

Perinatal and Infant Mental Health

Equality Impact Assessment Record

March 2021

Equality Impact Assessment Record

Title of policy/ practice/ strategy/ legislation etc.	Perinatal and Infant Mental Health	
Minister	Clare Haughey Minister for Mental Health	
Lead official	Rebecca MacPherson	
Officials involved in the EQIA	name	team
	Rebecca MacPherson	Perinatal and Early Years Mental Health Team
Directorate: Division: Team	Mental Health and Social Care Directorate	
Is this new policy or revision to an existing policy?	New policy	

Screening

Policy Aim

Improving perinatal and infant mental health as a key commitment. We will provide three tiers of support across Scotland, in line with the needs of individuals:

- For those 11,000 women a year who would benefit from help such as counselling we will support the third sector to provide this
- For those 5,500 women in need of more specialist help we will ensure rapid access to psychological assessment and treatment
- For those 2,250 women with the most severe illness we will develop more specialist services and consider the need for a small number of additional inpatient beds or enhanced community provision”

This commitment is supported by **£50 million of investment** in perinatal and infant mental health services over the next 4 years.

This investment will cover:

1. Community and third sector support, including peer support, for issues that can occur during and after pregnancy.

2. New models of service delivery for specialist perinatal mental health services across Scotland, including what models would look like for different geographies and birth rates.
3. Specialist care for acute perinatal mental health problems.
4. Improved infant mental health services.

In moving forward with this plan, Perinatal and Infant Mental Health, the Scottish Government is mindful of the three needs of the Public Sector Equality Duty (PSED) - eliminate unlawful discrimination, harassment and victimisation, advance equality of opportunity between people who share a protected characteristic and those who do not, and foster good relations between people who share a protected characteristic and those who do not - and recognises while the plan may positively impact on one or more of the protected characteristics¹, also recognises that the introduction of the measures may have a disproportionate negative impact on one or more of the protected characteristics. Where any negative impacts have been identified, we have sought to mitigate/eliminate these. We are also mindful that the equality duty is not just about negating or mitigating negative impacts, as we also have a positive duty to promote equality. We will seek to do this through support and guidance.

The desired outcome is that every family can expect a service which meets the expectations set out in the Women and Families Maternal Mental Health Pledge. The foundation of the pledge is - 'I should have the right to good care from NHS Scotland for my baby, my family and me'.

I expect that:

1. *I am fully involved, and at the centre of my care, so that I have the information I need to make the best decisions for me, my pregnancy and my infant's future health*
2. *I can be confident that staff who assess and care for me will have the appropriate level of knowledge and skills*
3. *I will receive preconception and pregnancy advice and care if I have a pre-existing mental health problem*
4. *I will receive expert advice and care about my maternal mental health when I require it, wherever I live in Scotland*
5. *I will have rapid access to talking therapies during my pregnancy and postnatal period*
6. *I can openly discuss my maternal mental health without fear of stigma or of being judged*
7. *My family are given the information and support they need to help me and to get help for themselves*
8. *I can be confident that my baby will have parents who are supported with their mental health*

¹ Section 4 of the Equality Act 2010

The new perinatal and infant mental health policy will contribute to these National Outcomes;

Children and Young People – We grow up loved, safe and respected so that we realise our full potential

Communities – We live in communities that are inclusive, empowered, resilient and safe

Health – We are healthy and active

Barriers to accessing antenatal care

What do we mean by access?

Early access to antenatal care is important however access is not just about physical access to antenatal booking at a particular point in time - it is about the quality and impact of ongoing access to, and engagement with, antenatal healthcare.

Specific barriers that impact upon access are two-fold; those experienced by the woman herself, i.e. feeling awkward or fear of being judged; those experienced by staff including poor attitudes, lack of understanding of the issues faced by the woman and her family or lack of knowledge about where women and families can get support.

Women may not seek help for perinatal psychological distress, despite regular contact with primary care services. Pregnant women are more likely than non-pregnant women to be diagnosed with depression, and less than half of those diagnosed receive appropriate treatment. However, there is contradictory evidence within the literature that woman may not be more likely to develop depression in the perinatal period than their counterparts but it is picked up in the perinatal period due to the increased interaction with primary care during this time and significant change in circumstances. Around 20% of women have diagnosable depression within 12 months post birth and between 10-13% in the antenatal period. Figures on the prevalence of depression in women vary greatly, from 3% to up to 65% in self-reported wellbeing questionnaires. Several sources put the range around 20% for the likelihood of a woman suffering diagnosable depression during her lifetime which would mirror the rates predicted around the perinatal period.

Common themes related to the experience of barriers in accessing antenatal care across the 'exemplar groups' included in the draft NICE guideline (2010) are:

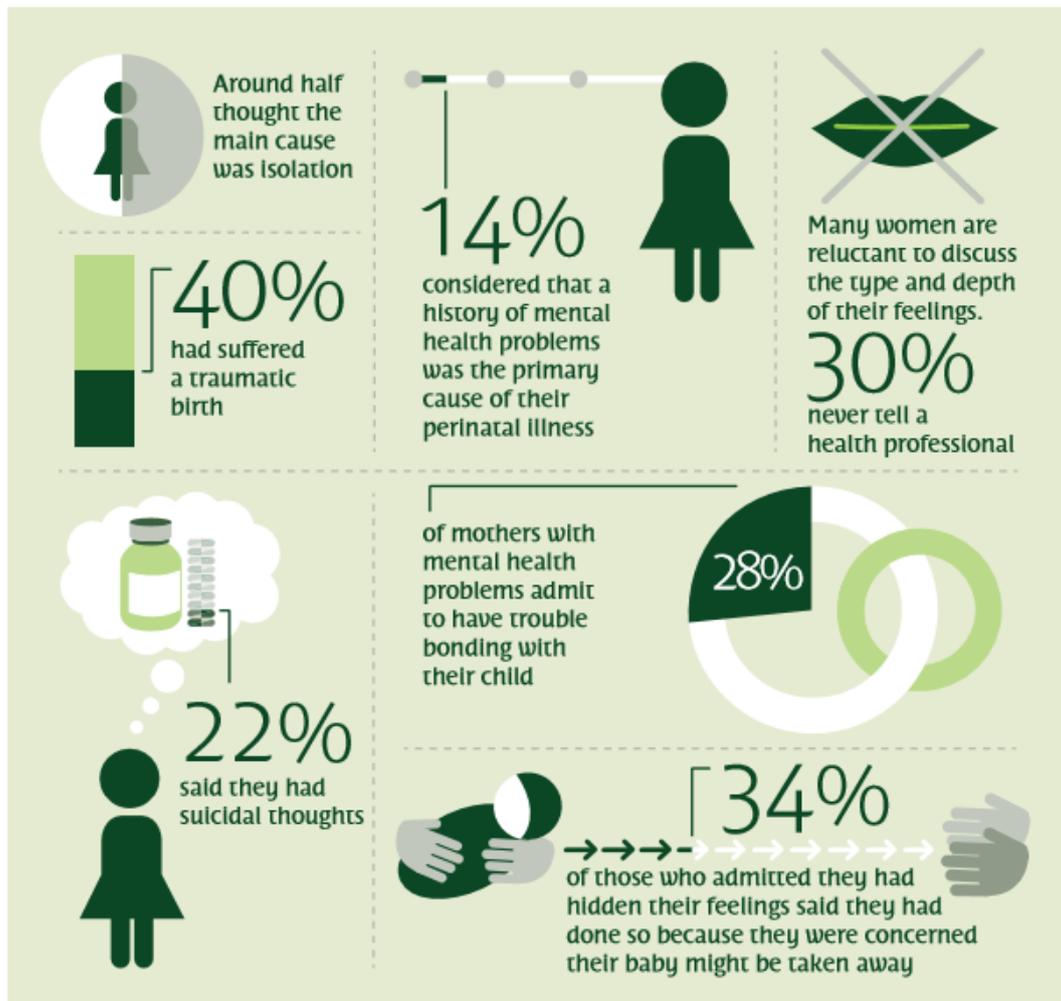
- treatment by and attitudes of staff
- lack of integrated care involving different service providers
- lack of knowledge about the life experiences of women with socially

complex needs, for example, lack of awareness of religious, cultural or social differences and needs.

Barriers to access

- Women's perceptions and fears of how they will be treated
- Women's fear that their baby will be 'taken away' if they disclose for example- substance misuse or domestic abuse
- Treatment by and attitudes of staff
- Poor continuity of individual care and lack of Integrated care by local service providers
- Lack of staff knowledge and sensitivity about the impact of social inequalities on women's lives
- Poor communication between staff and women. The information may not be available in different community languages, easy to read language and accessible format such as British Sign Language. There may not be an interpreter available at every meeting or appointment so this will lead to a breakdown in communication.

