a mother's wellbeing as well as the health of their baby.

The cost of perinatal mental health problems is estimated at £8.1 billion a year in the UK. At least half of women with mental health problems at this time do not receive any help for them. For many women, this leads to problems escalating to the point of a distressing and costly crisis.

Centre for Mental Health was commissioned by NCT to review the cost of providing a GP check-up appointment dedicated to the mother's wellbeing throughout England and to assess the feasibility and implications of taking this step.

We estimate that to ensure all new mothers received a 10-minute check-up in addition to a similar appointment for their baby would cost in the region of £27.74 million per annum. This is based on appointments for 693,600 women at a cost of £40 per ten minutes of patient contact.

To make the most of this opportunity, GPs need the resources to offer enough time for a full appointment to discuss the mother's wellbeing as well as training and a template to guide them through the session.

We spoke with GPs who are currently providing new mothers with dedicated six-week postnatal check-ups. They provided important insights into how to make the check-up as effective as possible, including:

- The importance of either having a separate appointment for the mother's wellbeing or of offering a double (20-minute) appointment for both mother and baby, and starting with the mother's needs;
- The need to create a safe environment and to ask open questions to enable women to talk about how they are feeling;
- The need to validate women's emotions and experiences and emphasise that mental health difficulties are common, and that help is available.

We recommend that GPs should be incentivised and supported to provide all women with a six-week post-birth health check for themselves as well as one for their baby. Having an automated system for sending out an appointment for the maternal check (and possibly also the baby's) would also help.

Introduction

Diagnosable mental health problems affect up to 20% of women at some point during pregnancy and/or during the first year after birth. And around half of women experience emotional problems during that time (NCT, 2017). Poor mental health during pregnancy and after birth covers a range of conditions ranging from mild to moderate anxiety and depression to more severe mental illness, such as bipolar disorder, post-traumatic stress disorder and postpartum psychosis. Left untreated, perinatal mental health problems have serious potential implications and are now the biggest cause of maternal death in this country (Knight *et al.*, 2014).

Research has demonstrated how poor perinatal mental health causes significant distress to mothers and partners, negatively impacting family relationships (Chew-Graham *et al.*, 2008). It can also be doubly damaging: as well as affecting the mother, it may also compromise the cognitive, emotional, social, educational, physical and behavioural development of the child (Khan, 2015).

Despite the serious implications of poor perinatal mental health, only half of mothers meeting diagnostic thresholds for perinatal depression and anxiety are identified (Ramsay, 1993). And 42% of women with an emotional or mental health problem recently reported that their need was not picked up by the health professionals they encountered (NCT, 2017). Women frequently come into contact with NHS health services during this period, but mental health problems often go undetected (Khan, 2015). This review will look at the costings provided by the National Childbirth Trust's *Hidden Half* report of resourcing for GPs to routinely carry out a postnatal six-week check-up to focus on the mother's health alongside the existing appointment for the baby. It will then explore the perceptions of GPs as to what creates an effective check-up that enables mothers to open up about how they are feeling and coping and to access support. It will finally provide examples, based on literature and the interviews, that might help GPs to use this check-up to better support maternal mental health.

Part one: Rapid evidence and economic review

What are the predicted benefits of adding a requirement for GPs to give every mother a separate appointment for the six-week postnatal check as proposed in the *Hidden Half* report?

What is the cost of unmet need?

Bauer et al. (2014) reported the findings of a project on the costs of mental health problems during the perinatal period. The report found that perinatal depression, anxiety and psychosis carry a total long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK. Nearly three quarters of this cost relates to adverse impacts on the child rather than the mother. Over a fifth of total costs (£1.7 billion) are borne by the public sector, primarily relating to the NHS and social services (£1.2 billion).

The average cost to society of one case of perinatal depression is around £74,000, of which £23,000 relates to the mother and £51,000 relates to impacts on the child. Perinatal anxiety (when it exists alone) costs approximately £35,000 per case, of which £21,000 relates to the mother and £14,000 to the child (Bauer *et al.*, 2014). Perinatal psychosis is estimated to cost around £35,000 per case, but due to the lack of evidence around the impact on the child, it is likely to cost more. Given the significant financial costs of not treating perinatal mental illness, not to mention the social costs which are much harder to

quantify, it is crucial to implement interventions which support a mother's mental health.

