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COVID-19 and perinatal mental healthcare: impact on patients and staff

Student name: Anna Gallagher
Supervisors: Dr Ashleigh Macaulay & Dr Amanullah Durrani

Introduction

In a time when mental wellbeing has been significantly impacted due to the COVID-19 pandemic[1], mental health services are more vital than ever. Due to social distancing guidelines, the NHS has had to rethink how its services are delivered. As with all services, the perinatal mental health service has been affected.

Perinatal mental health is an extremely important issue, with up to 1 in 5 mothers experiencing mental illness throughout pregnancy and the postnatal period[2]. Left untreated, mental illness is one of the leading causes of mortality in perinatal women[3], and can have a long-lasting detrimental impact on mothers, babies, and families. Research has shown a significant decline in maternal mental health during the pandemic[4] – consequently, the perinatal mental health service (PMHS) has had to balance an increase in demand with the difficulty of delivering care remotely. However, it is not just the patient population suffering poorer mental health during the pandemic – NHS staff have also felt the impact: the number of staff reporting mental health problems quadrupled after the first wave of the virus[5].

The aim of this study is to assess the impact of COVID-19 regulations on both the patients and staff of the PMHS in NHS Greater Glasgow & Clyde, and to identify any potential areas of improvement.

Perinatal mental health issues

Perinatal mental illness (PMI) encompasses a wide range of illnesses of varying severity. Examples include: depression, anxiety, OCD, psychosis, and PTSD; the most common being depression and anxiety, affecting between 10-15% of pregnant and postnatal women[6, 7]. Numerous factors contribute to the development of PMIs. For example, physical symptoms of pregnancy, such as severe morning sickness, may increase a woman's likelihood of suffering poor mental health. Women with previous psychiatric illness are more vulnerable to developing PMIs, however these issues can surface in any woman regardless of her previous medical history.

If left untreated, PMIs can have a serious negative impact on both mother and child. Mothers experiencing mental illness can face extreme emotional distress, causing a detrimental impact on their transition to motherhood and possibly their ability to care for their child[4]. Their self-esteem can also be affected. Many mothers feel that they are "not good enough", and become worried that their poor mental health will lead to their child being removed. Additionally, there is a stigma surrounding PMIs. This may exacerbate a woman's feelings of inadequacy and potentially be a barrier to them seeking treatment. At their most severe,

PMIs can be life-threatening - suicide is the leading cause of maternal death in the first year after giving birth[8].

PMIs in the mother can also affect the development of the baby. Children of mothers experiencing postnatal depression may be at increased risk of poorer cognitive development[9]. Maternal mental illness can also impact on the mother-child bond and attachment, particularly if separation of the mother and child is necessary for treatment[10].

Structure of the PMHS

The perinatal mental health service (PMHS) in NHS GGC is a specialist service for women who are pregnant or up to a year postnatal, and affected by or at risk of mental illness[11]. The PMHS also offers pre-conception advice for women at risk of serious mental illness. The service consists of three major branches: the inpatient Mother and Baby Unit, the community team, and the maternity liaison service. Patients can be referred to the PMHS by any healthcare professional involved in their care during pregnancy and up to 6 months postnatally, where the patient has a moderate to severe mental disorder or is at high risk of serious postpartum mental illness. Figure 1 shows the referral criteria for the PMHS[12].

- Referrals are accepted from health professionals involved in the care of women during pregnancy and within 6 months of delivery where the woman has a moderate to severe mental disorder or is at high risk of serious postpartum mental illness.
- Referrals are also accepted for women contemplating a pregnancy who have a diagnosis of psychotic disorder or previous postpartum psychosis.
- The PMHS acts as a 'one stop shop' – maternity services should refer where appropriate even if the woman is already known to other mental health services. The PMHS will liaise with the woman's existing service about ongoing care.
- Women with primary addiction problems should be referred to their local Community Addiction Team in the first instance.
- Women under 18 years of age should be referred to CAMHS in the first instance.
- Note: sudden changes in mental state in late pregnancy or the early postpartum period should always be taken seriously.

Pre-pregnancy	
Pre-existing bipolar disorder	Refer to PMHS
Pre-existing schizophrenia	Refer to PMHS
Previous postpartum psychosis	Refer to PMHS

Pregnancy	
Pre-existing bipolar disorder	Refer to PMHS
Pre-existing schizophrenia or other psychosis	Refer to PMHS
Previous postpartum psychosis	Refer to PMHS
Current suicidality, psychosis, severe depressive, severe anxiety or severe obsessive-compulsive symptoms, eating disorder	Refer to PMHS
Previous inpatient mental health care	Refer to PMHS for casenote review
Mild to moderate depression or anxiety	Refer to GP/Primary Care Mental Health Team, *unless (i.e., refer to PMHS if)* ○ 1^{0} relative with bipolar disorder or postpartum psychosis ○ significant change in mental state in late pregnancy
Family history of bipolar disorder in first degree relative	In absence of personal illness, ensure close monitoring by maternity and primary care. Refer if any change in mental state in late pregnancy.

Postpartum	
Current suicidality, psychosis, severe depressive, severe anxiety or severe obsessive-compulsive symptoms, eating disorder	Refer to PMHS
Mild to moderate depression or anxiety	Refer to GP/Primary Care Mental Health Team, *unless (i.e., refer to PMHS if)* ○ 1^{0} relative with bipolar disorder or postpartum psychosis ○ significant change in mental state in early postpartum ○ significant interference with mother-infant relationship
Family history of bipolar disorder in first degree relative	In absence of personal illness, ensure close monitoring by maternity and primary care. Refer if any change in mental state in early postpartum.

RCOG GP14 (2011); SIGN 127 (2012); NICE 192 (2014)

Figure 1: Referral criteria for the NHS Greater Glasgow and Clyde Perinatal Mental Health Service, detailing who should be referred to the PMHS in the first instance.

The inpatient Mother and Baby Unit cares for women experiencing severe mental illness in the late stages of pregnancy and the first year after delivery. The unit has six beds, with the mothers and babies remaining together. This is crucial for maintaining the mother-infant

bond[10], supporting infant development, and aiding the recovery of the mother. Inpatients are supported in caring for their baby by various professionals whilst receiving treatment for their own mental health: this multidisciplinary team includes psychiatrists, mental health nurses, psychologists, nursery nurses, health visitors and occupational therapists.

Infants are placed onto a Support and Supervision level throughout their time on the ward. This is decided using tools such as the Louis-Macro score[13] to determine the mother's support and supervision requirements in order to provide adequate care for her baby. The levels range from 1 to 5: Level 1 indicates that the mother can provide adequate and safe care to the baby independently; Level 5 indicates that there is a significant and imminent risk to the baby (whereby a designated member of staff must provide baby care at all times).