Figure 1. Results from a survey via Netmums of more than 1,500 women who had perinatal mental health problems, conducted by Boots Family Trust Alliance (Tommy's, Royal College of Midwives, Institute for Health Visiting and Netmums) in 2013 (Tommy's, 2013)².



Protected Characteristics which have to be considered in the EQIA process;

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation
- 'Marriage and civil partnership'*

² Tommys, Royal College Midwives, Institute for Health Visiting, Netmums. (2013) Perinatal Mental Health Experiences of Women and Health Professionals. *Boots Family Trust Alliance*. Available from: <http://everyonesbusiness.org.uk/wp-content/uploads/2014/06/Boots-Family-Trust-Alliance-report.pdf>

Specifically, the EQIA considers impacts on equalities groups based on the three tests it is required to address:

- Does this policy eliminate discrimination for each of the 9 PCs. If not is the discrimination justifiable? Can it be mitigated?
- Does this policy advance equality of opportunity for PC groups?
- Does this policy foster good community relations between people of PC groups.

These are considered in the analysis of protected characteristics that follows.

Main risk factors for Perinatal Mental Health Issues

According to several systematic reviews of the literature the main risk factors for perinatal illness are a previously diagnosed mental health condition. There is a recognised relationship between poor mental health in the antenatal period and the occurrence of poor mental health postnatally. The other main risk factors for perinatal mental illness identified from the literature are social support and lack thereof, deprivation and complex social circumstances.

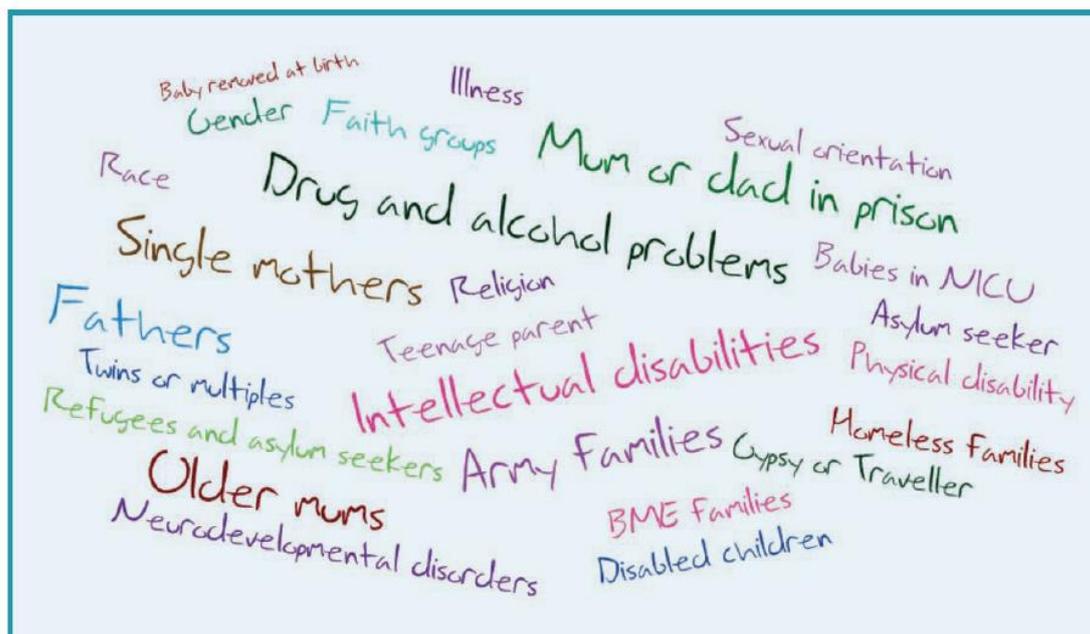


Figure 2. An illustration of specific groups of people whose needs around perinatal mental health may need to be considered differently, from a workshop by Maternal Mental Health Alliance and a group of midwives.

Evidence Summary

Age

Young people

It is well documented that perinatal depressive disorders are more common in teenage and young mothers (<24 years old) (Xavier et al., 2018)³. As a whole, teenage pregnant mothers (15-19) are significantly more at risk of developing perinatal mental illness than their adult counterparts (Nuffield Trust – Teenage Pregnancy)⁴. Generally, women who give birth aged 15-24 are more likely to suffer from perinatal depression. Antenatal anxiety and depression (during pregnancy) are also more common in younger mums. Some reports attribute this to younger women increased fear of judgement from society and healthcare providers, and perception of lack of social support and isolation from peers (Jenkins, 2013)⁵.

In Scotland, the additional needs of young families have been recognised by the Scottish Government. The Family Nurse Partnership was launched in 2009. This service offers additional support to young parents in the form of a schedule of home visits from a specialist nurse during pregnancy and until the child reaches 2 years old (Ormston, 2014⁶). This service replaces the standard health visiting pathway for young mums who join the programme and is offered to all primiparous women up to 19 years of age and those up to the age of 25 in some areas. The service provides intensive support to young mums around attachment, parenting skills, mental wellbeing, child safety and more. It has recently been evaluated and graduates from the scheme rate the service positively. It has been shown to help break to poor parenting cycle that some families get caught in, with multiple generations becoming parents in adolescence (Scottish Government, 2019)⁷. The programme provides a safety net for young, often vulnerable mums and new parents. The intensive support provides continuity of care which helps individuals engage with health services and provides regular opportunities for mental wellbeing to be discussed and interventions offered as appropriate. Several NHS boards, in collaboration with the third sector also offer specific antenatal classes for young mums and young dads which are offered by midwives, based on individual need (NHS Lothian, 2011)⁸.

³ Xavier, C. Benoit, A., & Brown, H.K. (2018) Teenage pregnancy and mental health beyond the postpartum period: a systematic review. *Journal of Epidemiology & Community Health*, vol 72. Available from: <https://jech.bmj.com/content/72/6/451>

⁴ Nuffield Trust Teenage pregnancy. Available from: <https://www.nuffieldtrust.org.uk/resource/teenage-pregnancy>

⁵ Jenkins, K. (2013) Young Mums Together: Promoting young mothers' wellbeing. *Mental Health Foundation*. Available from: [Mental Health Foundation Young Mums Together Promoting Young Mothers' Wellbeing \(2013\)](#)

⁶ Ormston, R., McConville, S., & Gordon, J. (2014) [Evaluation of the Family Nurse Partnership Programme in NHS Lothian, Scotland](#). *ScotCen Social Research*. Scottish Government: Edinburgh

⁷ Scottish Government (2019) [Family Nurse Partnership in Scotland: revaluation report](#)

⁸ NHS Lothian (2011) Parent Education Resources. Available from: <http://www.maternal-and-early-years.org.uk/nhs-lothian-parent-education-resources>

Advanced maternal age

The average maternal age at birth has been increasing for the last 20 years in the UK (Information Services Division (ISD), 2018)⁹. Societal shifts in women choosing to pursue further education and beginning their careers in their 20's has resulted in more and more first time mothers over 35. In 2014 the average age of first time mothers was 30.1 years, with over half of all mothers giving birth for the first time over age 29. In 2016 there were more mothers over 34 than under 25 for the first time since records began.

Women over 35, who are in the 4th and 5th most deprived categories, are just as likely to develop postnatal depression as younger mums (18-24 years old) (Ban et al., 2012)¹⁰. There are other risks associated with pregnancy over the age of 35, and therefore these women may have more contact with maternity services, allowing more opportunities for any development of poor mental health to be identified and managed. Although maternal age is consistently increasing, there may be a perception that older mums are more secure and their maturity can be a protective factor.

Between 90.2% and 93.3% of pregnancies were booked by the end of 15 weeks gestation. This leave a potential of 25 weeks of antenatal time for mental health problems to be identified for the majority of women (ISD, 2018). Key factors which were common in those who booked past 15 weeks were being under 20 years old and those in from the most deprived postcodes. Interestingly, those over 40 were just as likely to book after 15 weeks than those ages 20-24. There was a positive relationship between booking within 12 weeks and being in the least deprived postcode. Those living in the most deprived postcode were more than 5% less likely to attend a booking appointment than those in the least deprived. Both of these trends have been consistent since 2010 and are based on maternities with a known booking date (ISD, 2018).

