# What do women want healthcare professional to know about the needs of the perinatal mum with mental health challenges?

Wendy Jones PhD MRPharmS MBE.

## Abstract

Breastfeeding has many advantages for mother, baby and economically. It is recommended as having benefit for two years and beyond. However, during the period of lactation parents may encounter mental health challenges. When approaching health care professionals, mothers have reported that they sometimes fail to be treated with respect and empathy, having the importance to them of breastfeeding dismissed. In this article the voices of the women themselves seek to inform practitioners of how they would like to be treated. In addition, data is presented on the compatibility of medication to treat anxiety and depression is presented. In some areas work has been undertaken to liase mental health support with breastfeeding support in order to maximise the empowerment of mothers.

## Introduction

Exclusive breastfeeding for the 6 months of a baby's life is advocated by national and international health experts, thereafter it continues to be the best nutrition alongside suitable weaning foods for 2 years and beyond (1-5).

Breastmilk is infinitely variable responding to the needs of each baby, varying over time and even diurnally. It has been demonstrated to offer significant short- and long-term health benefits for both infant and mother. These include the protection of infants from childhood diseases including ear and gastric infections, respiratory illness, Necrotising enterocolitis, Sudden Infant Death Syndrome (SIDS) and long-term health benefits such as a reduction in the risk of obesity, Maternal health benefits include a reduction in the risk of breast and ovarian cancer, and a lower risk of hip fracture due to osteoporosis later in life [6]. Mothers who continue to breastfeed after returning to week take less time off to look for their children as they are ill less frequently.

Renfrew et al. further deduced that if 45% of babies were exclusively breastfed for four months, and if 75% of babies in neonatal units were breastfed at discharge, each year there would be:

- 3,285 fewer babies hospitalised with gastroenteritis and 10,637 fewer GP consultations, saving more than £3.6 million.
- 5,916 fewer babies hospitalised with respiratory illness, and 22,248 fewer GP consultations, saving around £6.7million.
- 21,045 fewer ear infection GP visits, saving £750,000.
- 361 fewer cases of the potentially fatal disease necrotizing enterocolitis NEC, saving more than £6 million (7).

In the Lancet series (8) Hansen commented "If breastfeeding did not already exist, someone who invented it today would deserve a dual Nobel Prize in medicine and economics".

Currently more than 80% of mothers in the UK initiate breastfeeding after delivery, (9) although prevalence falls rapidly in the first few weeks (10). The most recent data from Victora et al. the Lancet

series (11) suggests that 34% of mothers were breastfeeding at 6 months and 0.5% at 12 months, respectively. These are amongst the lowest figures in the world. Best available data suggests that 31.5% of babies were being breastfed exclusively at 6 weeks (7) but at 12 months the percentage receiving any breastmilk is 0.5% (11). The UK no longer collects detailed data on breastfeeding so comparisons with the earlier quintennial surveys is difficult.