The community team review women seeking pre-pregnancy advice and offer support to women who are pregnant or who have been referred up to 6 months postnatally. Antenatally, the team work with patients to produce a pregnancy plan, which details the patient's early warning signs of mental deterioration and their plans regarding medication in the immediate postnatal period. After the birth, patients may be offered changes in their medication and support to strengthen their bond with their baby, or be signposted to various support services in their local area. Patients can continue being seen until their baby is one year old, after which they will be discharged from the PMHS and may be referred onto primary care or a CMHT if required.

Methodology

Two anonymous online questionnaires were developed for patients and staff, both estimated to take between 10 and 20 minutes to complete. The patient survey consisted of 50 questions, split into 4 sections – "background information", "demographics", "experience" and "lessons for the future". The survey was sent to 28 patients and 7 responses were received (25% response rate). The staff survey consisted of 35 questions, split into 3 sections – "background information", "experience" and "lessons for the future". The survey was sent to 41 staff and 10 responses were received (24% response rate).

Results

Patient Survey

Background information

3 out of 7 respondents reported this was their first pregnancy. None of the 4 remaining respondents reported contact with the PMHS in a previous pregnancy. 100% reported pre-existing mental illness, including depression, anxiety, anorexia, EUPD and schizoaffective disorder (the most common answer being depression). Initial contact with the PMHS was antenatal for 4 respondents and postnatal for 3 respondents, with the stage ranging from 5 months of pregnancy to 7 months postnatal. Figure 2 shows what caused the respondents to get in touch with the PMHS and Figure 3 shows the number of children of the respondents.

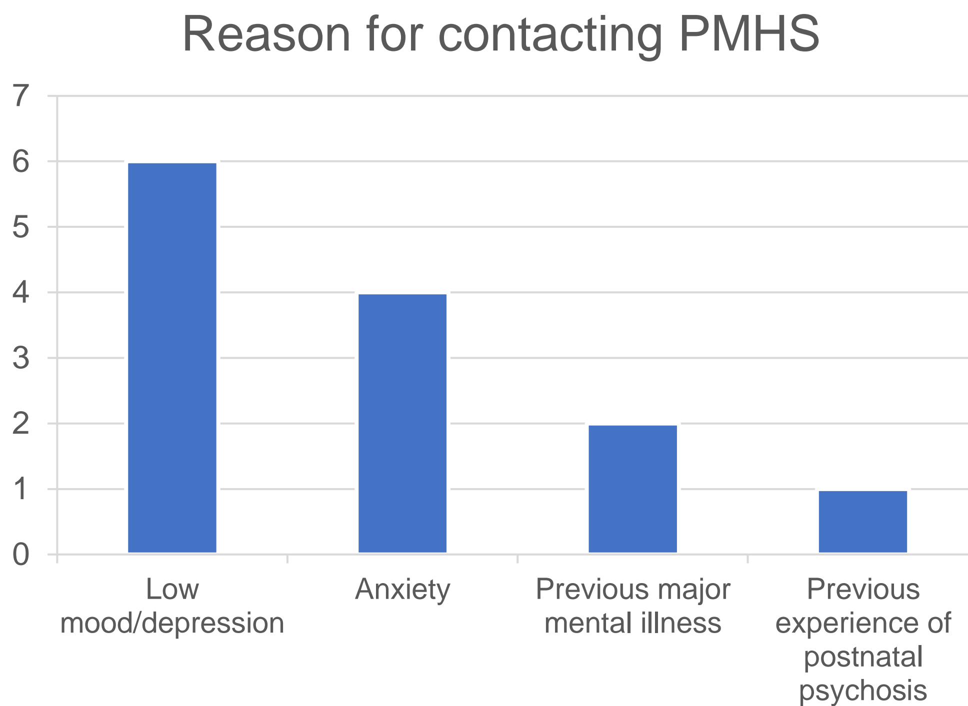

Figure 2: Bar graph showing the reasons that respondents contacted the PMHS. (Note: 1 respondent reported both low mood/depression and anxiety.)

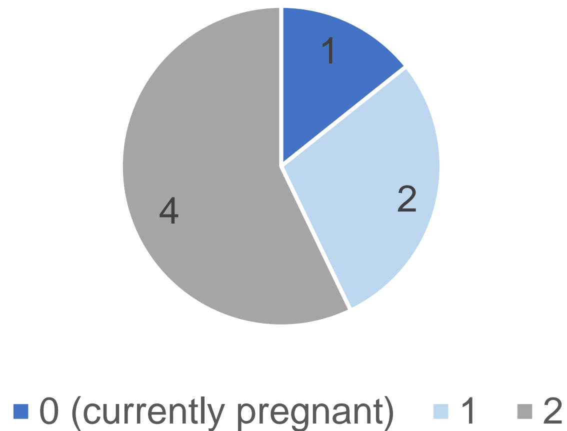

Figure 3: Pie chart showing the number of children the respondents had.

Every respondent had received outpatient care, 4 of them also having been inpatients. The professionals that respondents engaged with were doctors, CPNs and psychologists. Figure 4 shows the professionals involved in the respondents' care.

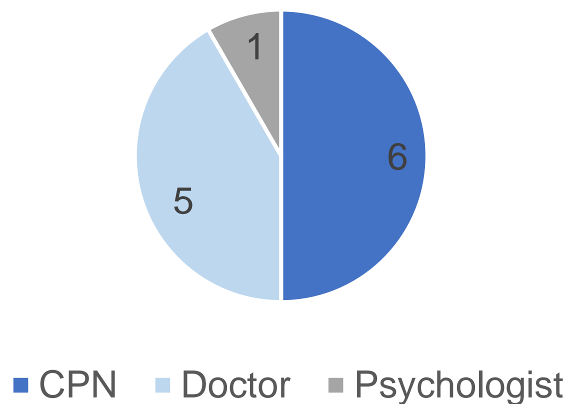

Figure 4: Professionals involved in respondents' care. (Note: some respondents had appointments with multiple different healthcare professionals.)

Demographics

The demographic categories included were age group, ethnicity, religion, disability status, marital status, sexual orientation, and gender identity. These categories and the answer options were developed from the UK Census. An additional question was added asking if English was their first language. Table 1 shows the results of this section.