Disability

It has been estimated that 9.4% of women giving birth in the United Kingdom have one or more limiting longstanding illness which may cause disability, affecting pregnancy, birth and early parenting (Redshaw et al., 2013)¹¹. Redshaw and colleagues carried out an England wide study to ask women of their experiences of maternity care, who identified as having one or more disability or life limiting condition including physical impairment, intellectual impairment and mental illness. The results indicated that overall women were happy with their care although the women felt they had less choices made

⁹ Information Services Division (2018) Births in Scottish Hospitals report. NHS National Services Scotland: Edinburgh. Available from: <https://www.isdscotland.org/Health-Topics/Maternity-and-Births/Publications/2018-11-27/2018-11-27-Births-Report.pdf>

¹⁰ Ban, L., Gibson, J.E., West, J., Fiaschi, L., Oates, M.R., & Tata, L.J. (2012) Impact of socioeconomic deprivation on maternal perinatal mental illnesses presenting to UK general practice. *British Journal of General Practice*, vol 62. Available from: <https://bjgp.org/content/62/603/e671.short>

¹¹ Redshaw, M., Malouf, R., Gao, H., & Gray, R. (2013) Women with disability: the experience of maternity care during pregnancy, labour and birth and the postnatal period. *BMC Pregnancy and Childbirth*, vol 13. Available from: <https://doi.org/10.1186/1471-2393-13-174>

available to them. Disabled women were in contact with health professionals just as early as non-disabled women (95% and 94% by week 12). Women with mental illness accessed maternity services more often than any other type of disability and were more likely to be negative about communication and support received than all other groups. Women with learning disabilities were the least likely cohort to record a positive maternity care experience. There were also confounding factors to consider which may impact mental health during this period. Disabled women were more likely to be over 35, have preterm births, low birth weight babies and significantly less likely to have a partner (Redshaw et al., 2013).

A report by Engender¹² around the reproductive rights of disabled women (mainly those with intellectual impairment) stated some of their concerns. The women interviewed felt scared about their baby or children being taken away from them by social services, so often did not engage fully with services. Although they did state that they would like more support in becoming a parent without the underlying fear of children being removed (Engender, 2019). Additionally, women felt they were unequipped to deal with a lot of antenatal and postnatal situations as they did not have the knowledge, even basic knowledge, of reproductive science. For example, one woman did not know she could get pregnant when her period started. There are actions in place to support people with disabilities to access and understand NHS services. Maternity care services have specific easy access information about antenatal testing, what will happen in labour etc and some NHS Boards in Scotland have specific pathways of care for disabled women and antenatal classes. There are also mechanisms like the health passport which disabled people can take with them to appointments and hospital visits to inform staff of their specific needs without having to explain (Carter & Evans, 2015).¹³

Mental Illness

Women who have had a previous episode of a serious mental illness, either following childbirth or at other times, are at an increased risk of developing another episode in the postnatal period even where they have been well during pregnancy and for many years previously. This risk is estimated as at least 50% (Iliadis et al., 2015)¹⁴. All women should be asked about this and previous mental health problems in their antenatal booking appointment, and any interventions or referral to the correct pathway should be provided. Recently, the links between bipolar and postpartum psychosis have become more evident. Women who have a diagnosis of bipolar have a 25-50% risk of developing postpartum psychosis (Iliadis et al., 2015). Preconception planning and education or early identification of a history of mental health conditions for those who are not currently under the care of mental health services, during routine antenatal appointments, is key in ensuring appropriate care is

¹² Engender - Our Bodies, Our Rights: Research Report – Available from: <https://www.engender.org.uk/files/our-bodies-our-rights-additional-research-report.pdf>

¹³ Carter, C., & Evans, R. (2015) Hidden Voices of Maternity: Parents with Learning Disabilities Speak Out. NHS England. Available from: <https://www.picker.org/wp-content/uploads/2016/01/Hidden-Voices-of-Maternity-Report-FINAL.pdf>

¹⁴ Iliadis, S.I., Koulouris, P., Gingell, M., Sylven, S.M. et al (2015) Personality and risk for postpartum depressive symptoms. *Archives of Women's Mental Health*, vol 18. Available from: <https://link.springer.com/article/10.1007/s00737-014-0478-8>

received throughout the perinatal period. Several confidential enquiries into maternal deaths in the UK have found suicide to be a leading cause of maternal death (Lewis, 2001, 2004, 2007)¹⁵ and it is clear that a high proportion of maternal suicides occur in women with an acute onset of psychosis in the early postpartum period (Oates 2003)¹⁶. Some of the women who present with postnatal psychosis have no clinical record of mental health problems, however history of previous mental illness can be a strong predictor and risk factor for developing perinatal mental health problems. Ensuring women are asked regularly and understand the importance of disclosing this history to their midwives (or other health professionals) is important.

Although suicide numbers are very low in pregnancy and postnatally, it still remains the leading cause of maternal death in the UK (MBRACE, 2018)¹⁷. One study on risk factors for perinatal suicide looked at 1439 women with psychiatric disorders who were patients at UK MBUs between 2001-2010 (Gressier et al., 2017)¹⁸. Out of these women, 11.86% attempted suicide; 3.7% in pregnancy and 7.97% in the year after giving birth. Different risk factors were significant for pregnancy and postnatally. In pregnancy, those who had issues with alcohol and smoking or had a history of miscarriage were more likely to attempt or complete suicide. On the other hand, in the postnatal period suffering a major depressive episode, recurrent depression and young age were shown to be significant risk factors. All of the women who have severe perinatal mental illness should be seen by specialists or admitted to MBUs however these factors could be highlighted to professionals as risk factors for suicide.

Coming forward with mental health concerns in pregnancy and after birth can be difficult for women. One study on help-seeking behaviours in pregnancy saw 13.6% of women seek help for depressive symptoms in pregnancy. Those without a clinical history of psychological problems were less likely to seek help than those who had (Fonseca et al., 2015)¹⁹. Some facilitators in helping women come forward with mental health concerns are; normalisation of mental health care as part of antenatal and postnatal care, hearing other women's emotional problems in this period, and knowing what is 'normal'/what to expect (Kingston et al., 2015)²⁰.

¹⁵ Lewis, 2001, 2004, 2007 Several confidential enquiries into maternal deaths in the UK have found suicide to be a leading cause of maternal death. Available from:

<https://www.publichealth.hscni.net/sites/default/files/Saving%20Mothers'%20Lives%202003-05%20.pdf>

¹⁶ Oates (2003) High proportion of maternal suicides occur in women with an acute onset of psychosis in the early postpartum period. Available from: <https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/suicide-the-leading-cause-of-maternal-death/7D7D78E8E7F515E2749C21366BF00C71>

¹⁷ UK (MBRACE, 2018) Suicide numbers are very low in pregnancy and postnatally, it still remains the leading cause of maternal death. Available from [MBRACE UK Perinatal Mortality Surveillance Report UK Perinatal Deaths for Births from January to December 2016](https://www.mbrace.org.uk/perinatal-mortality-surveillance-report-uk-perinatal-deaths-for-births-from-january-to-december-2016)

¹⁸ Gressier, F., Guillard, V., Cazas, O., Falissard, B. et al (2017) Risk factors for suicide attempt in pregnancy and the post-partum period in women with serious mental illnesses. *Journal of Psychiatric Research*, vol 84. Available from: <https://www.sciencedirect.com/science/article/pii/S002239561630509X>

¹⁹ Fonseca, A., Gorayeb, R., & Canavarro, M.C. (2015) Women's help-seeking behaviours for depressive symptoms during the perinatal period: Socio-demographic and clinical correlates and perceived barriers to seeking professional help. *Midwifery*, vol 31. Available from: <https://www.sciencedirect.com/science/article/pii/S0266613815002466>

²⁰ Kingston, D., Austin, M., Heamann, M., McDonald, S., Lasiuk, G. et al (2015) Barriers and facilitators of mental health screening in pregnancy *Journal of Affective Disorders*, vol 186. Available from: <https://www.sciencedirect.com/science/article/pii/S0165032715300811>

Ethnicity

The UK has been classed as ‘super diverse’, home to people with complex mixes of ethnicities, as well as asylum and refugee populations (Latif, 2014²¹; Public Health England, 2017)²². The diversity of the population in the UK is more evident in England, with Scotland home to fewer ethnic groups and a lower population of migrants. Nevertheless, Scotland has a responsibility to ensure women and families can access and receive proper care in the perinatal period no matter what ethnicity.

There is currently a lack of data on ethnicity and mental health in Scotland. Previous research has shown that the relationship between ethnicity and mental health is complex, such that it is difficult to discern any clear patterns between ethnic groups. This is also true specifically for perinatal mental illness in Scotland. More research is needed in understanding the prevalence of poor perinatal mental health and equity of access to perinatal mental health services for different ethnicities Scotland.

In general, the UK BAME population is more likely to have poor mental health and this may be true in the perinatal period (NHS Digital, 2019)²³. The evidence indicates that in the UK, BAME people are more likely to suffer from serious mental illnesses, particularly psychosis and schizophrenia, than other ethnic groups (Halvorsrud et al., 2019²⁴; Kirkbride et al., 2012)²⁵. There are likely to be underlying social, psychosocial and cultural stressors which may increase the rates of mental ill health in minority ethnic communities in the UK. There is a recent theory around increased levels of mental illness in minority ethnic communities in the UK – these communities are more likely to live in persistent hardship and suffer discrimination than the average citizen. Therefore, the driving factor may not be physiological/biological but systematic.