Other benefits

Early identification of need will in some cases avoid escalation of conditions, resulting in reduced severity and management without expensive secondary care interventions, reducing treatment costs. However, this is an assumption (albeit a likely reasonable one) that requires testing and further research.

What is the cost of adding a requirement for GPs to give every mother a separate appointment for the six-week postnatal check?

Direct Costs

NCT's *Hidden Half* report recommends that GPs are allocated resources to routinely carry out a postnatal maternal six-week check-up focused on the mother, in addition to the current mandatory checks on the baby, to lead to better identification and support of maternal mental health difficulties. At present, the six-week check-up is typically a ten-minute appointment at which the mother's health is included alongside the baby's. It is important to note that the time allotted to GPs for the six-week check-up varies enormously between practices: eight minutes was the minimum amount of time taken, as reported by GPs in interviews conducted for this review, all of whom had a special interest in perinatal mental health. One GP reported that check-ups lasted up to 30 minutes in some cases (seeing both mother and baby) or 10-15 minutes (seeing only mother) but this is likely to be highly unusual. Indeed, evidence was presented in *Hidden Half* that many GPs took considerably less than 10 minutes for these appointments and some did not enquire about the mother's health at all. It is therefore important to consider that GPs could benefit from a double timeslot of at least 20 minutes for this appointment.

The cost of providing an extra ten minutes of consultation – presuming every GP would be paid for delivering this additional time whether they offer it already or not – is £27.74 million per annum. This is based on appointments for 693,600 women at a cost of £40 per ten minutes of patient contact. This is higher than the figure quoted in the *Hidden Half* report, because:

- The PSSRU cost calculation of a ten-minute consultation is £10 greater than the Hidden Half, at an estimated £30.
- Calculations using ONS data estimate 33,600 more women giving birth in 2016 than the Hidden Half 660,000 estimate.

This still represents a low-cost intervention and one that would benefit nearly 1.4 million people (both mothers and their babies).

Indirect Costs

Increased identification of need via the six-week check-up may result in more women accessing psychological therapy and specialist perinatal mental health services, which may increase costs in the short term. However, the provision of earlier help may bring about reductions in the need for more costly care for women whose difficulties escalate into a crisis, as well as averting the far higher long-term costs of unmet need.

Further research questions

It is important to note that increased identification of need via the six-week check-up may result in more women accessing psychological therapy and specialist perinatal mental health services, which may increase costs in the immediate short-term. However, if early identification of need can steer women away from expensive secondary care interventions once problems have escalated, this will incur substantial savings that are worth aiming for in light of the £8.1 billion estimate outlined above.

A useful avenue of further research would therefore be to track the health outcomes of women according to the length of postnatal appointment offered and whether this has a statistically significant impact on their mental health and associated service use. It would also be important to identify other opportunities earlier in the perinatal period (particularly

during pregnancy) to identify emerging mental health difficulties as well as the six-week postnatal check-up. Evidence from longitudinal studies such as the Avon Longitudinal Study of Parents and Children, which has been tracking children in the Avon area since the early 1990s, has found that maternal depression and anxiety are just as common during pregnancy as after and that most cases develop during pregnancy. Bauer *et al.* (2014) argue that if most cases of perinatal depression and anxiety are present during pregnancy, the main focus of efforts to detect and treat need should be in the antenatal period. This sits in contrast to most evidence that emphasises the postnatal period. There are other important factors, which strengthen the case for earlier attention, such as evidence from neuroscience demonstrating the impact of maternal stress on the developing brain (Bauer *et al.*, 2014).