Age Group	**Number**	**Marital Status**	**Number**
Under 18 years	1	Single	1
25-29 years	1	Unmarried but in a relationship	2
30-34 years	4	Married	4
35-39 years	1	**Sexual Orientation**	
Religion		Heterosexual	5
No religion	5	Bisexual	1
Roman Catholic	1	Prefer not to say	1
Christian - Other	1	**Ethnicity**	
Disability Status		White Scottish, British, or Irish	6
Disabled	0	White Other	1
Not disabled	7	**First Language**	
Gender Identity		English	6
Female	7	Other	1

Table 1: Demographic questions on the survey. Results are shown on questions regarding age, religion, disability status, gender identity, marital status, sexual orientation, ethnicity, and first spoken language. For the sake of conciseness and legibility, options are only shown if they received a response (with the exception of disability status). See Appendix 1 for all options available.

As shown, 5 out of 7 respondents were in their thirties. All were white, with 6 being Scottish, British or Irish. Every respondent identified as female, and none identified as disabled. The majority (5 out of 7) were not religious and all but 1 were in relationships. Of those who chose to answer the sexual orientation question, 5 identified as heterosexual. Only 1 respondent spoke English as a second language, her first language being Russian.

Experience

Overall, respondents felt positively about their experience with the PMHS, and all reported feeling supported by the service (Figures 5 and 6).

The feelings on remote consultation were similarly positive, with 86% of respondents describing remote clinics as very or somewhat helpful (Figure 7). Positive aspects included were time saved on travel and feelings of safety and security in their own home. Negative aspects reported were connection issues and difficulty in conveying sensitive information over the phone to a relative stranger. When asked to compare remote clinics to in-person clinics, 3 respondents felt that remote consultations were better (Figure 8). 1 respondent

selected N/A for this question, as she had never had a face-to-face appointment for comparison.

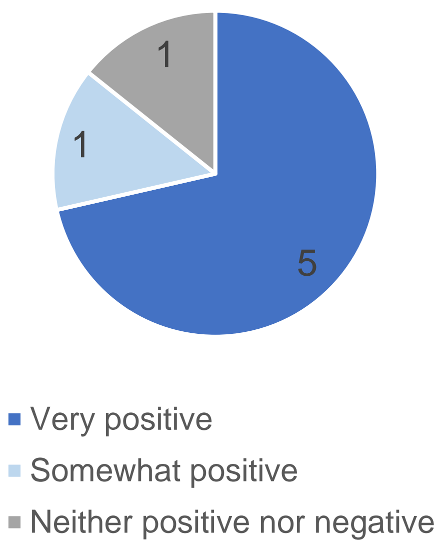

Figure 5: Pie chart showing respondents' overall feelings on PMHS.

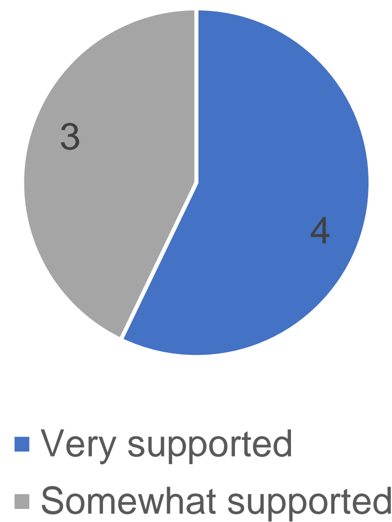

Figure 6: Pie chart showing how supported the respondents felt by the PMHS.

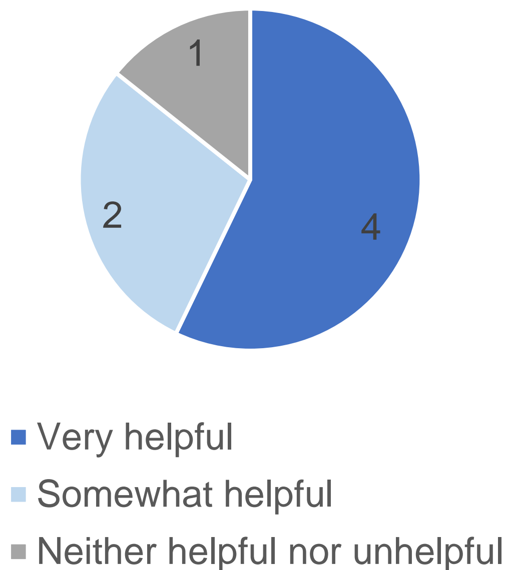

Figure 7: Pie chart showing respondents' feelings on helpfulness of remote clinics.

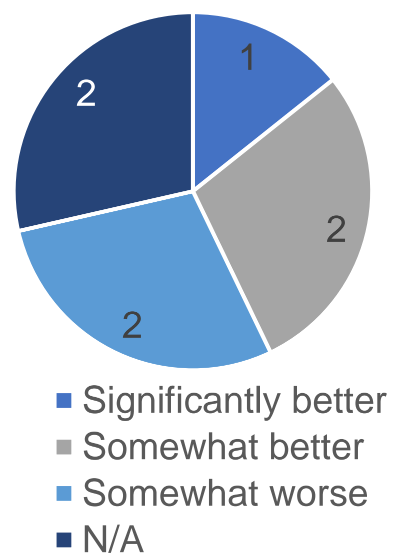

Figure 8: Pie chart showing comparison between remote clinics and in-person clinics.

On preferred methods of consultation, 3 respondents said video, 1 said telephone and 3 said face-to-face. Reasons in favour of video consultation were that it was easier, did not require travel and there was still the ability to see a person. The respondent who favoured telephone said she felt more at ease talking to someone without facial recognition. Those who selected face-to-face said that it was easier to convey information face-to-face, with no risk of disruption due to technological issues; also it was easier to remain focused at in-person appointments. One respondent who favoured video said that her preference varied depending on who the appointment was with – she preferred video consultation with the doctor but her CPN appointments as a phone call.

71% felt that remote consultation was more convenient (Figure 9), the main reasons being that there was no need to travel or organise childcare. One respondent said it was sometimes difficult to schedule appointments around work. 57% said their experience of remote consultation was better than expected (Figure 10). Neutral respondents said they had not known what to expect going into these remote appointments.

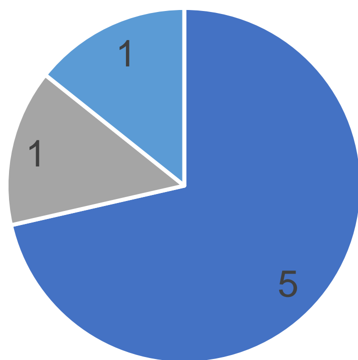

Figure 9: Pie chart showing convenience of remote consultation.

