CPD Article – Perinatal mental health

Learning objectives

You should be able to participate confidently in the early detection of perinatal mental health conditions.

- To identify and be aware of 'red flags' that constitute a psychiatric emergency.
- To assess a mother's mental state more thoroughly.
- To provide emotional support to families experiencing perinatal mental health problems and recognise the value of such interventions.

What is perinatal mental health?

Perinatal mental health refers to the mental and emotional health of parents during pregnancy and up to two years after a baby is born. This can include the worsening of an existing mental health condition, or the development of a new illness. Pregnancy and childbirth are major life events, with significant impact on physical and mental wellbeing. Up to 20 % of women are thought to be affected by perinatal mental health problems, with the most common being depression and anxiety (National Institute for Health and Care Excellence, (NICE), 2016). However as with other mental health statistics, this figure is likely to be higher due to underreporting of mental health problems.

Perinatal mental health challenges do not just affect women. The challenging transition to parenthood impacts dads, mums, co-parents and intended parents. Post-natal depression is no longer exclusive to women, with an estimated 1 in 10 fathers experiencing post-natal depression (Hanley & Williams, 2020). If a child is born into a two-parent family unit, equal importance must be given to the wellbeing of both parents. However, partners are still often ignored or overlooked in preference to the childbearing parent (Hanley & Williams, 2020). This is something that all services and practitioners need to improve upon.

There has been recent investment into specialist tertiary perinatal mental health services. The NHS five year forward view for mental health (Mental Health Taskforce, 2016) contained a clear objective for improving perinatal mental health services. A financial investment of £365 million up to 2020/21 was focused on increasing inpatient mother and baby (MBU) beds, and specialist community perinatal mental health teams. They boldly estimated that when implemented this would give 30,000 women access to evidence-based care closer to home. The truth of this claim is now up for debate as 2021 was the target date of full implementation.

Whilst this investment is much welcomed and needed, it could be argued that it side-lines primary care services. NICE (2014) estimate that most women experience mild to moderate perinatal mental health

difficulties and are treated in primary care. With most women being treated in primary care, this workforce needs vital investment and education around perinatal mental health

Early childhood development

The period from conception to age two, is crucial for long term development and wellbeing. This includes physical, social, emotional, and cognitive development. A baby's brain develops at an expediential rate before the age of 2 years, and this provides the building blocks and foundations for childhood and beyond (Leadsom, 2021). Early experiences have a profound effect on mental and physical health. This is well documented and globally recognised. It is part of the World Health Organisation's Global Strategy for women and children (World Health Organization and the United Nations Children's Fund, (UNICEF), 2020). In England, the NHS Long Term Plan (NHS England, 2019) recognises the importance of the first years in a child's life, and the cross-party manifesto into early years, coined the phrase the '1001 critical days' (Leadsom, 2021) This refers to a baby's development in pregnancy and the first 2 years of life.

Unfortunately stress and adverse experiences in the 1001 critical days can have a negative impact on a baby's brain development. Regular, repeated exposure to high levels of unresolved stress, shapes the architecture of the baby's brain development. Adverse Childhood Experiences (ACE's) are stressful and potentially traumatic events that occur in a child's life. They were originally identified by (Felitti et al., 2019). Amongst abuse and parental drug misuse, they cite parental mental illness as a risk factor in developing a range of physical and mental health conditions. This is backed up by the fact most long-term health costs (72%) associated with perinatal mental illness are spent on the child and their siblings (Bauer et al., 2015).

The ever developing and increasing knowledge around early brain development, all highlights the importance of early detection and intervention for perinatal mental health conditions. Having a universal service, that empowers families to give children the best start in life cannot be underestimated. According to (Marmot, 2020) investing in early childhood creates hope for the future. Early intervention can change the trajectory of a child's life.

The ripple effect of perinatal mental illness

Perinatal mental illness has a ripple effect on the whole family, making it a major public health issue. It is vital that primary care health professionals consider the needs of the whole family. The potential impact on the child is described above. NICE (2016) highlight other potential long-term effects if perinatal mental illness is left untreated. For the parent, it can affect confidence, and bonding with the new baby. Partners that witness a traumatic delivery, where mum and baby are subject to extreme stress and potential risk to

life, can suffer long term psychological impacts. This can lead to post-traumatic stress disorder. Additionally, a partner witnessing significant perinatal illness in their co parent, can cause long term stress and anxiety.