Part two: GP consultation

Interviews took place with six GPs, most from urban areas, but with two serving rural populations. These interviews explored what approaches GPs take to enable mothers to open up about how they are feeling. This included exploring the types of questions they asked as well as factors to bear in mind during the consultation (e.g. perceived stigma, body language, physical appearance). The interviews also explored what made it difficult for GPs to use the six-week check-up to explore mental health, as well as what would support GPs to better use this time. All GPs emphasised the importance of creating an environment where mothers felt safe and validated, not judged, and highlighted how they did this. The findings of these interviews complement key themes in existing literature on perinatal mental health and the role of GPs in securing effective help (e.g. Khan, 2015).

Creating a relaxed environment

GPs highlighted how difficult it was for mothers to disclose how they were feeling because of stigma, fear of judgment, and the significant guilt and shame they felt, as well as worrying about their baby being taken away. Therefore, it was crucial to create a safe and relaxed environment, where they felt comfortable to talk.

> *"Mothers don't want to say they're not coping, [they] see it as a safeguarding issue and a failure on their part to say they're not coping..."*

> *"Disclosure of a problem is a massive deal and you need to be able to facilitate it by creating an environment where it's okay..."*

GPs discussed what made a safe environment for mothers to talk about any difficulties, highlighting the importance of asking open questions in a non-judgmental and empathetic way, reassuring and normalising their experiences, making time to talk, separating out the baby's and mother's time, and having a relationship with their GP.

Open conversations

GPs discussed the importance of open questions, holding in mind the stigma associated with being a mother with a mental health difficulty. GPs highlighted the importance of being genuinely empathetic, non-judgmental and listening to what the mother was saying. Questions about concrete, practical events (e.g. the birth, getting to the appointment) were perceived to enable conversations about how the mother was feeling and experiencing motherhood. GPs gave examples of open questions they used to help the mother feel comfortable:

> *"Often the appointment will be in the morning, so I'd ask something like how did you find getting everything together this morning? And then really listening to the answer, so maybe she'll say it was fine or perhaps she'll say it was hard and the floodgates will open... and then you need to be reassuring, so I might say*

something like 'I found it really hard too', a way of making it normal but also validating it…"

"I'll start with an open question, like how are you finding being a mum? And they either are finding it fine and will say so, or it'll be followed by a sigh or floods of tears… not how are you feeling? People don't want to talk about how they're feeling because they feel guilty and like they're failing because they're not coping. But when you ask an open question about activities you're giving the mother permission to tell you what they want to tell you…"

"I ask: "how are you finding being a mum?" ("again" if it's a second or third baby). When I'm asking them I'm looking at them, smiling, being empathetic. They might be fine or this might open the floodgates, you need to really listen to the answers and read their body language. Answers like 'fine', which are short and reserved, may mean you need to ask another question… for example, tell me about the birth, everyone has a story about their birth, whilst they're talking you're listening to how they tell their story, what it says about their thought processes…"

Clinical language

GPs discussed that some of the assessment tools used to assess mental health could close down conversations and that it was easy for mothers to be dishonest or give one-worded answers. They suggested that the questions were not a natural way of asking questions and for a mother who is already feeling ashamed, they risked further stigmatising her. One GP discussed how patients come with preconceived stigma about mental health and motherhood and how the terminology can further stigmatise:

"Assessment tools that use terms like down, depressed, hopeless; it's not a natural way of talking and it feels clinical even though it's not necessarily clinical terms… and that language can be stigmatising…"

Reassuring and validating experiences

GPs highlighted the importance of normalising women's experiences and reassuring women that the problems they are experiencing were not "weird or unusual". Women experienced pressure to live up to ideals of motherhood, e.g. breastfeeding and having a home delivery, which could be reinforced by healthcare professionals. Some mothers felt a sense of failure if they had not had the "perfect birth or experience" and it was important to reassure mothers that everybody experiences difficulties and they are not failing:

"There's too much judgement about breastfeeding and instrumental delivery. As long as a baby is loved and fed it's okay. Lots of women are 30+ having babies so it's unlikely to be perfect…"

GPs emphasised the importance of discussing with mothers that having a baby is a difficult transition, which nothing can prepare them for, and that lots of women experience poor mental health and wellbeing during this time:

"You need gentle conversational language, phrases that normalise and reassure, that other people go through this and it isn't unusual or weird…"

"I tell mothers they're not a failure, nothing prepares you for being a parent and it's really hard. It's incredibly common to go through these difficulties…"

GPs discussed the importance of normalising experiences but to avoid doing so in a way which feels dismissive or minimising (e.g. "everyone feels tired after having a baby"). They emphasised that it was important that a mother's experience was validated ("that sounds really difficult") and reassured ("it's not unusual, lots of women feel like that, or get strange thoughts at this time").