Migrant women can be vulnerable for several reasons. Many, especially spousal migrants, speak little or no English. In theory interpreters are supposed to facilitate communication at medical appointments but in practice this is often difficult due to the lack of interpreters, lack of planning and lack of awareness of the rights a woman has to appropriate medical care (on patient and professional sides). Even the first step of communicating with medical receptionists can be challenging (Latif, 2014). It can be particularly difficult for urgent and emergency appointments where it can be very difficult to facilitate

²¹ Latif, Z. (2014) The maternal mental health of migrant women. *Race Equality Foundation*. Available from: <https://www.gmmh.nhs.uk/download.cfm?doc=docm93jjm4n895.pdf&ver=1674>

²² Public Health England (2017) Health Profile for England 2017: Chapter 5: Inequality in Health. Available from: <https://www.gov.uk/government/publications/health-profile-for-england>

²³ NHS Digital (2019) Common Mental Disorders. Available from: <https://www.ethnicity-facts-figures.service.gov.uk/health/mental-health/adults-experiencing-common-mental-disorders/latest>

²⁴ Halvorsrud, K., Nazroo, J., Otis, M., Hajdukova, E.B., & Bhui, K. (2019) Ethnic inequalities in the incidence of diagnosis of severe mental illness in England: a systematic review and new meta-analyses for non-affective and affective psychoses. *Social Psychiatry and Psychiatric Epidemiology*, vol 54. Available from: <https://link.springer.com/article/10.1007/s00127-019-01758-y>

²⁵ Kirkbride, J.B., Errazuriz, A., Croudace, T.J., Morgan, C., Jackson, D. et al (2012) Incidence of schizophrenia and other psychoses in England, 1950-2009: a systematic review and meta-analyses. *PLoS One*, vol 7. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/22457710>

meaningful interaction if an interpreter cannot be sourced. One paper on the views of migrant women on maternity care had a testimony from a Chinese woman who spoke very little English, only realising the midwife needed to take a blood samples as the midwife began the physical process of taking the sample. These instances may be rare but there is little hope of discussing complex and sensitive emotional and psychological issues when basic medical terms cannot be understood by some women. Often women come along to appointments with their husbands/partners/family members. This can often be seen as an easy solution to the language barrier especially if the other person speaks English. However, disclosure of mental health struggles to partners can be extremely difficult. Women understanding their rights as a patient can be frustrated by a poor communication of the information given at an appointment by the person who speaks better English. Ultimately, a woman who does not speak English well or who relies on someone they know for interpretation purposes is receiving inadequate care and this may be a potential equalities gap.

Every person in Scotland has the same rights to care and The Patient Rights (Scotland) Act 2011 was passed by the Scottish Parliament on 24 February 2011, and received Royal Assent on 31 March 2011. The Act gives all patients the right that the health care they receive will: consider their needs, consider what would most benefit their health and wellbeing, and encourage them to take part in decisions about their health and wellbeing, and provide them with the information and support to do so.

There is a clear intercultural communication barrier in perinatal mental health. Some ethnic minority women, specifically those of African or Asian descent, are unlikely to disclose emotional issues even when prompted by Health Visitors or Midwives (Babatunde et al., 2012;²⁶ Watson et al., 2019)²⁷. Reasons stated for this include cultural stigma, non-recognition of depression as an illness and fear or shame of judgement from their family and communities. This may make it difficult for women to receive adequate care for their mental health around pregnancy and birth. A focus group questioned the usefulness of the Edinburgh Postnatal Depression Scale for African women or those from African descent. There are difficulties in using standardised scales that have been developed with a white British (Western) demographic with different ethnic communities. Some cultures do not recognise depression as an illness, and many do not have a word for depression which make it's more difficult for them to acknowledge their feelings and need for additional support. Additionally, the gender roles and power balance in different cultures and communities can be starkly different from what is considered 'normal' in the UK today.

²⁶ Babatunde, T., & Moreno-Leguizamon, C.J. (2012) Daily and Cultural Issues of Postnatal Depression in African Women Immigrants in South East London: Tips for Health Professionals. *Nursing Research and Practice*, vol 2012. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3465899/>

²⁷ Watson, H., Harrop, D., Walton, E., Young, A., & Soltani, H. (2019) A systematic review of ethnic minority women's experiences of perinatal mental health conditions and services in Europe. *PLoS One*, vol 14. Available from: <https://pubmed.ncbi.nlm.nih.gov/30695019/>

Asylum Seekers and Refugees

Asylum seekers and refugees are at risk of developing mental health problems both due to their exposure to trauma in the home countries that they have fled, and from a range of post-displacement stressors, including social isolation, poverty, lack of access to resources and discrimination (Miller & Rasmussen, 2017;²⁸ Turrini et al., 2017)²⁹. There is evidence that asylum seeker and refugee populations experience a higher burden of poor mental health however; one meta-analysis reported that common mental disorders (anxiety and depression) are twice as prevalent among asylum seekers and refugees than among labour migrants (Lindert et al., 2009)³⁰. There is little evidence around the prevalence of perinatal mental health disorders in asylum and refugee population in Scotland.

An issue for some migrants, asylum seekers and refugees accessing care is the fear of being charged for health services. There have been several reports in the media about non UK citizens being charged up to £11,000 for the standard antenatal and postnatal care provided in the UK (Gentleman, 2017;³¹ Greenfield, 2019)³². Some reports suggest that pregnant women are not accessing any antenatal care up until the point they give birth in order to save money. Maternity care is classed as an urgent care and women are entitled to medical treatment related to pregnancy care even if they do not have the immediate ability to pay for the services and they do not have to pay before they receive services. The fear surrounding sizable bills for medical care may prevent migrant women from accessing perinatal health services including mental health services. Money worries has been cited by new parents as a significant stressor (Bauer et al., 2014³³) therefore demanding payment for medical services could be a very real barrier to care for some populations. Asylum seekers and refugees do not have to pay for medical care, however during the period of seeking asylum, people have wrongly received bills and demands for payments which has stopped them from attending future appointments in fear of not being able to pay.

Ultimately, although perinatal mental illness affects all women regardless of ethnicity or social class, additional contributory risk factors include social exclusion, deprivation, and relationship complexities. Despite all the attempts

²⁸ Miller, K.E., & Rasmussen, A. (2017) The mental health of civilians displaced by armed conflict: an ecological model of refugee stress. *Epidemiology and Psychiatric Sciences*, vol 26. Available from: <https://doi.org/10.1017/S2045796016000172>

²⁹ Turrini, G., Purgato, M., Ballette, F., Nosè, M., Ostuzzi, G., & Barbui, C. (2017) Common mental disorders in asylum seekers and refugees: umbrella review of prevalence and intervention studies. *International Journal of Mental Health Systems*, vol 11. Available from: <https://doi.org/10.1186/s13033-017-0156-0>

³⁰ Lindert, J., von Ehrenstein, O.S., Priebe, S., Mielck, A., & Brähler, E. (2009) Depression and anxiety in labor migrants and refugees – A systematic review and meta-analysis. *Social Science & Medicine*, vol 69. Available from: <https://www.sciencedirect.com/science/article/pii/S0277953609002627>

³¹ Gentleman, A. (2017) Pregnant women without legal status 'too afraid to seek NHS care'. *The Guardian*. Available from: <https://www.theguardian.com/uk-news/2017/mar/20/pregnant-asylum-seekers-refugees-afraid-seek-nhs-maternity-care>

³² Greenfield, P. (2019) End NHS maternity charges for vulnerable migrants, say midwives. *The Guardian*. Available from: <https://www.theguardian.com/society/2019/sep/09/end-nhs-maternity-charges-for-vulnerable-migrants-say-midwives>

³³ Bauer, A., Parsonage, M., Knapp, M., Lemmi, V., & Adelaja, B. (2014) The costs of perinatal mental health problems. *Centre for Mental Health*. Available from: <http://eprints.lse.ac.uk/59885/>

in the literature to explain mental illness in different ethnicities, it is too complex to identify a cause.

Gypsy/Traveller Communities

Mental health needs in the perinatal period are widely unknown for this community. It is difficult to estimate the wider health needs of Gypsy/Traveller communities as a whole in Scotland, due to a lack of routine monitoring and difficulties in estimating the size of this population. At the most recent census, the Gypsy/Traveller population was recorded at 4000 (Scottish Government, 2011)³⁴. Activist groups estimate the number to be close to 15,000 – 20,000. This represents less than 0.3% of the population of Scotland however, women in this community are more likely to have multiple children, exceeding that of the Scottish average of 2.1 per family (Scottish Government, 2018)³⁵. Despite these challenges, it is widely accepted that Gypsy/Traveller communities typically experience poorer health outcomes and shorter life expectancy than the general population. Women from this ethnic group are twice as likely as 'White British' women to have a life limiting health problem or disability (Scottish Government, 2018). Multiple health inequalities are likely attributable to a range of broader social inequalities experienced by Gypsy/Traveller communities, including relatively poor living conditions, high rates of homelessness, low educational attainment, social exclusion and stigma and discrimination. It is feasible that these would also be additional risk factors for poor perinatal mental health outcomes.