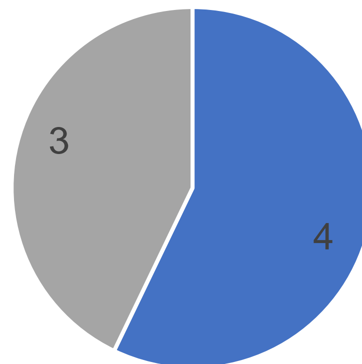

Figure 10: Pie chart showing respondents' feelings on remote consultation compared to expectations.

The majority of respondents said text message would be their preferred method of communication of their appointment details. One respondent said she would prefer postal notification, and another said both text and post would be helpful. 57% said they would prefer remote consultation over face-to-face consultation in the future (Figure 11). Reasons included travel factors, comfort of the home environment, and this now being the method of consultation they are used to. Those preferring face-to-face consultation in future said that

they felt face-to-face would have been more helpful and that these appointments would motivate them to get out of the house.

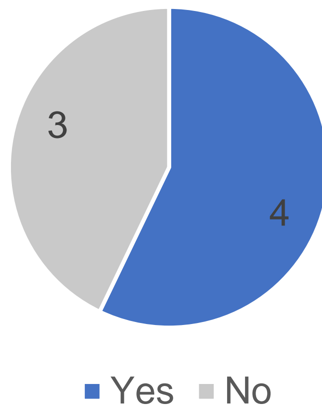

Figure 11: Pie chart showing preference between remote and face-to-face consultation in future.

As previously mentioned, 4 of the 7 respondents had received inpatient care in the MBU. Figure 12 shows the respondents' overall feelings on their inpatient experience – results were mixed. Staff were described as friendly, supportive, and understanding, and the ward itself as "nicer than expected", with lots of toys for the babies. On the other hand, some described a lack of consistency regarding application and communication of rules and one respondent mentioned instances where she was walked in on whilst changing. The monitoring levels were described as "alarming" and patients being unable to see their families whilst self-isolating was understandably difficult.

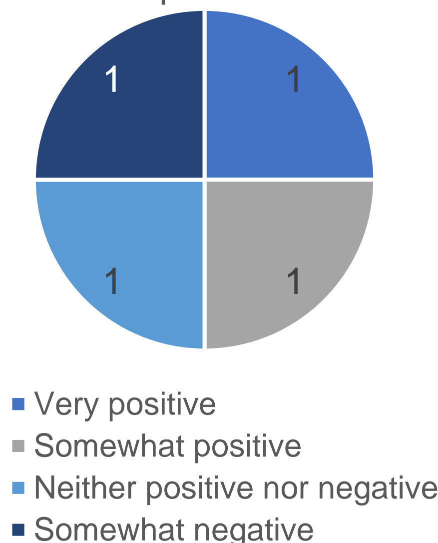

Figure 12: Pie chart showing respondents' overall feelings on their inpatient experience.

Several pandemic stressors were identified (either exacerbated or directly caused by the pandemic). Figure 13 shows the stressors respondents said particularly affected them.

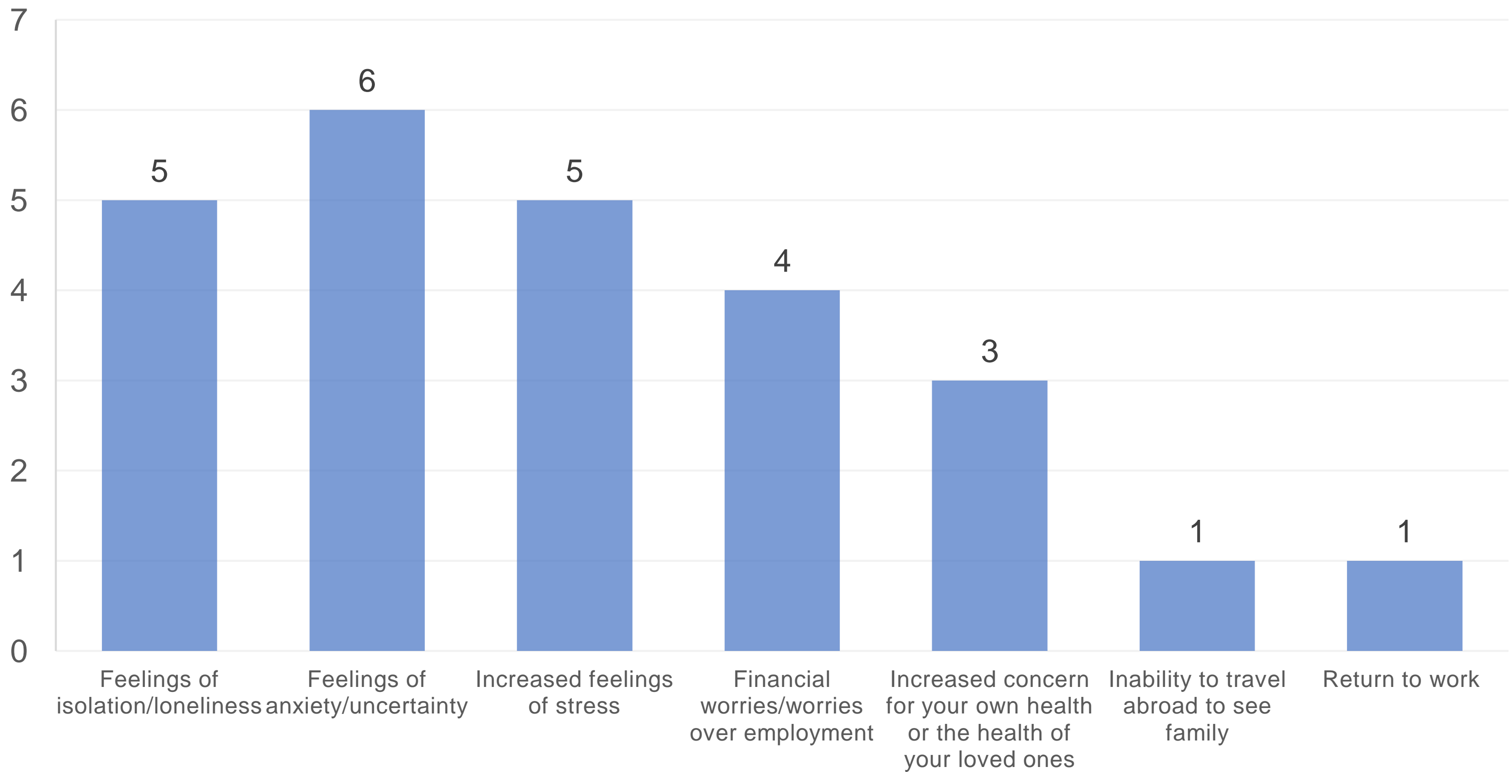

Figure 13: Bar chart showing the pandemic stressors identified by respondents as having a particular effect on them.

