

Understanding mothers' mental health and wellbeing during the transition to parenthood



This Good Practice Point provides health visitors with an overview of key aspects relating to perinatal mental health and wellbeing of mothers. This resource aligns with the [2022 NMC Standards for Proficiency for SCPHN Health Visiting](#), with a focus on Sphere C: Promoting human rights and addressing inequalities: assessment, surveillance, and Intervention, in particular C.HV5 & 6. For more information on the [perinatal mental health of fathers](#), and of [LGBTQI+ parents](#), please see our corresponding GPPs.

It is estimated that 1 in 4 women are affected by mental health problems during pregnancy and in the first year after childbirth¹, and suicide remains the leading cause of direct maternal death in the first postnatal year².

Perinatal mental illness (PMI) encompasses a range of mental health conditions that can affect parents during the perinatal period (preconception to the first two years of baby's life)^{3,4}. Recent evidence demonstrates that health visiting has a clinical and cost-effective role in perinatal mental health care, by identifying families at risk of, or suffering from, mental health problems and providing effective evidence-based treatments, or facilitating referrals to specialist teams⁵. Health visitors are highly skilled in building trusting therapeutic relationships with families, and research highlights that the therapeutic relationship is one of the strongest predictors of positive treatment outcomes for perinatal mental illness⁶. While depression and anxiety disorders are the most common, other conditions include post-traumatic stress disorder (PTSD) / birth trauma, obsessive compulsive disorder (OCD), eating disorders, drug and alcohol use disorders, postpartum psychosis, bipolar disorder and schizophrenia⁷.

Risk factors for PMI include^{8,9}:

- History of mental illness
- Family history of mental illness
- History of childhood trauma and poor parenting
- Assisted conception / IVF
- Pregnancy-related complications
- Major life events
- Low social support
- Domestic abuse
- Substance misuse
- Relationship problems
- Birth trauma
- Miscarriage and baby loss (including termination of pregnancy or child removal)
- Baby with special needs/admitted to neonatal unit
- Teenage parents

- Poverty, unemployment, debt
- Housing problems

Many perinatal mental health problems have a similar presentation as mental health problems at other times in life, however, there can be differences. Mental health problems during this period may often need more urgent intervention than they would at other times because of the potential effect on the parent's health and wellbeing and their ability to function and care for their baby and family. However, problems frequently go unrecognised and untreated and there are many barriers to seeking help, including stigma, or fear of intervention by social services⁷.

Parents from minority groups or underserved communities, such as parents from minoritised ethnic groups, are at risk of a range of poorer mental health outcomes, less likely to be asked about their mental health, and less likely to receive the care they need, in comparison to the general population¹⁰.

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For additional resources see www.ihv.org.uk

The information in this GPP version was created on 20/09/2024.

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National guidance recommends that parents are asked about their emotional wellbeing at every contact^{7,11,12}. Standardised evidence-based identification questions, such as Patient Health Questionnaire-2 (PHQ-2) / Whooley Questions and Generalized Anxiety Disorder 2-item (GAD-2), can inform a wider discussion around parental wellbeing. Where there are concerns for mental health, additional tools, such as the Edinburgh Postnatal Depression Scale (EPDS), Patient Health Questionnaire-9 (PHQ-9) or Generalised Anxiety Disorder Questionnaire (GAD-7) can be used – alongside clinical judgement- as part of a holistic assessment. National guidance also recommends discussing the importance of bonding and emotional attachment with parents, and the approaches that can help them to bond with their baby¹³. Sensitive exploration with the whole family can identify vulnerabilities and early signs of distress that may not meet threshold for diagnosis. It also identifies strengths and enables culturally sensitive, personalised care¹⁴.

Onset, deterioration, and escalation of symptoms can be very quick in the perinatal period and therefore PMI requires a lower threshold for intervention. It is also important to hold in mind that persistent sub-threshold symptoms can have cumulative effects for mothers and their families⁷. Although not inevitable, perinatal mental illness can have a significant effect on the developing foetus and baby after birth¹⁵. Children of parents with PMIs are at increased risk of a range of poorer outcomes, especially in relation to their cognitive, social, and emotional development¹⁶. PMI can also affect the parent-infant relationship and impact on the baby's ability to form a secure attachment, which is key for their future emotional wellbeing¹⁷. Early identification and the right treatment at the right time is key to breaking the intergenerational cycles of mental ill health⁵. Therefore, it is vital that health visitors are familiar with:

- Signs and symptoms of perinatal mental illness (training is available via the iHV (bit.ly/4dyYOgm) or NHSE elearning for healthcare (bit.ly/4deLVly))
- National and local perinatal mental health pathways:
 - » England (bit.ly/3SB84bt)
 - » Wales (bit.ly/3YyFxFp)
 - » Scotland (bit.ly/3LWh0V9)
 - » Northern Ireland (bit.ly/4dB5TwU)
- Red flags which may indicate a parent is in crisis (see below)

Suicide Red Flags

The following are known risk factors for maternal suicide and should always be taken seriously¹⁸:

-  recent significant change in mental state or emergence of new symptoms
-  new thoughts or acts of violent self-harm
-  new or persistent expressions of incompetency as a mother or estrangement from the infant

If there are red flag warning signs and/ or you are concerned about risk of suicide, make an immediate referral to mental health services, such as Crisis, 999, or the Specialist Perinatal Mental Health Team (SPMHT), in accordance with your local emergency PMH pathway.

Parental mental health problems are frequently present in cases of child abuse or neglect¹⁹, however, a mental health diagnosis alone does not equate to safeguarding issues. Children become more vulnerable to abuse and neglect when parental mental illness coexists with multiple disadvantage²⁰. A parent's individual symptoms may also impact their parenting capacity in various ways, such as difficulty anticipating potential hazards or providing adequate supervision, leading to an increased risk of accidental childhood injury²¹. Nevertheless, with the right support, many parents with a perinatal mental health problem can parent well.

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Good practice points to promote perinatal mental health and provide support:

- Inform parents about the role of health visiting in promoting perinatal mental health, invest time in building and maintaining a therapeutic relationship, and provide continuity of care where possible.
- Raise awareness of PMI and offer routine information about mental health conditions, treatments, and coping techniques to parents and their families, ideally in the antenatal period. Include key facts about postpartum psychosis (see Antenatal Toolkit by Action on Postpartum Psychosis - bit.ly/3YybNut). This can enable parents to access help early if they notice any signs and symptoms in themselves or their partners.
- At each contact, ask parents about their emotional wellbeing and relationship with their baby, and observe how the parent and baby interact in accordance with national guidance. See iHV's GPP Strengthening Parent-Infant Relationships (bit.ly/46USFYv) for more information.
- Ask sensitively but directly about thoughts of self-harm and suicide. Asking about these thoughts will not trigger someone to harm themselves.
- If a parent presents with signs of postpartum psychosis, refer for emergency psychiatric assessment. See iHV's GPP Postpartum Psychosis (bit.ly/3SF3wRD) for more information.
- Instil a sense of hope, helping families to understand that mental health difficulties are common in the perinatal period and treatment can be effective.
- Be aware of unconscious bias, attitudes and assumptions and the impact which these can have on practice. Engage in training, reflection and supervision to promote inclusive, individualised, high-quality perinatal mental healthcare for all families.
- When discussing PMI, use accessible, simple language, and professional interpreters as required.
- Think family: if a mother has a perinatal mental illness, their partner is at an increased risk of developing a PMI, too (see iHV GPPs Understanding fathers' mental health and wellbeing during the transition to parenthood (bit.ly/3QAwkKM) and Understanding mental health and wellbeing during the transition to parenthood: LGBTQI+ parents (bit.ly/46GiZq8)).
- Facilitate access to the right support at the right time. Integrated and collaborative care may include community resources such as peer support or voluntary organisations, health visitor emotional wellbeing visits (bit.ly/4bHfSAq), GP, talking therapies, medication, specialist perinatal mental health team (SPMHT), mother & baby unit, crisis team.
- Encourage anyone who is taking medication whilst pregnant or breastfeeding to have an individualised risk assessment with their GP or Specialist Perinatal Mental Health Team (SPMHT). Medication should not be stopped abruptly or without specialist advice.
- Valproate should not be used in pregnancy²². If a woman is taking valproate while pregnant or breastfeeding, refer for an urgent medication review. Medication should not be stopped abruptly or without specialist advice.
- Follow recommendations from the Royal College of Psychiatrists²³ to refer any woman with a diagnosis of bipolar disorder, schizoaffective disorder, or postpartum psychosis, to SPMHT, even if she is currently well. For more information, please refer to the iHV's GPP Postpartum Psychosis (bit.ly/3SF3wRD) or the website Action on Postpartum Psychosis (bit.ly/3WVJB3m).
- Seek to understand the lived experience of the baby / child; recognise how parental mental health affects parenting capacity and assess the impact it may be having on the child. When risks are identified, follow local safeguarding protocols.
- Access regular training and updates, alongside reflective clinical supervision.