An international review of Gypsy, Roma and Traveller populations' use of, and engagement with, healthcare services identified a number of common barriers to accessing services: difficulties in registering with healthcare services (e.g. due to no fixed address), difficulties in physically accessing/ getting to services: perceptions and experiences of discrimination from health services, including attitudes of service staff and a lack of cultural understanding and sensitivity; mobile lifestyles that make it difficult to establish continuity of care and relationships with healthcare workers, and; health literacy issues including knowledge of how to access health services and information.

An NHS Health Scotland (2016)³⁶ report on frontline health staffs' experiences of working with Gypsy/Travellers in Scotland highlighted a number of social and structural barriers to these communities accessing health services, in particular primary care and mental health services. Registering with a GP can be particularly difficult, as Gypsy/Travellers may not have the necessary legal documentation and some practices will require patients to have a permanent address to register. This can be exacerbated by literacy issues, and Gypsy/Travellers also report experiencing stigma and discrimination in health care settings. Actions are underway to help rectify these issues, like educating

³⁴ Scottish Government (2011) Census Data Explorer. *National Records of Scotland*. Available from: <https://www.scotlandscensus.gov.uk/ods-web/home.html>

³⁵ Scottish Government (2018) *New Scots Refugee Integration Strategy 2018-2022*

³⁶ NHS Health Scotland (2016) Good Mental Health For All. Available from: <http://www.healthscotland.scot/media/1805/good-mental-health-for-all-feb-2016.pdf>

frontline NHS staff on the needs and preferences of this ethnic minority and ensuring staff and ensuring the gypsy/traveller community know they have a right to register with a GP without a fixed address (using c/o for example) as part of the 'Improving the lives of Gypsy/Travellers: 2019-2021' strategy (Scottish Government, 2019)³⁷.

A report by a Gypsy Traveller Women's organisation, asked women what they felt the positive factors in their community around pregnancy and birth were. Many stated that having family as a central part of their everyday life, including support from female relatives (mums, sisters, aunts) provided a welcome support network during pregnancy and after birth. Unattended home births are still more common in this community as tradition often plays a major role in the community. Women felt that the close relationships and immediate support network around them acted as protective factors for their mental health in the perinatal period. However, maternity and health visiting services are amongst the most accepted by this community. Community midwives and health visitors can visit sites and homes, without perceived stigma from within the community for asking for help (McFadden et al., 2018)³⁸. At a recent Gypsy/Traveller event about improving mental health, people from the gypsy/traveller community stated that they would be unlikely to allow a mental health professional to visit them at home for fear of discrimination from within the community and also unlikely to seek help via a GP because of the many barriers to accessing primary care service previously mentioned. For perinatal and infant mental health in this community, midwives and health visitors are amongst the most likely frontline staff to pick up and support families that need it.

Basic issues like not being able to register with primary care, may make it very difficult for poor perinatal mental health to be recognised and supported by health professionals. Ensuring this community has access to the care they are entitled to starting with receiving basic information about perinatal care (both routine, physical and mental health care in the perinatal period) may need further development.

Socio-economic status

There is a clear social gradient in mental health, where mental health and wellbeing is consistently found to be worse in the most deprived areas of Scotland compared to the most affluent. This is true for perinatal mental illness too, with higher levels of deprivation correlating with higher prevalence of poor perinatal mental health (Liu et al., 2017)³⁹. The considerable primary care burden of maternal perinatal mental illness found in a study by British

³⁷ Scottish Government (2018) [New Scots Refugee Integration Strategy 2018-2022](#)

³⁸ McFadden, A., Siebelt, L., Jackson, C., Jones, H., Innes, N. et al (2018) Enhancing Gypsy, Roma and Traveller peoples' trust: using maternity and early years' health services and dental health services as exemplars of mainstream service provision. *University of Dundee*. Available from: <https://doi.org/10.20933/100001117>

³⁹ Liu, N.H., Daumit, G.L., Dua, T., Aquila, R., Charlson, F., Cuijpers, P. et al (2017) Excess mortality in persons with severe mental disorders: a multilevel intervention framework and priorities for clinical practice, policy and research agendas. *World Psychiatry*, vol 16. Available from: <https://onlinelibrary.wiley.com/doi/full/10.1002/wps.20384>

Journal or GPs (Ban et al., 2012)⁴⁰ highlights that women in more socioeconomically-deprived circumstances are at high risk, which may need greater recognition at policy level. Women who are addicted to drugs or alcohol are usually offered increased monitoring by primary and secondary care services during pregnancy to track foetal growth and health throughout the pregnancy, as well as additional support and monitoring after birth.

Women with complex social factors may be less likely to access or maintain contact with antenatal services (Scottish Government, 2011)⁴¹. A lack of engagement with antenatal services can affect birth outcomes and mothers. These include; substance misuse; recent arrival as a migrant; asylum seeker or refugee status; difficulty speaking or understanding English; age under 20; domestic abuse; poverty; homelessness. Often there are several cross cutting equality issues affecting women from preconception long in to parenthood. There is some strong evidence that those individuals with complex social factors have poorer birth outcomes (Asif et al., 2015)⁴². In terms of accessing services, fear of judgement has been cited as a major factor in engaging with antenatal services, especially in the case of substance misuse. The perceived threat of the child or other children being removed can be a barrier to people engaging maternity and mental health services. Also people affected by substance misuse can find it hard to break the cycle of addiction and poverty, are often also battling with additional factors such as domestic violence, being in the justice system and accommodation issues which are known to negatively impact mental health.

Gender

Women

As mentioned, it is estimated that between 1 in 4 or 5 women experience poor mental health in the perinatal period, making it a prevalent issue. There are well documented health inequalities for women and these may play in to women not seeking or not engaging with the services they need.

Health inequalities are avoidable differences in health status or determinants between population groups. They are usually the result of a complex matrix of lifestyle choices, personal history and circumstances, and access to services. In the most affluent areas of Scotland, men experience 23.8 more years of good health and women experience 22.6 more years compared to the most

⁴⁰ Ban, L., Gibson, J.E., West, J., Fiaschi, L., Oates, M.R., & Tata, L.J. (2012) Impact of socioeconomic deprivation on maternal perinatal mental illnesses presenting to UK general practice. *British Journal of General Practice*, vol 62. Available from: <https://bjgp.org/content/62/603/e671.short>

⁴¹ Scottish Government (January 2011) *Reducing Antenatal Health Inequalities: Outcome Focused Evidence into Action Guidance*

⁴² Asif, S., Baugh, A., & Wyn-Jones, N. (2015) The obstetric care of asylum seekers and refugee women in the UK. *The Obstetrician & Gynaecologist*, vol 17. Available from: <https://doi.org/10.1111/toq.12224>

deprived areas. Women tend to live longer but be in poorer health for longer than men (Public Health Scotland)⁴³.

Inequalities begin before birth, can adversely impact health throughout adult life, and can persist across generations. Inequalities can impact on pregnancy, including maternal and perinatal death. Ethnicity and deprivation remain important associates of stillbirth and neonatal death, and reducing stillbirths and neonatal deaths in these groups remain a difficult but vital public health challenge (CMACE, 2011)⁴⁴.

Perinatal mental health problems affect between 10 to 20% of women during pregnancy and the first year after having a baby.

Estimates suggest that up to 1 in 7 mothers will experience a mental health problem in the antenatal or postnatal period. Engagement with services during pregnancy offers valuable opportunities to promote mental wellbeing and for the prevention of mental health problems.

Men

Rates of depression in fathers to be and new fathers has been estimated to be between 3.9%-12% however, most studies cite around 10% for the prevalence of postnatal depression (Edward et al., 2014⁴⁵; Wong et al., 2015)⁴⁶. By far the most significant risk factor for paternal depression is maternal depression (Paulson & Bazemore, 2010)⁴⁷. It has been estimated that 50% of the women who have postnatal depression have partners who would consider themselves to have depressive symptomology (Paulson & Bazemore, 2010).