Respondents were asked to elaborate on any of the stressors they had selected (shown in Table 2).

Quotes from patients on pandemic stressors particularly affecting them
"I found it difficult to leave the house."
"Not being able to travel and having to look after a toddler with nowhere to take her and no childcare worsened the stress."
"Stressful being pregnant during the pandemic."
"There were stories about pregnant women dying soon after giving birth."
"It was horrible being in hospital on my own."
"Returning to work after furlough was an unprecedented workload that we were expected to meet."

Table 2: Quotes from patient respondents (anonymised) on pandemic stressors that particularly affected them.

Many felt that the pandemic had a positive impact on their bonding with their infant, with 4 reporting a slight or significantly positive impact (Figure 14). Those who felt a positive impact mentioned being able to spend more time with their baby and feeling less pressure to sign up to classes as contributing factors. One respondent reported a slight negative impact as she felt she had not been able to take her son out enough.

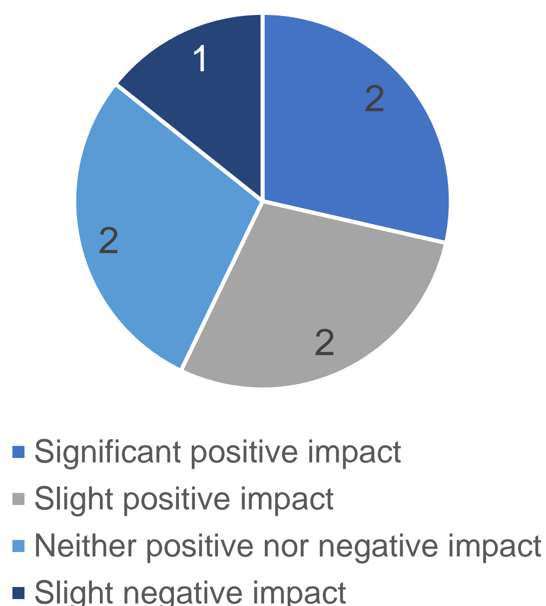

Figure 14: Pie chart showing the impact of the pandemic on respondents' bonds with their babies.

Respondents were asked to describe their most positive and negative experiences with the PMHS during the pandemic. Positive aspects included: feeling listened to and supported; having, and not being judged for, the option to take medication; and being given the option of admission to the MBU. Negatives involved COVID testing issues at the MBU, difficulties in organising prescriptions around Christmas, and not being able to have in-person appointments. Two respondents' most negative experiences related to their referrals – one felt she should have been referred earlier in her pregnancy and acknowledged that this was not the fault of the PMHS, while the other felt that she waited an excessive amount of time for her first appointment and that she was not adequately checked upon in the post-natal period. She described feeling extremely alone and unsupported, at a time when she was already feeling "hopeless and suicidal".

Lessons for the future

Areas of potential improvement identified are shown in Table 3. One respondent also mentioned the importance of staff knocking on doors before entering patient rooms, due to being walked in on whilst changing on multiple occasions.

Areas of potential improvement identified by patients
Speed of contact after referral
COVID testing setup in the MBU
Lack of group activities on the ward
Advance communication of ward rules and different monitoring levels
Availability of baby vitamins for inpatients
Improvement of ward internet connection

Table 3: Areas of potential improvement identified by patient respondents (anonymised).

71% of respondents felt that the option for remote consultation should remain available as the pandemic restrictions ease.

Staff survey

Background Information

Respondents included 4 CPNs, 3 inpatient nurses, 1 nursery nurse, 1 psychiatrist and 1 administrative staff. Five were community-based, four were ward-based and the administrative staff member covered both inpatients and outpatients. Their time working in the PMHS ranged from 6 months to 17 years.

Experience

100% described their overall feelings on working throughout the pandemic as positive (Figure 15). A common theme was the supportiveness and adaptability of the team. 70% believed restrictions had a negative impact on the quality of the service provided by the PMHS (Figure 16). Reasons included a reduction in the number of available appointments, less interaction with partners and families, difficulties in visiting and passes for inpatients, and a perceived reduction in patient engagement. However, it was noted that the team had continued to provide the service to the best of their ability, and had adapted well to the changes required.

The majority felt positively about remote consultation (Figure 17). Positive aspects included reduced travel time for clinicians, ability to reach patients who could not travel and video clinics allowing a visual connection with patients, whilst the negatives were difficulty building rapport, technical issues, and increased likelihood of missing subtle changes in mental state. When asked to compare remote consultation with face-to-face, 50% said it was somewhat

worse (Figure 18). Four respondents replied N/A to this question, having not conducted remote clinics. The most preferred consultation method was face-to-face (Figure 19), and 90% said they would not prefer remote consultation over face-to-face in the future as restrictions ease.

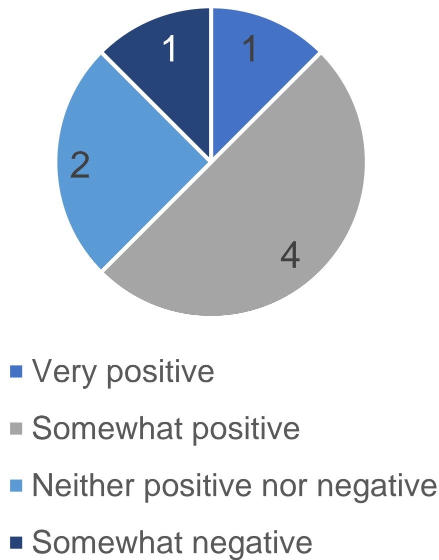

Figure 17: Pie chart showing overall feelings of staff respondents on remote consultation.

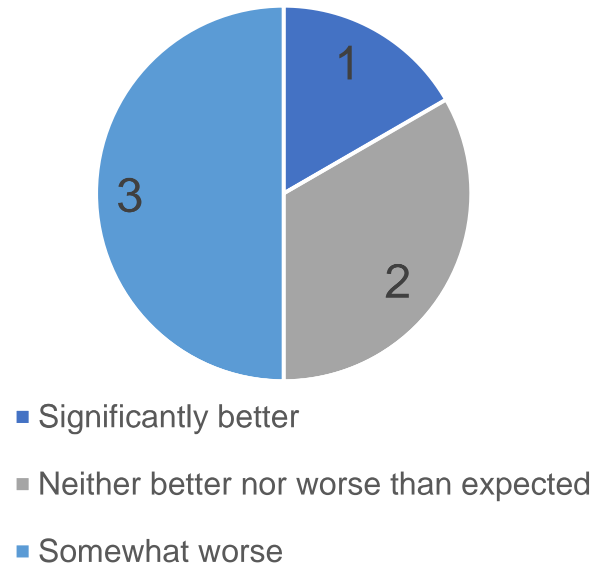

Figure 18: Pie chart showing feelings of staff respondents on remote vs in-person consultation.