Relatives provide invaluable support to women, complementing the care provided by universal and specialist services. However, they should not be given responsibilities beyond their capabilities or be expected to act as a substitute for an effective mental health response. This has been identified as a new recommendation from the latest MBRRACE report (Knight M, Bunch K, Tuffnell D, Patel R, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK, 2021) The charity Action on Postpartum Psychosis (www.app-network.org) offer partners and grandparent support groups. Dad Matters (dadmatters.org.uk) offer face to face and online support for dads, whilst working alongside health and social care organisations. Older children in the family can also be impacted by either parent being unwell.

Time out

Consider the long-term impact of perinatal mental illness. Think about the mother, partner, baby, older children, and wider family. Think about how important your role is in early detection of perinatal mental illness. Encourage yourself with how better outcomes are with early detection and early help.

The role of primary care

Health professionals in primary care are ideally placed to identify early signs of illness and ensure prompt intervention. For example, at routine midwife and health visitor appointments, and the 6-week GP check. Being a universal service, they are accessible and available to all. According to NICE guidelines (2014) women should be asked about their mental and emotional health at each routine antenatal and post-natal contact (Quality statement 4). Any history of mental health problems should be identified as early as possible. Women with a history of mental health problems are at higher risk of perinatal mental health problems, even if they were mentally well before pregnancy. Identifying these women early on allows for increased monitoring post-delivery.

If a mental health problem is suspected, a comprehensive mental health assessment should be completed. NICE (2014) recommend that this comprehensive assessment is started in primary care and continued by specialist perinatal mental health services. It is clear the vital role primary care has in the identification of potential mental illness. According to NICE guidelines (2014) primary care service providers should offer resources that support professionals to carry out comprehensive mental health assessments for women. Do these resources exist in your area?

There are limitations of NICE Guidance. There is growing evidence to suggest universal services are struggling to fully implement NICE guidance (Marks, 2017). The NICE guidelines focus almost exclusively on women. As previously discussed, perinatal mental health problems are not limited to women. NICE guidelines fail to acknowledge this and as a result further ostracisers dads and partners from support.

Screening questions

The below screening questions are recommended by NICE (2014), and to be asked at each antenatal and postnatal appointment. As previously discussed, NICE focuses on the woman, however I would argue that these screening questions should be applied to both parents.

The depression identification questions: (Whooley questions)

- ***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?***

The anxiety identification questions (Generalized Anxiety Disorder scale, GAD 2)

- ***Over the last 2 weeks, have you been feeling nervous, anxious or on edge?***
- ***Over the last 2 weeks, have you not been able to stop or control worrying?***
- **Do you find yourself avoiding places or activities and does this cause you problems?**

Worryingly Ford et al (2019) report that only 31% of women reported being asked the screening questions by their GP. There are limitations of this survey, however it does illustrate an important concern around if women are asked about their mental wellbeing at every contact. If not, there is high risk of perinatal mental illness going undiagnosed and untreated. The long terms risks to the whole family have already been highlighted.

If the questions are being asked, they are only as affective and useful as the practitioner that asks them. If screening questions are skimmed over or rushed, they will not generate open discussion. This is supported by (Marks, 2017). There is a risk practitioners aim to 'tick a box' by asking the screening questions, and quickly move onto other agenda items. In addition, Bauer (2014) identified lack of expertise and confidence as a barrier to professionals asking parents about perinatal mental health. This limits the opportunities to discuss mental health.

This is further compounded by parents being reluctant to disclose any mental health struggles. NICE (2016) cites fear of stigma and the involvement of social services as two reasons why. It is a dangerous

combination when parents *and* health professionals are reluctant to have these important conversations. This CPD article aims to tackle some of the lack of confidence and expertise in staff.

There are limitations of standardised screening questions. However, if used effectively and intuitively they can generate vital conversations around perinatal mental health. They require effective communication skills to maximise their potential. Professionals also need the confidence and skills to know how to respond to any disclosure of mental health challenges. If partitioners suspect that a family maybe struggling with perinatal mental health concerns, then they need the skills to ask further gentle probing questions. The ability to form a therapeutic relationship with a family is vital.

Time out

Think about the women and families you see in practice. Do you always have the time and confidence to ask them about their mental health? Reflect on what stops you asking questions or digging deeper. When this is combined with reasons a parent might be reluctant or fearful in talking about their mental health, think about the potential risks/missed opportunities. What steps can you take to minimise parents concerns.