Poor paternal mental health is associated with poor child outcomes. Children in one study where father had depression in the postnatal depression shower decreased emotional and social scores (strengths and difficulties questionnaires) at 4-5 years and paternal depression was a significant predictor of these reduced scores (Fletcher et al., 2011)⁴⁸. Another study supported this theory, with adverse emotional and behavioural outcomes at 3.5 years and psychiatric disorders at age 7 (oppositional/conduct disorders)

⁴³ Public health Scotland Women tend to live longer but be in poorer health for longer than men. Available from: <http://www.healthscotland.scot/health-inequalities/what-are-health-inequalities#:~:text=The%20existence%20of%20health%20inequalities%20in%20Scotland%20means,is%20not%20being%20enjoyed%20equally%20across%20the%20population.>

⁴⁴ CMACE (2011) Saving Mothers' Lives: reviewing maternal deaths to make motherhood safer: 2006–08. *Centre for Maternal and Child Enquiries*. Available from: <https://www.hqip.org.uk/resource/cmace-and-cemach-reports/#.X3snxGhKg2x>

⁴⁵ Edward, K., Castle, D., Mills, C., Davis, L., & Casey, J. (2014) An Integrative Review of Paternal Depression. *American Journal of Men's Health*, vol 9. Available from: <https://journals.sagepub.com/doi/full/10.1177/1557988314526614>

⁴⁶ Wong, O., Nguyen, T., Thomas, N., Thomson-Salo, F. et al (2015) Perinatal mental health: Fathers - the (mostly) forgotten parent. *Asia-Pacific Psychiatry*, vol 8. Available from: <https://doi.org/10.1111/appy.12204>

⁴⁷ Paulson, J.F., & Bazemore, S.D. (2010) Prenatal and postpartum depression in fathers and its association with maternal depression: a meta-analysis. *The Journal of the American Medical Association*, vol 303. Available from: <https://jamanetwork.com/journals/jama/article-abstract/185905>

⁴⁸ Fletcher et al., 2011 Poor paternal mental health is associated with poor child outcomes. Available from: <https://www.onlinelibrary.wiley.com/doi/abs/10.5694/mja11.10192>

(Ramchandani et al., 2005, 2008)⁴⁹. Depressed fathers are more likely to display more negative and fewer positive parental behaviours, engaging with their child less.

The role of fathers as primary nurturers is likely to increase with sociocultural shifts. There tends to be more of a focus on maternal mental health issues following childbirth and women with existing psychiatric mental illness however attitudes are changing and more support is being made available to men around the experience of becoming a parent.

Sexual Orientation

Lesbian women may be at heightened risk of displaying depressive symptoms in the perinatal period. Discrimination and a lack of social and familial support is common for lesbian mothers and may contribute to depression and anxiety around the pregnancy (Dahl et al., 2013)⁵⁰. In many cases, lesbian mothers have had a carefully planned pregnancy and are more likely to be with their partner during pregnancy and the postnatal period. In many lesbian parenting couples, the division of labour is often more balanced and Ross (Dennis et al., 2007)⁵¹ described this as a protective factor from postnatal depression.

The evidence around perinatal mental health in those who do not identify as heterosexual is very limited. In general, people who identify as part of the LGBTI community are more likely to experience poor mental health (Semlyen et al., 2016⁵²; Stonewall, 2018)⁵³. The Scottish Health Survey (Scottish Government, September 2018)⁵⁴ showed that adults who identify as gay, lesbian or “other” have a higher prevalence of common mental disorders, and lower levels of subjective wellbeing, compared to heterosexuals. These differences are more prominent in early adulthood (under 35) which would indicate that LGBTI women may be at higher risk of suffering poor mental health in the perinatal period. The lack of evidence around LGBTI and perinatal mental health indicates a potential equalities gap.

Bisexuality is a potential evidence gap. Most evidence centres around heteronormative women, and some around lesbian women but evidence in the literature around bisexuality is sparse.

⁴⁹ Ramchandani et al., 2005, 2008 Oppositional/conduct disorders. Available from: [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(05\)66778-5/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(05)66778-5/fulltext)

⁵⁰ Dahl, B., Fylkesnes, A.M., Sorlie, V., & Malterud, K. (2013). Lesbian women's experiences with healthcare providers in the birthing context: A meta-ethnography. *Midwifery*, vol 29. Available from: <https://www.sciencedirect.com/science/article/pii/S0266613812001088>

⁵¹ Dennis, C., Fung, K., Grigoriadis, S., Robinson, G.E., Romans, S., & Ross, L. (2007) Traditional Postpartum Practices and Rituals: A Qualitative Systematic Review. *Women's Health*, vol 3. Available from: <https://journals.sagepub.com/doi/full/10.2217/17455057.3.4.487>

⁵² Semlyen, J., King, M., Varney, J., & Hagger-Johnson, G. (2016) Sexual orientation and symptoms of common mental disorder or low wellbeing: combined meta-analysis of 12 UK population health surveys. *BMC Psychiatry*, vol 16. Available from: <https://doi.org/10.1186/s12888-016-0767-z>

⁵³ Stonewall Scotland, Scottish Trans, Equality Network, LGBT Youth (2018) LGBTI Populations and Mental Health Inequality. Stonewall: Edinburgh. Available from: <https://www.lgbthealth.org.uk/wp-content/uploads/2018/08/LGBTI-Populations-and-Mental-Health-Inequality-May-2018.pdf>

⁵⁴ Scottish Government (September 2018) [Scottish Health Survey 2017: Volume 1: Main Report](#).

Gender Reassignment

How people who transition or do not identify with the sex they were assigned at birth feel around the perinatal period is also missing from the evidence base. Gender reassignment and carrying a child are relatively new scenarios to medicine in the UK. To date there has been very few documented cases where full gender reassignment has taken place across the trans and non-binary umbrella and individuals have gone on to give birth. Public Health England⁵⁵ has been doing work on making sure pregnant trans men are given equal quality of care and has published some issues with accessing care that are specific to trans people including;

- gendered (designed with one gender in mind specifically) materials, such as leaflets aimed at women
- gendered spaces, such as maternity units
- IT systems which cannot always identify if a person's gender is different to the sex they were assigned at birth

This can make trans people feel they:

- are not included
- do not have relevant information or services
- may be treated badly or differently when accessing services

This area may be better evidenced in the near future as gender reassignment and gender identity issues become more familiar to a wider audience. As this area is emerging further, engagement with appropriate stakeholders may help provide better knowledge on whether this group is at risk of poor perinatal mental health.

Religion and Beliefs

There is very little evidence in how religion and belief impacts perinatal mental health, and mental health in general, in a Scottish context.

Culturally sensitive care

Sadness post birth occurs in all countries but is not always considered an illness. Migrant women therefore may be unable to express their feelings and present more frequently with somatic symptoms. Unfamiliarity with healthcare

⁵⁵ Public Health England (March 2020) Ensuring pregnant trans men get equal quality care [Ensuring pregnant trans men get equal quality care - PHE Screening \(blog.gov.uk\)](https://www.blog.gov.uk/2020/03/23/ensuring-pregnant-trans-men-get-equal-quality-care/)

pathways, lack of social support, economic hardship, cultural stigma and traumatic past experiences may pose a barrier to seeking help, in addition to language barriers.

Female Genital Mutilation

Although female genital mutilation (FGM) is against the law in Scotland and has been since 1985 (The Female Genital Mutilation (Scotland) Act 2005 re-enacted the Prohibition of Female Circumcision Act 1985), the diversity of the population today still means there is risk. A particular study showed that one third of women who have gone through FGM met the threshold for affective anxiety disorders and around 17% had diagnosable PTSD (Behrendt & Moritz, 2005)⁵⁶. Between 2001-2012 there were 2,750 girls born to women who were born in countries where FGM is common, living in Scotland (Scottish Government, 2016)⁵⁷. It is important to note that not all women and children from these countries are at risk – the issues around FGM in Scotland are complex and needs to be handled with sensitivity by healthcare providers.

From a Scottish perspective the asylum population in the UK has been increasing, and around 10% of all those who seek asylum in the UK are dispersed to Glasgow (Scottish Government, 2018)⁵⁸. According to the latest census, the African population in Scotland has grown from 5,000 in 2001 to 30,000 in 2011 (Scottish Government, 2011)⁵⁹. These figures suggest that there could be in an increasing population of women from FGM practising countries. NHS GGC see around 150 women a year with FGM, and the Nigerian population in Scotland are the highest risk group for FGM. The Scottish Government is working through an action plan on Gender Based Violence including FGM and primary care professionals and maternity professionals (also the Police, Social Work, Schools) have been given up to date guidance and information on how to recognise potential signs of FGM and honour based violence in girls and women.

Several cultures practice a tradition called 'sitting the month'. This is common in eastern Asian cultures, specifically Chinese and Korean, where a period of around 40 days of rest after the birth is taken by the mother. The tradition involves restrictions on the new mother which can include; no showering, restricted diet, handing over newborn caring responsibilities (usually to mother in-laws), not receiving visitors and not leaving the home/specified area in the home. This practice is standard in many countries and some migrants still

⁵⁶ Behrendt, A., & Moritz, S. (2005) Posttraumatic Stress Disorder and Memory Problems After Female Genital Mutilation. *The American Journal of Psychiatry*, vol 162. Available from: <https://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.162.5.1000>

⁵⁷ Scottish Government (2016) [Scotland's national action plan to prevent and eradicate FGM](#)

⁵⁸ Scottish Government (2018) [New Scots Refugee Integration Strategy 2018-2022](#)

⁵⁹ Scottish Government (2011) Census Data Explorer. *National Records of Scotland*. Available from: <https://www.scotlandscensus.gov.uk/ods-web/home.html>

abide by the tradition (Callister, L., 2006⁶⁰; Dennis et al., 2007)⁶¹. There are some reports in the literature that this immediate support can be beneficial, however some families do not accept postnatal midwife and health visitor home visits (Sharma et al., 2016)⁶². This may put women and families at risk of falling through the gaps in the postnatal period. Additionally, one international report indicated that the women who practised this tradition felt their mental health suffered during this period, specifically when a mother-in-law was the primary care giver to the child.