To learn more, take a look at the iHV's Perinatal and Infant Mental Health training programmes (bit.ly/4dyYOgm), or contact training@ihv.org.uk

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Additional Resources:

- Action on Postpartum Psychosis (APP): bit.ly/3WVJB3m
- Maternal Mental Health Alliance: bit.ly/3WT91yD
- Mind: www.mind.org.uk
- NCT: www.nct.org.uk
- NHS: www.nhs.uk
- PANDAS: bit.ly/4cyPSqt
- Parent-Infant Foundation: bit.ly/3WSEnW6
- RCGP Toolkit perinatal mental health: bit.ly/4deYjrM
- The Perinatal Mental Health Care Pathways: bit.ly/3WERBnT
- Tommy's- Pregnancy and Post-birth Wellbeing Plan: bit.ly/4dzNdxp

References

1. Howard LM, Ryan EG, Trevillion K, Anderson F, Bick D, Bye A. et al. Accuracy of the Whooley questions and the Edinburgh Postnatal Depression Scale in identifying depression and other mental disorders in early pregnancy. *Br J Psychiatry*. 2018; 211(1): 50-56.
2. Knight M, Bunch K, Kelly T et al, eds, on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care: Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20. National Perinatal Epidemiology Unit, University of Oxford 2022.
3. Parent Infant Foundation. First 1001 Days Movement Evidence Briefs Series. 2021
4. NHS England. NHS Long Term Plan. 2019
5. Bauer A, Tinelli M, Knapp M. The economic case for increasing access to treatment for women with common maternal mental health problems. Care Policy and Evaluation Centre London School of economics and Political Science. 2022.
6. Lowenhoff C, Appleton JV, Davison-Fischer J, Pike N. NICE guideline for antenatal and postnatal mental health: The health visitor role. *Journal of Health Visiting*. 2017; 5(6).
7. National Institute for Health and Care Excellence. Clinical Guideline 192. Antenatal and postnatal mental health: clinical management and service guidance. 2014; London: NICE
8. Howard LM, Moylneaux E, Dennis C-L, Rochat T, Stein A, Milgrom J. Non-psychotic mental disorders in the perinatal period. *The Lancet*. 2014; 384;1775-1788.
9. Hughes K, Bellis M, Hardcastle K, Sethi D, Butchart A, Mikton C, Jones L, Dunne M. The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. *The Lancet Public Health*. 2017; 2(8): 356-366.
10. Maternal Mental Health Alliance. Maternal Mental Health: A Briefing for Integrated Care Systems. Centre for Mental Health. 2023.
11. National Institute for Health and Care Excellence. Antenatal and postnatal mental health. Quality Standard 115. NICE, 2016
12. Scottish Intercollegiate Guidelines Network. SIGN 196: Perinatal mental health conditions. A national clinical guideline. Healthcare Improvement Scotland 2023
13. National Institute for Health and Care Excellence. Clinical Guideline 201. Antenatal care. NICE, 2021
14. Austin MP, Priest SR, Sullivan EA. Antenatal psychosocial assessment for reducing perinatal mental health morbidity. *Cochrane Database Syst Rev*. 2008;(4):CD005124.
15. Stein A, Pearson RM, Goodman SH, Rapa E, Rahman A, McCallum M, Howard LM, Pariante CM. Effects of perinatal mental disorders on the fetus and child. *Lancet*. 2014 Nov 15;384(9956):1800-19
16. Goodman JH. Perinatal depression and infant mental health. *Arch. Psych. Nurs*. 2019; 33: 217-224.
17. Royal Foundation Centre for Early Childhood. Big Change Starts Small. 2021
18. Knight M, Tuffnell D, Kenyon S, Shakespeare J, Gray R, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. 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. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2015.
19. Dickens J, Taylor J, Cook L, Cossar J, Garstang J, Hallet N, et al. Learning for the future: final analysis of serious case reviews, 2017 to 2019. Department for Education (DfE). 2022.
20. NSPCC. Parents with a mental health problem: learning from case reviews. Summary of key issues and learning for improved practice around parental mental health and child welfare. 2023.
21. Baker R, Kendrick Dm Tat L, Orton E. Association between maternal depression and anxiety episodes and rates of childhood injuries: a cohort study from England. *BMJ*. 2017, 23(6).
22. Valproate use by women and girls. Medicines and Healthcare products Regulatory Agency. 2024. Available at <https://bit.ly/3AdjwO> [Accessed 10/06/24]
23. Royal College of Psychiatrists. Postpartum Psychosis. 2018. Available at <https://bit.ly/4fym4g5> [Accessed 13/05/24].

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