Impact of Covid-19/equality and diversity

If lack of staff confidence, and families fear of stigma was not enough, the covid-19 pandemic has added an extra layer of complexities. As a result of the pandemic, routine appointments decreased or took place remotely and family's access to services was reduced (Papworth et al., 2021). This increases the risk of undetected cases, and potential negative long-term consequences for the whole family.

The maternal mental health alliance commissioned a report on maternal mental health during a pandemic (Papworth et al., 2021) They reviewed the evidence around virtual communication and digital contacts with families. They found face to face contact to be vital especially for families with additional risk factors. Digital contact makes effective assessment difficult. Additionally, not all families have adequate access to digital technology. According to (Filippetti et al., 2022) the covid-19 pandemic significantly amplified women's vulnerability to perinatal mental health problems. However, above mentioned research focuses exclusively on women. The impact on fathers cannot be underestimated and unfortunately does not appear in current literature regarding covid 19 and perinatal mental health.

There are some important equality and diversity considerations for women in the perinatal period. Worryingly women from ethnic minority backgrounds are disproportionately affected by perinatal mental health difficulties. This is due to a complex melting pot of socioeconomic status, language, culture, and co-morbidities. Pilav et al, (2022) describes the covid-19 pandemic as having an additional negative impact on women from ethnic and minority backgrounds.

There are also practical barriers to accessing services such as, language, childcare, and financial constraints. Worryingly, these barriers impact women from ethnic minority backgrounds to a greater degree (Pilav et al, 2022). If primary care professionals are aware of these practical and emotional barriers, they can take steps to overcome them. For example, the use of interpreters and reassuring families about social services involvement

Time out

Think about the additional challenges that you and families face when contacts are completed digitally. What are the risks regarding a mother's mental health? How many incidents of mental distress could be missed? How can you make digital contacts more personable? How can you address mental wellbeing digitally?

Signs of perinatal mental illness/early detection

Depression and anxiety are the most common mental health conditions in the perinatal period. They can occur together, or separately. Any woman with a history of anxiety and depression is at higher risk of becoming unwell postnatally, and primary care professionals such as midwives and health visitors should be aware of the woman's history.

While the symptoms of anxiety and depression in the perinatal period maybe similar to other life stages, the manifestation of these symptoms is distinctly different due to the context of pregnancy and birth. Below you will find common signs of anxiety and depression and examples of how these symptoms may manifest in the perinatal period. Then you will find examples of explorative questions. This is equally applicable to **both** parents. The sections in red link to the Red Flags discussed later in this article.

Depression

SYMPTOM (BASED ON ICD-11)	**MANIFESTATION IN THE PERINATAL PERIOD**	**EXPLORATIVE QUESTIONS**
Feeling sad and down	Unable to take pleasure in the new baby. Lack of enjoyment of being a new parent. Low motivation levels.	How is your mood? How are you feeling in yourself? You look sad, are you okay? Are you enjoying your new baby/parenthood?

Lack of interest and pleasure in activities	Preference to staying at home with the baby. Little interest in groups or activities. Feeling indifferent towards the baby. Difficulties in finding pleasure with baby milestones. Feeling like they have not bonded with the baby.	What are you enjoying about being a new parent? What activities have been doing with the baby? Are you going out and doing things that you enjoy? How do you feel about your new baby? Have you been able to bond with your baby?
Low self-esteem and self-worth, excessive feelings of guilt	Feeling/expressing incompetence as a parent. Feeling they are 'not doing a good job.' 'Not cut out to be a parent.' Feeling guilty about parenting decisions – for example breast or bottle feeding. High and unrealistic expectations of themselves as a parent.	How do you feel you are managing as a new parent? Do you think/know you are doing a good job? Are you feeling guilty about anything? Do you feel confident in what you are doing with the baby?
Poor concentration and indecisiveness	Repeated questions to health professionals. Writing things down. Poor recall of previous information given. Forgetting appointments.	Are you finding it difficult to take in information and remember it? Are you able to make decisions, or does it take a long time? Are you able to concentrate to read a book or watch TV?
Feeling hopeless about the future	Not making plans. Unable to look forward to things. Feeling pessimistic/stuck – 'the new-born stage will never end', 'it will always be this hard.' Not feeling a connection to baby or issues around bonding.	What are you looking forward to doing with the baby? What plans do you have for maternity leave? You seem sad, how are you feeling?