Justice System

Corton Vale has been the main prison for women in Scotland since 1975. The Scottish Prison Service is currently in the process of closing Corton Vale fully, to be replaced by five smaller community custody units. These centres will use be based on the Carecel Welfare Model, focussing on rehabilitation in order for women to transition back into the community in a positive way and go on to live fulfilled lives (Community Action on Prison Expansion, last accessed 2020). Locations for two units have been secured and the remaining units will follow. The Glasgow CCU will have capacity for 24 women, including two dedicated mother and baby rooms. It is hope the CCU's will enhance visits, provide more opportunity to accommodate children's visits including overnight stays and relational development.

Currently, Corton Vale has a dedicated mother and baby unit which was built to house women late in the pregnancy and those with infants under 12 months. However, there were concerns about how much this unit was being used in the past. From 2010 to 2015, there were 117 women who were pregnant at Corton Vale. Of these, 401 babies were born in custody but only 11 of these women stayed in the MBU (up to 15 including those who did not give birth in custody but did have an infant under 12 months) (HMIPS, 2006)⁶³. The MBU often housed other low risk prisoners however, it may not be being used as intended. At the 2011 inspection, there were two mother and baby pairs in the MBU and four other low risk inmates, although there were currently 6 pregnant women being housed in the general population area of the prison (SPS, 2012)⁶⁴. The unit is normally staffed by residential prison staff. These staff are a key group of professionals who should undergo basic perinatal and infant mental health training to help identify when women need extra support and what pathways they can refer into to ensure

⁶⁰ Callister, L. (2006) Doing the month: Chinese postpartum practices. *The American Journal of Maternal Child Nursing*, vol 31. Available from:

https://www.researchgate.net/publication/6650493_Doing_the_month_Chinese_postpartum_practices

⁶¹ Dennis, C., Fung, K., Grigoriadis, S., Robinson, G.E., Romans, S., & Ross, L. (2007) Traditional Postpartum Practices and Rituals: A Qualitative Systematic Review. *Women's Health*, vol 3. Available from: <https://journals.sagepub.com/doi/full/10.2217/17455057.3.4.487>

⁶² Sharma et al., 2016 Literature shows that some families do not accept postnatal midwife and health visitor home visits. Available from: <https://core.ac.uk/download/pdf/42635561.pdf>

⁶³ HMIPS (2006) Report on HMP and YOI Cornton Vale. *HM Inspectorate of Prisons for Scotland*. Available from: <https://www.prisonsscotland.gov.uk/publications/hm-inspectorate-prisons-report-hmp-and-yoi-cornton-vale-0?page=7>

⁶⁴ SPS (2012) The 2011 inspection for numbers of women and babies in the MBUs and pregnant women in the general population area of the prison. Available from: https://external.parliament.scot/ResearchBriefingsAndFactsheets/S4/SB_12-30.pdf

appropriate support. As Corton Vale will be closing in the coming years, many of the problems with the MBU will no longer be an issue but ensuring mother and baby rooms are consistently used for their purpose is something that the SPS should consider in their practice going forward and in the development and running of the new facilities. Until the new sites have been completed, the MBU at Corton Vale will still be in use, as the only site where mothers can be with their babies.

Women in the justice system seem much more likely to suffer from mental health worries. It is well known that the majority of women in prison often live in very complex social situations including previous trauma, abuse, substance misuse issues, generally chaotic lives and can get stuck in negative intergenerational patterns. In 2015, more than 1 in 3 inmates at Corton Vale stated they were care experienced (Rose Report, 2016)⁶⁵. Poor mental health is deep rooted in these factors so it is unsurprising that in prison, the rates of mental health difficulties is higher than in the general population. In terms of perinatal mental health in women in prisons, 80% of pregnant women in Corton Vale showed depressive symptoms and the vast majority were being housed in the general population area of the facility (Rose Report, 2016). This is an extremely high percentage of women showing difficulties with their mental health in the perinatal period. This statistic coupled with the fact that during many inspections, the mother and baby units have not been utilised for what they were designed for, this population is clearly at risk of poor perinatal mental health and additional work may be required to identify and support women who are in prison through pregnancy, birth and in the postnatal period.

Who will it affect?

The new policies set out for perinatal mental health aim to ensure all women and families are aware of potential mental health issues surrounding pregnancy and after birth and know where to seek support and what support is available to them. These policies apply should apply to everyone in Scotland.

What might prevent the desired outcomes being achieved?

Lack of robust empirical data and evidence on inequalities in perinatal mental health in a Scottish context may make it more difficult to ensure every person who is planning on becoming pregnant, is pregnant or has recently had a child has equitable access to perinatal mental health services.

A major barrier to ensuring equality across perinatal mental health is the stigma attached to perinatal mental health. One of the main barriers to people seeking support is admitting they need support as they experience social

⁶⁵ Rose Report (2016) Women in Corton Vale were care experienced. Numbers of 80% of pregnant women in Corton Vale showed depressive symptoms and the vast majority were being housed in the general population area of the facility. Available from: <https://www.barrowcadbury.org.uk/wp-content/uploads/2016/08/Rose-Project-Best-for-Babies-report-2016.pdf>

pressure and fear of judgement surrounding pregnancy and having a baby which is often portrayed as a wholly positive experience.

Lack of awareness of the rights a woman, her infant and her family have around access to mental health services and the voice they have in their treatment options could be a barrier to equitable treatment.

Stage 1: Framing

Results of framing exercise and extent/level of EQIA required

The evidence around barriers to accessing specialist perinatal mental health services is limited. However, there is good evidence around the barriers of access to mental health services and maternity services. Using this evidence at the moment, while the planning and delivery of specialist perinatal mental health services is in development will provide a basis for how different equality characteristics need to be considered.

The main gaps in evidence are around specific perinatal mental health needs in those with disabilities, those in specific ethnic/belief groups, and those in the LGBTI community. Further engagement with relevant stakeholders in these areas would ensure due regard has been given to these groups. More evidence from these groups would allow their needs to be considered in a Scottish context.

A Fairer Duty Impact Assessment would more adequately cover the inequalities in perinatal mental health in more difficult socio-economic circumstances.

An Islands Impact Assessment would help to clarify the specific barriers services and families face in remote and rural communities.

Stage 2: Data and evidence gathering, involvement and consultation

Include here the results of your evidence gathering (including framing exercise), including qualitative and quantitative data and the source of that information, whether national statistics, surveys or consultations with relevant equality groups.

Characteristic ⁶⁶	Evidence gathered and Strength/quality of evidence	Source	Data gaps identified and action taken
Age	Review of academic literature and government report/findings. Use of national statistics on age and pregnancy as well as deprivation, smoking status, alcohol consumption.	National Statistics	There is strong evidence and policy measures in place across SG that recognise inequalities in age in terms of parenting and perinatal mental health.
Disability	There is little specific information in the literature about disability and perinatal mental health. A campaign and report from Engender provided much of the evidence on the impact of physical and learning difficulties on parenting and mental health.	Consultation	The Engender 'Our Bodies, Our Rights' report provides a current perspective on the views of disabled women around their experiences and support made available during pre-conception, pregnancy and after birth, in a Scottish context.
Sex	Perinatal mental health predominantly effects woman – because biologically they carry the fetus and give birth. Men can also see worsening mental health in the perinatal period however this would primarily be recognised and treated by adult mental	National Statistics	The policy target population is women however fathers/partners are recognised as an intergral part of familial unit so are included in our policies.

