Working with Primary Care: How to maximise care of the woman and her infant

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What they do and why they matter

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Saving Lives, Improving Mothers’ Care
Surveillance of maternal deaths in the UK 2011-13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13

December 2015
What is primary care?
Primary care Team - perinatal

- Midwife
- Maternity support workers
- GP
- Practice nurse/Phlebotomist
- IAPT
- Health visitor

Add receptionist!
Maternity services should ensure smooth transition between midwife, obstetric and neonatal care, and ongoing care in the community from their GP and health visitor.

National Maternity Review 2016
Learning Point

Communication

“There is a clear duty on all health professionals to pass on relevant information which may affect the care a woman receives during pregnancy or alter her outcomes.”

“GPs should inform maternity services of any past psychiatric history and maternity services should ensure that the GP is made aware of a woman’s pregnancy and enquire of the GP about past psychiatric history.”

“If the woman is already known to mental health services, they should be made aware that she is pregnant, and they have the same duty of care to the woman to inform maternity services of any risk she faces.”

NB: Links with private healthcare
The six week appointment by GPs “a particularly crucial element of post-natal care” (not funded)

Women need to be clear what the appointment will cover and it should happen at a different time from the baby’s check.

The check should include:

• The transition to motherhood, including her mental health;
• Recovery from the birth, using direct questions about common morbidities;
• Longer term health risks for any morbidity identified;
• Any further help whether or not connected with the birth;
• Advice about future family planning.
• Nothing about the baby

National maternity review 2106
Health Child Programme –
Child health surveillance – 6-8 week physical check

• cardiac;
• developmental dysplasia of the hips;
• eyes;
• testes (boys);
• general examination; and
• matters of concern to parents

• *Nothing about bonding, attachment*
Perinatal mental health – burden of care on primary care

Average practice: 10k patients
120 deliveries/year

15-20 postnatal depression
  4-5 receive anti-depressants
  1-2 referrals to psychiatry
One case perinatal psychosis/10 years
  All referred
3 cases in my experience (30 years)
What do you think is the role of the GP in perinatal mental health?

• As a provider
• As a commissioner
The perinatal journey

Stage 1: Prepregnancy planning
Stage 2: First trimester
Stage 3: Second trimester
Stage 4: Third trimester
Stage 5: Birth of child
Stage 6: Postnatal
Stage 7: Future family planning

Miscarriage or termination
Birth of child
Family complete
Actions for every practice

• Consider having a GP lead for maternity and maternal mental health in every practice
• Ensure community midwives can access information about the medical history of all pregnant women
• Hold regular meetings with attached midwife and health visitor to discuss possible mental health issues for mothers and safeguarding issues
Actions for every GP

Training in perinatal mental illness.
Ask about anxiety and intrusive thoughts as well as depression
Local knowledge of
• local pathways for perinatal mental health
  • Access
  • Assessment
  • Integrated care – a care plan for every woman who may have a problem
• When to refer to secondary specialist care and how to access it
• Details of local support services
• How to get advice about medication queries
Detection and treatment gap in PMI

• 40-50% of perinatal depression is recognised clinically and only half of these women receive any treatment

• 50% - 70% of untreated women with antenatal or postnatal depression will still have depression 6 months later

• Is this anything to do with GPs?
Falling through the gaps: perinatal mental health and general practice

Lorraine Khan
Barriers to detection for women:
Put significant effort into hiding their distress
• Stigma
• Wanting to be a good mother
• Fear the child might be taken away
• Don’t recognise that they are ill; it takes time

Were put off disclosing to health practitioners due to:
• Feeling dismissed or told that what they were feeling was ‘normal’.
• Feeling rushed, judged or processed
• Lack of continuity/fragmentation of care: different GPs, midwives, health visitors
• Experiencing inconsistent responses

By the time mums speak to a GP they are on a “knife edge”
Barriers for GPs

• Lack of time: workload and workforce issues
• Competing priorities
• Assumption that someone else has dealt with it
• No specialist service
• Lack of training and confidence
• Fragmentation of care with MW and HVs
Red flag for detection

If a woman consults a GP saying she thinks she has a perinatal mental health problem, she is almost certainly right.

Do not dismiss her or normalise her symptoms
How could you/your service collaborate with GPs and primary care in your area?
Relevant to GP

- Referral
- Acknowledgement of referral
- Information to GP if referred by someone else
- Telephone advice e.g. prescribing, emergency
- Written peripartum management plans
- Training for community
Training

• eLfH, commissioned by HEE
Free access to all healthcare staff with NHS email address

Five sessions of 20-30 minutes
Two core sessions
One antenatal, one around time of birth, one postnatal
Authors: GP, Perinatal psychiatrist, Midwife, Obstetrician, Health Visitor
4 sessions launched 25/2/16, 5th next week
Not enough on its own
Blended learning


• Coming June 2016 – toolkit

• Knowledge of local services
  • Joined up with Infant mental health
  • What to do in an emergency/trouble shooting/consultation skills/lived experience
  • GPs will not attend a whole day meeting on PMH
Practical implications for primary care of the NICE guideline CG192 Antenatal and postnatal mental health - 10 questions a GP should ask themselves (and their team)

Opportunities and threats to joined up care

• Massive enthusiasm

• £290m in budget for specialist community teams?

• Fragmented care between secondary, primary, community, social, third sector

• Local authority cutbacks - Children’s centres
  Health visiting