Thoughts of suicide	Expressing ideas around the baby being better off without them. Feeling like a burden. Feeling like a 'bad parent.' Making plans for the baby/other children to be taken care of by others.	Have you had thoughts about not wanting to be here anymore? Thoughts of suicide/wanting to die/not be here can be very distressing but we know that some women do experience them after having a baby. Have you thought about how you would end your life? Have you told anyone about this? These thoughts don't make you bad parent, it could be a sign that you are struggling with your mental health.
Disturbed sleep	Unable to sleep or rest even with the opportunity – for example if baby is asleep or being looked after. Problems falling asleep. Problems staying asleep.	Sleep is difficult with a new baby, but are you able to sleep when baby is asleep or being looked after by someone else? You seem tired, are you able to fall asleep and stay asleep? Do you wake up even when baby is still asleep?
Disturbed appetite	Weight loss or weight gain that cannot be explained by other causes – e.g. diet, physical health.	How is your appetite? Has it changed recently? Have you lost or gained any weight since baby was born?

Anxiety

SYMPTOM (BASED ON ICD-11)	**MANIFESTATION IN THE PERINATAL PERIOD**	**EXPLORATIVE QUESTIONS**
General worry or apprehensiveness	Concerns over baby's wellbeing. Are they 'doing the right thing?' Asking lots of questions around feeding,	How do you feel you are managing as new parent? Do you have any specific worries?

	sleep, bathing, and general baby health.	Is your confidence growing as a parent? You seem very worried, is this becoming a problem?
Excessive worry about negative events occurring	Could be related to the baby's wellbeing and safety. Fear of sudden infant death (SID), physical illness, fear of dying and leaving the baby without a parent. Avoiding going out with baby.	All parents worry about their baby's wellbeing, but sometimes this can take over. How often are you worrying about….? Are there times in the day/night where you are able to stop worrying/thinking about this? Is it stopping you doing things and getting in the way of life?
Physical symptoms of anxiety	Increased sweating, palpitations, shaking, nausea, restlessness, not being able to sit down or sit still.	You seem quite anxious and on edge. I can see you are finding it difficult to sit down. Do you feel like this a lot of the time? Are you able to relax?
Poor concentration	Repeated questions to health professionals, writing things down. Poor recall of previous information given. Forgetting appointments.	Are you finding it difficult to take in information and remember it? Are you able to make decisions, or does this take a long time? Are you able to concentrate to read a book or watch TV?
Sleep disturbances	Unable to sleep/rest even with the opportunity – for example if baby is asleep or being looked after.	Sleep is difficult with a new baby, but are you able to sleep when baby is asleep or being looked after by someone else? You seem tired, are you able to fall asleep and stay asleep? Do you wake up even when baby is still asleep?

Postpartum Psychosis

Postpartum psychosis is a severe but treatable perinatal mental health illness. It affects between 1 and 2 in 1000 women. It can occur in women with no previous psychiatric history. However, women with bi-polar disorder or a first degree relative with bi-polar or psychotic disorder are at increased risk. They are 50% more likely to develop post partum psychosis. This highlights the need for early screening. If a woman is at increased risk, they should be referred to the community perinatal mental health team for monitoring and support during pregnancy.

The below are some symptoms of postpartum psychosis. These require urgent referral to specialist perinatal mental health services, and it should be classed as a 'psychiatric emergency.' Women with Postpartum Psychosis may present as excited, elated, or 'high'. This can lead to excessive irritability or rapidly changing moods. They also could be depressed, anxious, or confused.

Postpartum Psychosis includes one or more of the following:

- Strange beliefs that could not be true (delusions).
- Hearing, seeing, feeling, or smelling things that are not there (hallucinations).
- High mood with loss of touch with reality (mania).
- Severe confusion.

(Action on Postpartum Psychosis, 2008)

Suicide risk

Tragically suicide is the leading indirect cause of death in the first year after pregnancy (Knight et al, 2021). This has far-reaching implications for the rest of the family, particularly partners and children left behind. Maternal deaths from mental illness have remained much the same since 2003. Ford et al (2019) note that other leading causes of maternal death, for example, hypertension are at their lowest ever rate. This is following the implementation of successful evidence-based guidelines, that have dramatically improved patient care and public awareness. In stark contrast, maternal deaths from mental illness have remained much the same since 2003.