Appointment set up and time

GPs told us how much the postnatal six-week appointment varied across practices, from a phone call, a short appointment for mother and baby or a separate appointment for both. We were told of appointment times varying across their own practices between eight and 30 minutes for mother and baby combined. GPs suggested that a double appointment (15-20 minutes), which could focus on just the mother (or the mother first) was optimal. GPs

highlighted how it was easy to focus on the baby's health and how mothers, particularly if anxious, were likely be preoccupied with their child. Therefore, having two separate appointments was perceived to be helpful. GPs highlighted the preference for separate appointments but noted that this created childcare problems. At some practices they booked a 15-20-minute appointment for the mother and then looked at the baby afterwards.

> *"It'd be great to have mother on her own, but this proves difficult with the baby care so it's together. But I'll chat to the mother first; 'we'll see to little xx in a moment, but first how are you doing?'..."*

Relationships

Finally, GPs highlighted how many of their patients had been in the practice for a long time and had built trust and a relationship with the GP. Many of the women had seen the same GP throughout their pregnancy and some had been at the practice for several years. Having a trusting relationship with the GP was perceived to be helpful in enabling mothers to discuss any difficulties they were experiencing.

Considerations during the consultation

GPs all highlighted key considerations that would be helpful for healthcare professionals to bear in mind when having any check up with the mother.

GPs discussed the importance of noticing how the mother and baby were on arrival and during the appointment. For example, one GP discussed watching out for how organised the mother looked, whether the child was well kempt, whether the mother appeared flustered. They discussed how they sensitively asked "who's looking after you?" and gently enquired about their eating, sleeping and washing. Another GP commented that a mother can make lots of effort (e.g. baby well turned out, well dressed) despite struggling underneath and thus warned against making any assumptions.

GPs tried to find out who was in the mother's social network and whether they felt able to seek support from those around them. This included finding out who was helping to look after them and any existing children, discussing local support groups and online forums as well as who was in their phonebook, and encouraging them to make use of these.

Challenges for GPs

Time

The main pressure highlighted by GPs was the extreme time pressure they faced in managing their workload. This created pressures for GPs in giving the six-week postnatal check-up the time it needed: "you just have to make time". GPs discussed that often they were running late, stressed and hurried, presenting challenges to effectively carrying out the postnatal six-week check-up. There were concerns that under such time pressures some GPs may shorten or not schedule check-ups:

> *"There's a lack of knowledge to the damage that can be caused by postnatal depression and because of the time and money, the postnatal check can be the thing that gets ditched..."*

GPs discussed booking double appointments for the postnatal check well in advance to ensure that sufficient time was given.

What would support this process?

Collaborative approach

All GPs highlighted the need for a collaborative approach among perinatal healthcare professionals (i.e. GP, health visitor and midwife) to supporting mental health. This included recognising how recommendations around breastfeeding could put unhelpful pressure and shame on mothers who were struggling. GPs had different ideas about how health care professionals could work together to support a mother's mental health, but most were positive about the benefits of multidisciplinary teams. One GP said it would be helpful if health visitors could weigh the

baby at the six week-check up as this would free up 5-7 minutes' time for GPs to check in with the mother. Another GP suggested that health visitors could complete a simple wellbeing measure with mothers in order to flag any concerns before the GP appointment, but it is important to ensure that this doesn't lead to a tick-box style of questioning.

Healthcare professionals' understanding of perinatal mental health

There were mixed views about whether GPs were adequately equipped to identify and support perinatal mental health. All interviewees felt that GPs had sufficient clinical training and skill to be able to ask open questions in a consultation and had lots of experience of patients coming in with mental health difficulties. Some interviewees felt that GP trainees could do with a better understanding of perinatal mental health, particularly signs, symptoms and different mental health conditions. GPs pointed out that new mothers were a group who experienced significant stigma and may be trying to hide how they were feeling, and that it thus may be difficult to recognise potential signs of distress. One GP suggested having short, to-the-point information on perinatal mental health conditions as part of the online education and continuing professional development that GPs are required to do.