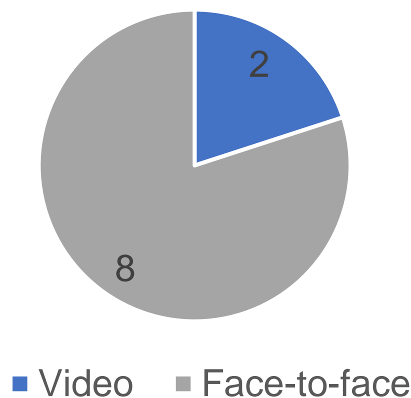

Figure 19: Pie chart showing preferred methods of consultation.

In terms of risk assessment, 5 respondents felt their assessment of risk was somewhat worse remotely. Many felt that seeing the patient face-to-face and being in the home environment provided a more robust assessment. Respondents were also asked about their feelings on working from home – 3 selected N/A for these questions. Of those who did respond, opinions on working from home varied from somewhat positive to very negative (Figure 20). Negatives highlighted were isolation from colleagues, technical difficulties, increased stress, and childcare issues.

30% felt that working through the pandemic had a negative impact on their mental wellbeing (Figure 21). However, all respondents felt supported by their employers (Figure 22). Table 4 shows some quotes from staff regarding their mental wellbeing working through the pandemic.

Feelings on working from home

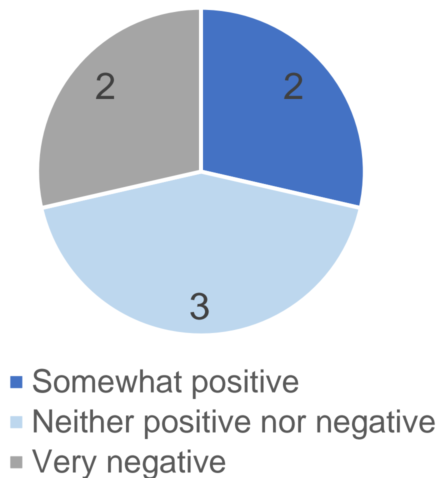

Figure 20: Pie chart showing respondents' feelings on working from home.

Impact of working through pandemic on staff mental health

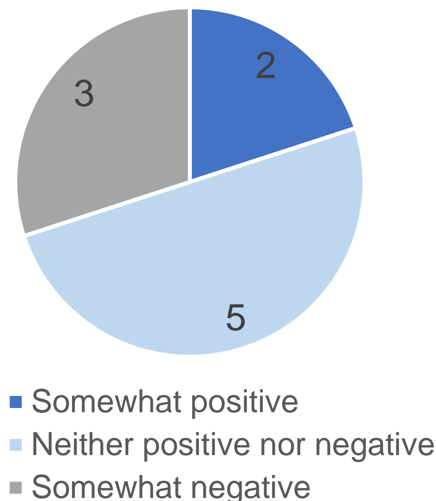

Figure 21: Pie chart showing the impact of working through the pandemic on the mental health of respondents.

How supported did you feel by your employers?

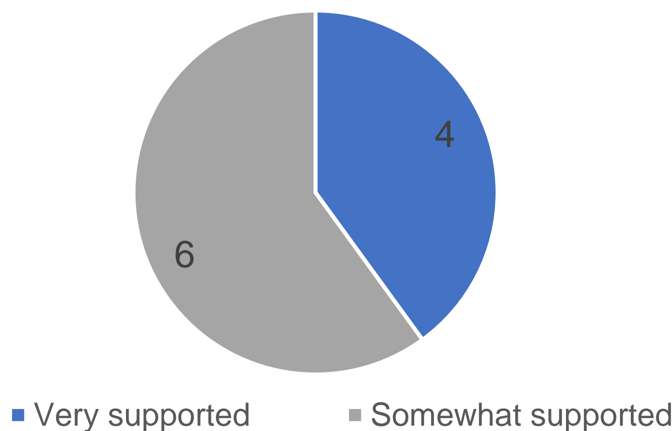

Figure 22: Pie chart showing how supported respondents felt by their employers.

Quotes from staff on mental wellbeing whilst working through the pandemic	
Negatives	**Positives**
"Demand for the service has increased."	"Has been good to remain at work."
"Often feeling isolated from team."	"Being able to see colleagues at work was enjoyable and provided a sense of normality."
"Difficult working whilst home-schooling"	"Very grateful to still have my routine and work colleagues for support throughout the last year."
"Perception that I was putting my family at increased risk of COVID despite PPE and precautions in place."	"Good sense of teamwork and camaraderie at work during the pandemic."
"Poor work-life balance – unable to see family and friends."	"Support is available upon request and employers have tried hard to provide this."
"Working longer hours from home."	"Staff have gone through this together and are very supportive and encouraging of each other."
"Increased stress, anxiety and workload."	
"Home environment became work environment as well so there was difficulty separating the two."	

Table 4: Quotes from staff respondents (anonymised) on mental wellbeing whilst working through the pandemic. Negative quotes are shown on the left column, and positives are shown on the right.

Figure 23 shows the impact of four factors related to the pandemic on respondents' experiences working in the PMHS. Of these, COVID-19 restrictions and staff changes were identified as having the strongest negative impact. Other negative factors identified were staff shortages, lack of group team-building opportunities, and a possible need for more support from "higher up" regarding equipment etc.