Suicide risk in the perinatal period can present differently to other life stages. There is a dangerous misconception that a new baby is a protective factor against thoughts and plans of suicide. However, many women feel they are doing the best thing for their baby by taking their own life. Any thoughts or expressions of suicide must be taken seriously in the perinatal period, given the high risk of suicide.

A further difference in the perinatal period is methods that women use to end their lives. In contrast to methods women are most likely to use at any other life stage, during the perinatal period they are most likely to choose violent methods. Hanging was the most common cause of death by suicide in the UK and Ireland between 2017-2019 (Knight et al, 2021). These violent methods are usually associated with male suicide. Again, this further highlights the need for timely and effective interventions.

It is crucial the primary care workforce is aware of the suicide risk in the perinatal period and can effectively refer women on to specialist services. A vital tool to assist with this is the 'red flags' published by MBRRACE (2021).

Signs to be aware of – red flag symptoms

- **Do you have new feelings and thoughts which you have never had before, which make you disturbed or anxious?**
- **Are you experiencing thoughts of suicide or harming yourself in violent ways?**
- **Are you feeling incompetent, as though you can't cope, or estranged from your baby? Are these feelings persistent?**
- **Do you feel you are getting worse, or at risk of getting worse?**

The role of the primary carer worker would be to refer a woman onto perinatal mental health services should they have concerns based on any of the above red flags. Families need an advocate to ensure they get access to specialised services to ensure the safety of the women and begin treatment and intervention. What is perhaps most tragic from the latest MRRACE report (Knight et al, 2021) is that assessors felt improvements in care could have made a difference to the outcome of 67% of the women who died by suicide. We all have a role to play in improving outcomes for women and families.

Time out

Read the red flags and try and memorise these. Commit to look for these in your practice and have the courage to raise your concerns. Identify any worries you may have in raising these with other professionals. Be prepared with your rationale and evidence base.

Emotional support

If a potential mental health concern is identified a referral to a variety of services maybe appropriate, for example psychological services or secondary perinatal mental health teams. This is not the end of the role of primary care. The universal service is still available for families, despite them being involved with other

specialist services. Health visitors and other primary care workers are ideally placed to provide meaningful interventions alongside, or prior to, other support.

However, (Fisher, 2017) recognises that primary care workers may question their ability to provide meaning interventions around perinatal mental health. This is because they may not see themselves as the 'expert' therefore leaving emotional support to mental health professionals. This does not need to be the case. According to (Fisher, 2017) when in distress families seek basic human connection and compassion. This can be provided by any health professional and is not exclusive to mental health workers.

The below is a guide to providing emotional support to families, with the memorable mnemonic 'haven.'

H	**H**ear
A	**A**sk
V	**V**alidate
E	**E**ncourage
N	**N**ormalise

HEAR

Listening is a powerful intervention. To truly hear what someone says and means, requires active listening. Silence is also important; it gives parents space and time to open up. Often our natural desire is to say something to help fix the problem. However often people just want to be heard. To allow parents the space to be heard and express themselves is a key aspect of emotional support. Wright (2021) acknowledges the power of connection and it's ability to make people feel valued and heard.

ASK

If you are not sure what a parent is trying to say or explain, then don't second guess. Don't make any assumptions. Perinatal mental health challenges impact everyone differently. Be curious and ask. Try and understand someone's personal narrative. This demonstrates compassion and that you value their story and experiences.

'Do you mean….?'

'How does that impact your life?'

'Can you explain that in more detail so I can understand exactly what you mean?'

'Am I okay to ask you about…?'

Validate

Engaging with someone's personal narrative through active listening and gentle questioning demonstrates a genuine desire to understand parents' perspective and experiences. This demonstrates empathy. Validation is a form of empathy. It conveys an acceptance and understanding of someone's experiences and acknowledges a shared humanity.

'This sounds really difficult.'

'It is not surprising that you are feeling overwhelmed.'

'I can see this is distressing for you,'

Encourage

Another critical aspect of effective emotional support is encouragement. (Wright, 2021)empathises that instilling hope and optimism helps people realise the potential for recovery. Hope is vital for recovery from perinatal mental illness. One of the greatest honours is to hold onto hope for someone when they cannot hold it for themselves (Jane Fisher, 2021). Health professionals must remain hopeful for change and recovery.