⁶⁶ Refer to Definitions of Protected Characteristics document for information on the characteristics

	<p>health services. Midwifery, health visiting and GP services will be key in identifying problems and supporting fathers and other primary carers in this period.</p> <p>There are universal inequalities in women health which are well evidenced and these should be taken in to consideration.</p>		
Pregnancy and Maternity	n/a – pregnancy is a part of the perinatal period therefore this characteristic had no discrimination potential.		
Gender Reassignment	There is a gap in evidence around gender assignment and perinatal mental health.		The current need for evidence on this is unknown due to the rarity of this issue to date.
Sexual Orientation	There is some academic literature around mental health in lesbian mothers, indicating that they are more prone to mental health problems due to discrimination about their sexuality. However, there are indications that lesbian women tend to have planned pregnancies and a strong support from their partner.	National Statistics	It would be beneficial to engage more with some Scottish LGBTQ equalities groups to discuss how sexual orientation can impact people’s perinatal mental health. Literature is limited to lesbian mothers and focuses on planned pregnancies in stable relationships. Engagement with youth LGBTI groups would also be beneficial in understanding the overlap of age and sexual orientation

			in regard to perinatal mental health. Additionally there is little evidence for male same-sex couples and mental health problems in the perinatal period. Overall, this is an area where more evidence is needed.
Race	Ethnicity and perinatal mental health are not well understood. The literature suggests that ethnicity and perinatal mental health depends on the peer/community network around the individual and it would be difficult to categorise ethnic minority groups as more or less at risk of poor perinatal mental health. Ensuring equity of access across ethnic minorities may be the most pertinent way forward, with one key barrier being communication. Peer support has been identified as particularly effective in supporting ethnic minority groups in the perinatal period.	Equalities Team advised no known evidence is available	Engagement with large urban health boards on their experience of engaging with ethnic minorities around perinatal mental health would provide a better evidence base around what the hubs of ethnic minorities in Scotland need. Investigating which services ethnic minority groups find most acceptable to them would help to ensure policy is supporting them properly.
Religion or Beliefs	There is no evidence that indicates one religious group are at heightened risk of developing perinatal mental health problems, or mental health conditions in general. Specific cultural practices can be a barrier to people accessing the services they In some		None for religion. Cultural beliefs like sitting the month, could impact negatively on access to mental health services and identification of poor mental

	cases, depression is not a recognised condition and therefore providing people with the right support can be challenging.		health in the perinatal period. More information the prevalence of practices like this would help to indicate if more any special measures are needed but this could be included in our evidence gathering for ethnic groups.
Marriage and Civil Partnership (the Scottish Government does not require assessment against this protected characteristic unless the policy or practice relates to work, for example HR policies and practices - refer to Definitions of Protected Characteristics document for details)	n/a		

Stage 3: Assessing the impacts and identifying opportunities to promote equality

Having considered the data and evidence you have gathered, this section requires you to consider the potential impacts – negative and positive – that your policy might have on each of the protected characteristics. It is important to remember the duty is also a positive one – that we must explore whether the policy offers the opportunity to promote equality and/or foster good relations.

Do you think that the policy impacts on people because of their age?

Age	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination, harassment and victimisation	x			There is strong evidence and policy measures in place across SG that recognise inequalities in age in terms of parenting and perinatal mental health.
Advancing equality of opportunity	x			There is strong evidence and policy measures in place across SG that recognise inequalities in age in terms of parenting and perinatal mental health.
Promoting good relations among and between different age groups	x			There is strong evidence and policy measures in place across SG that recognise inequalities in age in terms of parenting and

				perinatal mental health.
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Do you think that the policy impacts disabled people?

Disability	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination, harassment and victimisation			x	There is little specific information in the literature about disability and perinatal mental health. A campaign and report from Engender shows disabled women had the same access to support as non-disabled women.
Advancing equality of opportunity			x	There is no evidence that the policy impacts on advancing equality of opportunity for disabled people
Promoting good relations among and between disabled and non-disabled people			x	There is little specific information in the literature about disability and perinatal mental health. A campaign and report from Engender shows disabled women had the same access to support as non-disabled women.

Do you think that the policy impacts on men and women in different ways?

Sex	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination	x			The Perinatal mental health services is for women who are pregnant or have recently given birth. There is support also available to men who may need support during this time but they may feel the services available do not give them as adequate support.
Advancing equality of opportunity	x			There is strong evidence and policy measures in place across SG that recognise inequalities in age in terms of parenting and perinatal mental health.
Promoting good relations between men and women	x			The policy is mainly for women and their partners during the perinatal stage.

Do you think that the policy impacts on women because of pregnancy and maternity?

Pregnancy and Maternity	Positive	Negative	None	Reasons for your decision

Eliminating unlawful discrimination	X			Perinatal mental health services are only offered to pregnant women or to those who have recently given birth. The increase in specialist perinatal mental health services will positively impact pregnant and recently pregnant women.
Advancing equality of opportunity	x			Perinatal mental health services are only offered to pregnant women or to those who have recently given birth. The increase in specialist perinatal mental health services will positively impact pregnant and recently pregnant women.
Promoting good relations	x			Scottish Government has worked closely with NHS and Third Sector organisations to improve the mental health services during the perinatal stage

Do you think your policy impacts on transsexual people?

Gender reassignment	Positive	Negative	None	Reasons for your decision
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Eliminating unlawful discrimination			x	We are not aware of any evidence that suggests changes to perinatal mental health services will create any particular inequalities for this protected characteristic
Advancing equality of opportunity			x	We are not aware of any evidence that suggests changes to Perinatal mental health services will create any particular inequalities for this protected characteristic
Promoting good relations			x	We are not aware of any evidence that suggests changes to Perinatal mental health services will create any particular inequalities for this protected characteristic

Do you think that the policy impacts on people because of their sexual orientation?

Sexual orientation	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination			x	There is little evidence to show the policy has had an impact because of people's sexual orientation
Advancing equality of opportunity			x	There is no evidence that the policy impacts on

				advancing equality of opportunity because of people's sexual orientation
Promoting good relations			x	There is little literature available to evidence the policy has had an impact because of people's sexual orientation

Do you think the policy impacts on people on the grounds of their race?

Race	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination			x	There is no evidence to show the policy has had an impact on the grounds of people's race
Advancing equality of opportunity			x	There is no evidence that the policy impacts on advancing equality of opportunity on the grounds of the people's race
Promoting good race relations			x	There is no evidence to show the policy has had an impact on the grounds of people's race

Do you think the policy impacts on people because of their religion or belief?

Religion or belief	Positive	Negative	None	Reasons for your decision
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Eliminating unlawful discrimination			x	We are not aware of any evidence due to peoples beliefs or cultures
Advancing equality of opportunity			x	We are not aware of any evidence due to peoples beliefs or cultures
Promoting good relations			x	We are not aware of any evidence due to peoples beliefs or cultures

Do you think the policy impacts on people because of their marriage or civil partnership?

Marriage and Civil Partnership⁶⁷	Positive	Negative	None	Reasons for your decision
Eliminating unlawful discrimination			x	We are not aware of any evidence that the policy has an impact due to people's marriage or civil partnership

⁶⁷ In respect of this protected characteristic, a body subject to the Public Sector Equality Duty (which includes Scottish Government) only needs to comply with the first need of the duty (to eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010) and only in relation to work. This is because the parts of the Act covering services and public functions, premises, education etc. do not apply to that protected characteristic. Equality impact assessment within the Scottish Government does not require assessment against the protected characteristic of Marriage and Civil Partnership unless the policy or practice relates to work, for example HR policies and practices.

Stage 4: Decision making and monitoring

Identifying and establishing any required mitigating action

If, following the impact analysis, you think you have identified any unlawful discrimination – direct or indirect - you must consider and set out what action will be undertaken to mitigate the negative impact. You will need to consult your legal team in SGLD at this point if you have not already done so.

Have positive or negative impacts been identified for any of the equality groups?	No negative impacts have been identified. The new policy sets out to support all women and families in Scotland and there are several actions being undertaken in the work of the Perinatal and Infant Mental Health Programme Board and the Perinatal and Early Years policy team at SG to ensure that 'at risk' groups are identified and specific measures put in place to support them.
Is the policy directly or indirectly discriminatory under the Equality Act 2010 ⁶⁸ ?	No
If the policy is indirectly discriminatory, how is it justified under the relevant legislation?	No
If not justified, what mitigating action will be undertaken?	n/a

⁶⁸ See EQIA – Setting the Scene for further information on the legislation.

Monitoring and Review

An Equalities group which reports to the Perinatal and Infant Mental Health Programme Board has been convened and meets every 2 months to discuss embedding equalities in to policy and service development. The group will help to further identify and fill gaps in the evidence around inequalities in perinatal and infant mental health and inform any further mitigation required. Monitoring and evaluation will be embedded in to the work of this group, directed by the recommendations from Public Health Scotland and the Monitoring and Evaluation Group of the Programme Board.

Stage 5: Authorisation of EQIA

Please confirm that:

- ◆ This Equality Impact Assessment has informed the development of this policy:

Yes No

- ◆ Opportunities to promote equality in respect of age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation have been considered, i.e.:

- Eliminating unlawful discrimination, harassment, victimisation;
- Removing or minimising any barriers and/or disadvantages;
- Taking steps which assist with promoting equality and meeting people's different needs;
- Encouraging participation (e.g. in public life)
- Fostering good relations, tackling prejudice and promoting understanding.

Yes No

- ◆ If the Marriage and Civil Partnership protected characteristic applies to this policy, the Equality Impact Assessment has also assessed against the duty to eliminate unlawful discrimination,

harassment and victimisation in respect of this protected characteristic:

Yes No Not applicable

Declaration

I am satisfied with the equality impact assessment that has been undertaken for the Perinatal and Infant Mental Health and give my authorisation for the results of this assessment to be published on the Scottish Government's website.

Name: Angela Davidson

Position: Deputy Director

Authorisation date: 18 December 2020

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Footnotes

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