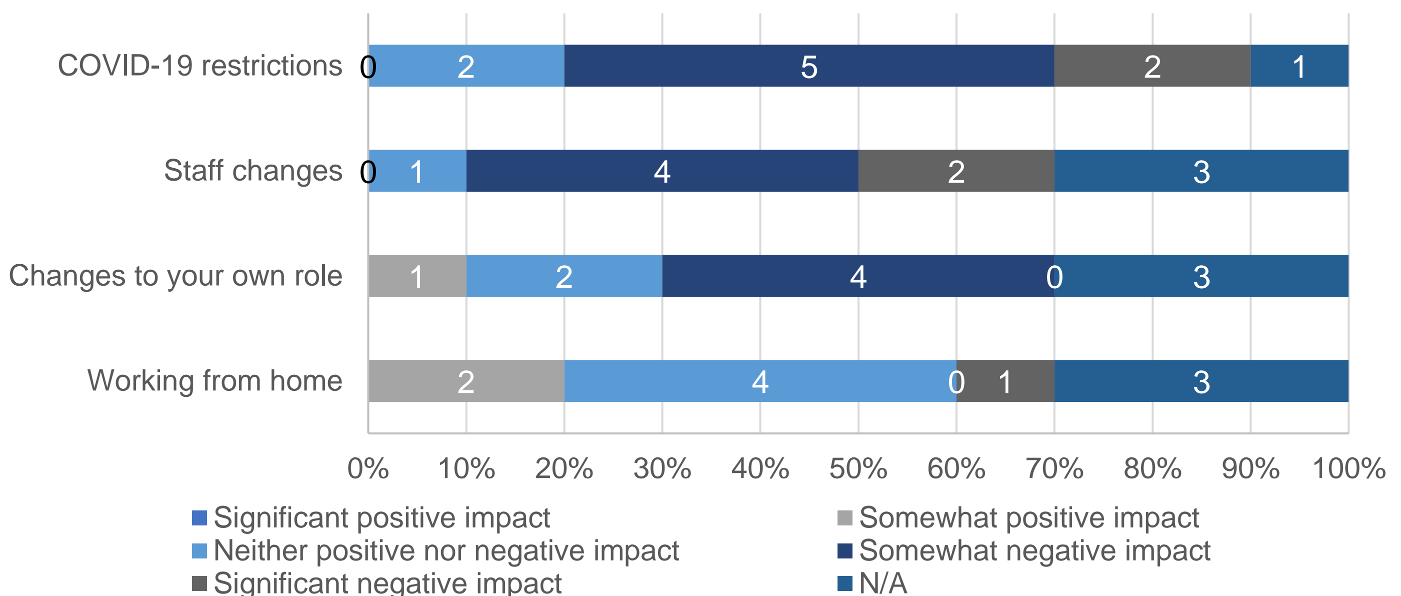

Figure 23: Stacked bar chart showing the impact of COVID-19 restrictions, staff changes, changes to respondents' own roles and working from home on respondents' experience working in the PMHS during the pandemic.

Lessons for the future

Areas for potential improvement identified are shown in Table 5.

Areas of potential improvement identified by staff
Staffing levels and supervision
IT equipment and infrastructure
Training on IT systems
Opportunities to reflect upon challenging cases
Adapting some treatments into online settings
Better contact with partners and families
Reviewing of setups to ensure it works best for staff e.g. structure of team meetings
Communication with staff in the event of COVID-19 outbreak
Staff consistency with interpreting COVID-19 rules on the ward
Opportunity for home visits

Table 5: Areas of potential improvement identified by staff respondents (anonymised).

4 respondents highlighted the importance of regularly checking in with staff to safeguard mental wellbeing. In terms of keeping any changes brought in due to the pandemic, respondents mentioned keeping the option of remote consultation available, maintaining an agile working rota, keeping MDT meetings online, and ongoing COVID-19 testing for staff.

Discussion

Limitations of data

As discussed, the response rates to the patient and staff surveys were 25% and 24% respectively. Therefore, both sets of data are from a small sample size and thus may not be representative of both populations as a whole. A number of factors may have contributed to the lower response rate.

- The patients contacted were all either pregnant or had a young baby – looking after a baby or preparing for one is very time-consuming, and so the patients may not have had time to complete the questionnaire. Furthermore, the patients are also having to focus on their own mental health and wellbeing.
- At the outset, had deadline been more clearly emphasised to patients there may have been a higher response rate.
- Various staff were away on annual leave or sick leave during the research period.

Comparison of results

There were some interesting comparisons between the patient and staff survey results. Figure 24 shows the overall feelings of patients on their experience with the PMHS versus staff feelings on the quality of service provided. 85% of patients felt positively about their experience, whilst 70% of staff had perceived a negative impact on the quality of service during the pandemic. This shows that despite the restrictions and changes the service has undergone, patients still felt they received high-quality care. Possible reasons for these staff feelings may include difficulty in assessing the wider picture (due to seeing less interaction between patients and their babies or partners) and difficulty in gauging patient satisfaction remotely.

Figure 25 shows the differences in preferred methods of consultation between patients and staff. Patients were equally split between video and face-to-face consultations, whereas staff overwhelmingly preferred face-to-face with 80% stating this as their preferred option. This would be useful to keep in mind when considering the option of using remote consultation in the future.

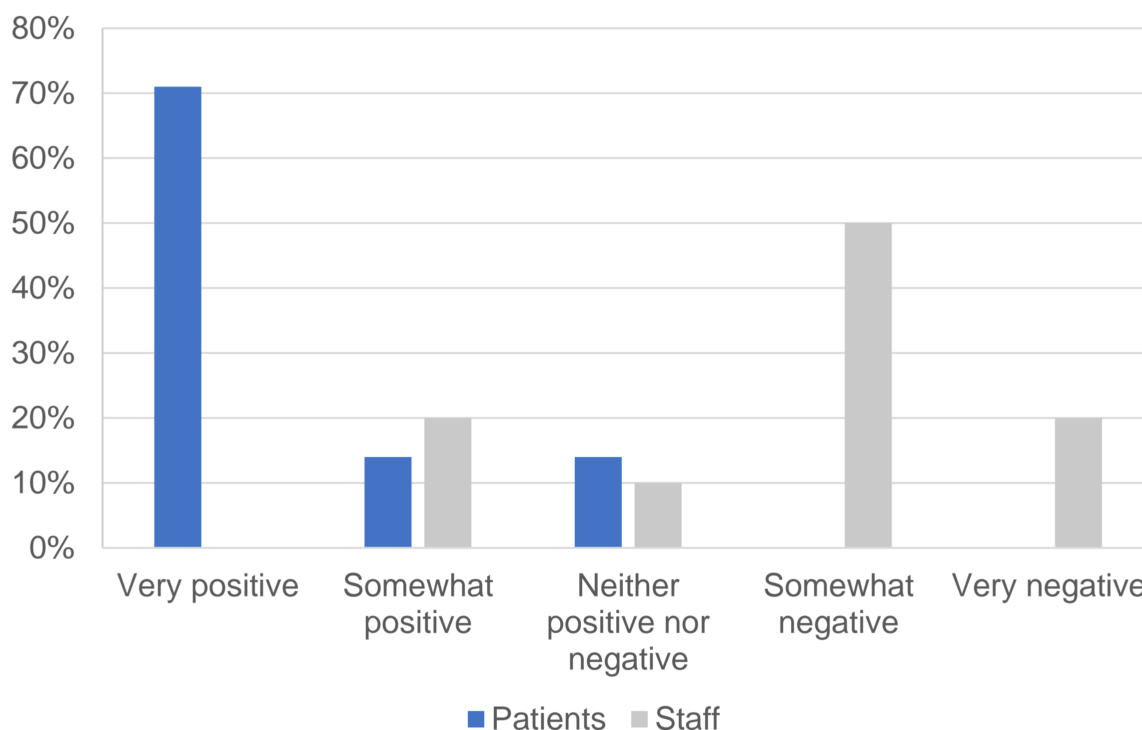

Figure 24: Clustered bar chart showing patient feelings on the PMHS against the staff feelings on the quality of service provided.