Raising awareness among mothers and families

GPs highlighted that mothers would often have unrealistic expectations of motherhood and were not aware of how tough it could be. They commented that healthcare professionals and antenatal classes spoke with mothers and partners about some of the difficulties mothers face with the intention of reassuring them if they started to feel down, anxious or unwell:

> *"What would support GPs is mother education in antenatal classes. There could be more discussion that it's not all rosy… 1 in 10 mums experience postnatal depression and there's not enough awareness amongst mothers. So to discuss the importance of speaking to a GP or health visitor if you're not doing ok, that problems do happen and you're not alone, speak to someone…"*

Awareness of local groups

One GP discussed that it would be useful to have an up-to-date list of local groups visible in the practice waiting room, so that they could signpost mothers and let them know what was available locally. As voluntary and community groups change over time, GPs advised that it would need to be someone's responsibility to keep the information up-to-date.

Guidance around the six-week postnatal check up

Finally, GPs discussed that it might be helpful to provide GPs with a loose template that they could keep in mind when having a six-week check up with a mother. This could include a section on perinatal mental health conditions, signs to look for as well as examples of open questions to enable conversations with the mother. We have provided some pointers for such a template in the appendix of this report.

Part three: Conclusions and implications

There is a wealth of evidence pointing to the need to improve early detection of perinatal mental health difficulties and to refer women to effective help quickly when problems are detected. The six-week post-birth health check is an important (and in some cases unique) opportunity for GPs to enquire about a new mother's wellbeing and identify mental health difficulties at this time. For those with difficulties that have not been identified, it can be a crucial 'safety net'. It is vital that other opportunities, including during pregnancy, are also taken to raise awareness, reduce stigma, pick up issues early and ensure effective help is offered quickly.

We estimate that the additional cost to the NHS of ensuring that all women get an appointment for their own wellbeing as well as for their baby's health six weeks after they have given birth would be in the region of £27.74 million a year in England. This could bring about significant health benefits both immediately and in the long term. To realise these benefits, it will be necessary to ensure GPs have not just the time to devote to this appointment but the knowledge and skill to have an effective consultation.

Drawing on the GP consultation and existing examples of consultation models, we have developed a table with recommendations of what a six-week check-up could look like (see appendix), which would support GPs to have open conversations with mothers about their mental health and wellbeing.

Recommendation

GPs should be incentivised and supported to provide all women with a six-week post-birth health check for themselves as well as one for their baby. Support should include the provision of training, advice and guidance on how to conduct an effective health check focusing on the mother's wellbeing. This should be in addition to other efforts throughout the perinatal period to create opportunities to talk about mental health and disclose any difficulties. Automating the sending out of an appointment for a baby at six weeks and also an appointment for the mother will likely help this process.

Appendix

Section one: Mental health conditions

(Brief information on different perinatal mental health conditions and links to useful sources of information)

Section two: Signs and symptoms to look for

E.g.:

Anxiety

Fatigue

Insomnia

Suicidal thoughts

Physical appearance

Worrying about child (i.e. does the mother keep coming with different concerns relating to the child?)

Section three: Examples of open questions to enable conversations about mental health and wellbeing

How are you finding being a Mum (again – if already has children)?

How was it getting everything together this morning?

Tell me about the birth?

Who's looking after you?

Section four: Consultation tone and style

Separate out time to enquire about the mother's health – ideally before talking about the baby

Create a safe environment to make it easier to talk about wellbeing without fear

Discuss with mothers that having a baby is a difficult transition, which nothing can prepare them for and lots of women experience poor mental health and wellbeing during this time

Read their body language and really listen to their answers – if necessary ask again if they say they are 'okay' or 'fine'

Show you have listened to their answers and offer reassurance that what they are saying is valid and not unusual

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