'Despite everything you have going on, you are still managing to give your baby everything they need.'

'You are managing the best way you can.'

'Things will not be this hard forever.'

'You will come through this – I have seen other parents do the same.'

'Your baby is thriving and doing well.'

Normalise

This links back to the reluctance of both health professionals, and families to talk about mental health. We need to normalise asking people about their mental health and normalise this being part of our conversations with families. Another aspect to this is helping parents feel like they are not alone in perinatal mental health challenges. This is a powerful aspect of emotional support.

'Having a new baby is a major life event and we cannot underestimate the impact of this.'

'We know that around 1 in 5 new mums will struggle with their mental health.'

'You might find it helpful speaking to other families who have had similar experiences.'

‘You are not alone in feeling this way.’

Time out 5

Now you have completed this article, reflect on your next steps. Consider making local contacts with specialist perinatal mental health teams and mother and baby units. Consider the importance of your role and the long-term positive impact you can have on families.

Time out 6

Consider how perinatal mental health relates to The Code: Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates (Nursing and Midwifery Council 2018) or, for non-UK readers, the requirements of your regulatory body.

Time out 7

Now that you have completed the article, reflect on your practice in this area and consider writing a reflective account. See https://rcni.com/nursing-standard/revalidation/reflective-accounts/write-a-reflective-account-90981

References

Action on Postpartum Psychosis. (2008). *Insider Guide Postpartum Psychosis: a guide for partners*

Bauer, A., Knapp, M., & Parsonage, M. (2015). Lifetime costs of perinatal anxiety and depression. *Journal of Affective Disorders, 192*, 83-90. 10.1016/j.jad.2015.12.005

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (2019). REPRINT OF: Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 56*(6), 774-786. 10.1016/j.amepre.2019.04.001

Filippetti, M. L., Clarke, A. D. F., & Rigato, S. (2022). The mental health crisis of expectant women in the UK: effects of the COVID-19 pandemic on prenatal mental health, antenatal attachment and social support. *BMC Pregnancy and Childbirth; BMC Pregnancy Childbirth, 22*(1), 68. 10.1186/s12884-022-04387-7

Fisher, J. (2017). A nurse's journey through perinatal mental illness. *Journal of Health Visiting, 5*(5), 248-249. 10.12968/johv.2017.5.5.248

Fisher, J (2021). A crisis of identity. *Asylum Magazine,*

Hanley, J., & Williams, M. (2020). Fathers' perinatal mental health. *British Journal of Midwifery, 28*(2), 84-85. 10.12968/bjom.2020.28.2.84

Knight M, Bunch K, Tuffnell D, Patel R, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. (2021). *Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity*

care from the UK and

Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2017-19

Leadsom, A. (2021). *The Best Start for Life: A Vision for the 1,001 Critical Days. The Early Years Healthy Development Review Report*. TSO.

Marks, L. (2017). Overview of challenges to implementation of good practice in perinatal mental health promotion and management, in universal primary care and community services. *Journal of Public Mental Health, 16*(3), 100-103. 10.1108/JPMH-03-2017-0009

Marmot, M. (2020). Health equity in England: the Marmot review 10 years on. *Bmj; Bmj, 368*, m693. 10.1136/bmj.m693

Mental Health Taskforce. (2016). *The Five Year Forward View for Mental Health: A Report from the Independent Mental Health Taskforce to the NHS in England*

National Institute for Health and Care Excellence, (NICE). (2016). *Antenatal and postnatal mental health Quality standard 192*

NHS England. (2019). The NHS long term plan. *BMJ (Online), 364*, l84. 10.1136/bmj.l84

Papworth, R., Harris, A., Durcan, G., Wilton, J., & Sinclair, C. (2021). *Maternal mental health during a pandemic.* ().Centre for Mental Health.

World Health Organization and the United Nations Children's Fund, (UNICEF). (2020). Protect the progress: rise, refocus and recover. 2020 progress report on the Every Woman

Every Child Global Strategy for Women's, Children's and Adolescents' Health. https://www.who.int/data/maternal-newborn-child-adolescent-ageing/global-strategy-data

Wright, K. M. (2021). Exploring the therapeutic relationship in nursing theory and practice. *Mental Health Practice, 24*(5), 34-41. 10.7748/mhp.2021.e1561