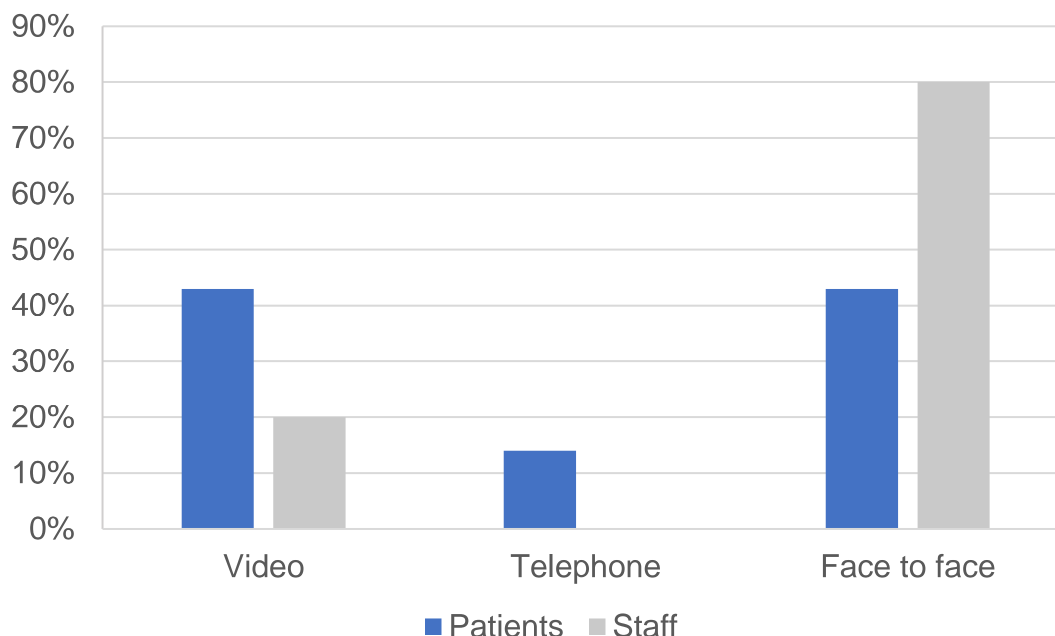

Figure 25: Clustered bar chart showing preferred methods of consultation of patients and staff.

Suggested improvements

From these results, the following suggestions for improving the PMHS are proposed (Table 6):

Suggested Improvement	**Rationale**
Keep the option of remote consultation available in future.	This would allow more patients to engage if they live further away.
Consider adapting some groups and therapies into an online format.	This would allow many benefits to patients whilst keeping within COVID guidelines.
Make COVID tests available to partners/families.	This could allow more flexibility for visiting the ward or letting patients out on pass provided everyone in their household has a negative test result.
Keep MDTs online and streamline meetings.	Online MDTs allow more professionals to be involved and give their expertise in more complex cases. However, long meetings which take up most of the day are detrimental to staff morale – possible suggestions include using the SBAR handover format[14] and keeping the MDT and allocations meetings separate.
Have a regular meeting with staff to check in on mental wellbeing.	Several staff highlighted the importance of this and expressed a desire to be able to reflect on difficult experiences with their colleagues. A meeting such as this would also be an opportunity for the team to reflect on things they have done well which would increase morale.
Ensure training on using IT systems is available to staff.	This may help to reduce the number of technical difficulties faced by staff using new systems.

Table 6: Improvements to the PMHS suggested based on anonymised results from both patients and staff. The suggested improvements are shown on the left with the rationale behind this improvement shown on the right.

Conclusion

The pandemic has impacted significantly on the PMHS in multiple ways. Overall, patients were satisfied with the care they received during the pandemic, despite staff perceptions of a reduction in service quality. Remote consultation proved to be a valuable tool and there are several benefits in keeping this option available. The PMHS staff feel they are part of an extremely supportive and encouraging team and support of colleagues was highly valued. The changes suggested would ensure the PMHS continues delivering high standards of care in the best way for patients and staff. In conclusion, despite the challenges posed by restrictions the PMHS has continued to deliver a high-quality service, and with the suggested changes this standard will only improve.

Appendix 1

The following is all available answer options for the demographic questions of the patient survey. These options were developed based on the UK Census categories.

Age group

- Under 18 years
- 18 - 24 years
- 25 - 29 years
- 30 - 34 years
- 35 - 39 years
- 40 - 44 years
- 45 years or over
- Prefer not to say

Ethnicity

- White Scottish, White British, White Irish
- White Traveller
- White Polish
- White Other
- Mixed or multiple ethnic group
- Asian, Asian Scottish, Asian British or Asian Other
- Pakistani, Pakistani Scottish or Pakistani British
- Indian, Indian Scottish or Indian British
- Bangladeshi, Bangladeshi Scottish or Bangladeshi British
- Chinese, Chinese Scottish or Chinese British
- African, African Scottish or African British
- Caribbean, Caribbean Scottish or Caribbean British
- Black, Black Scottish or Black British
- Arab, Arab Scottish or Arab British
- Prefer not to say
- Other

Religion

- Buddhist
- Church of Scotland
- Hindu
- Jewish
- Muslim
- Roman Catholic
- Sikh
- Christian - Other
- No Religion
- Prefer not to say
- Other

Disability status

- Disabled
- Not disabled
- Prefer not to say

Marital status

- Single
- Unmarried but in a relationship
- Married
- Civil partnership
- Divorced
- Widowed
- Dissolved civil partnership
- Prefer not to say

Sexual orientation

- Heterosexual
- Lesbian
- Bisexual
- Gay
- Prefer not to say
- Other

Gender identity

- Female
- Male
- Non-binary
- Prefer not to say
- Other

Is English your first language?

- Yes
- No

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