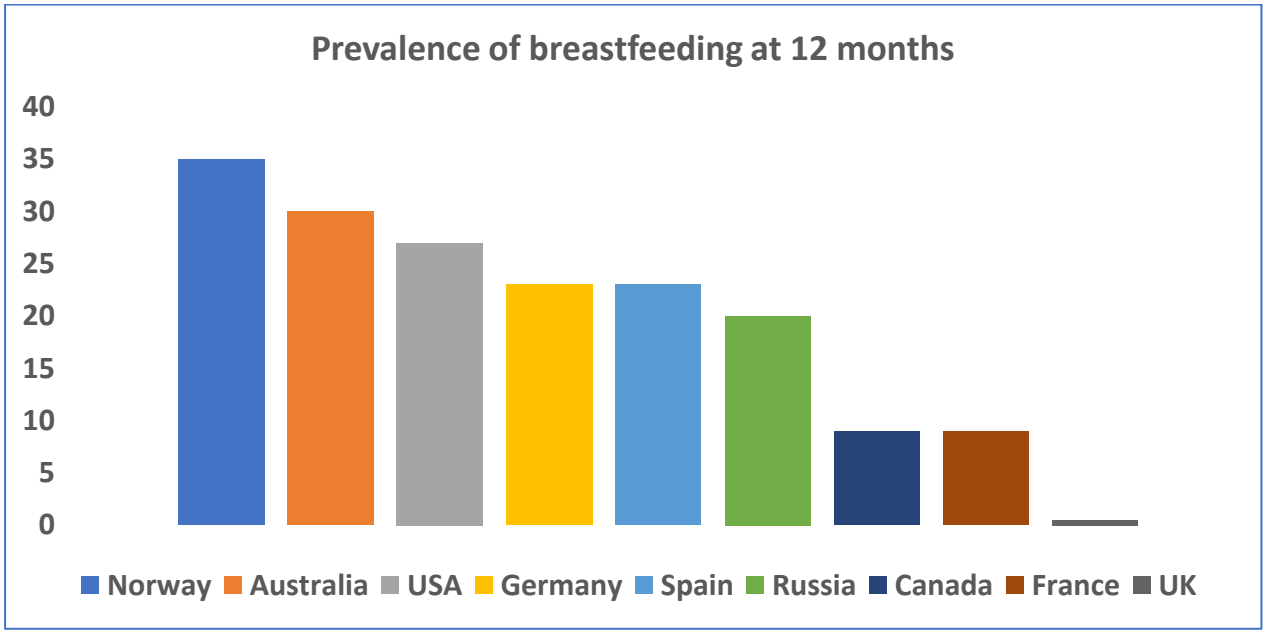


Fig 1 Prevalence of breastfeeding at 12 months across countries (11)

Whilst in common parlance, breastfeeding has advantages, in fact because it is the biological norm, we should be discussing the harms of interrupting breastfeeding and introducing artificial formula.

## Prevalence of perinatal mental health issues

Research tells us that Perinatal mental health affects 10-15% of women at some time in pregnancy and for the first year after birth (15). It remains a leading cause of maternal death (16). Anxiety is more common than depression after delivery and affects 1 in 6 mothers (1 in 5 first time mums). (17) They call upon more healthcare use in first 2 weeks for themselves but not their baby. They are more likely to stop breastfeeding before the baby is 6months and perceive their feeding experience as less "successful." Depression affects about 20% of mothers in the first 6 months after delivery (15). It has been described as "a thief which steals motherhood". Life as a new mother should be joyous and happy but for many women is difficult (17).

Sharifi (18) showed that pre-partum anxiety and depression, can lead to postpartum symptoms, and have an effect on breastfeeding cessation and that there is an inverse association between breastfeeding frequency and maternal anxiety level – whilst many professionals might recommend letting other people offer formula milk via a bottle to give the mother some space away from the baby. Breastfeeding cessation is also a cause of intensification of anxiety and depression due to loss of the positive effects of oxytocin. In trying to do no harm we may inadvertently cause harm.

It is often said that the pressure from breastfeeding advocates is what causes depression. Borra (19) showed that the lowest risk of postpartum depression was found among women who had planned to breastfeed, and who had actually breastfed their babies as they had envisaged. Whilst the highest rates were in mothers who planned to breastfeed but were unable to do so or who stopped before they had anticipated. The pressures came from the goals set by the women themselves and the failure

came from professionals, family and society who did not support them in a timely way. Cutbacks across the maternity sector have been widespread over recent years and it seems that only those determined to seek out, and possibly pay, for support or who have a family and cohort of friends for whom breastfeeding is the norm will meet the gold standard of exclusive breastfeeding for 6 months.

The UNICEF Baby Friendly Initiative has made huge strides in showing that implanting continuous, evidence-based practice across maternity and community settings increases breastfeeding rates (20)

Breastfeeding experience rather than breastfeeding duration is predictive of depressive symptoms in the postpartum period. Mothers perceive antenatally that breastfeeding should be straightforward, so they had failed when it wasn't as simple as they expected. Mothers who stop breastfeeding due to pain or physical difficulties are at greater risk of depressive symptoms (21).

# Responses from mothers

## Study Part One

A call for experiences of mothers was placed on the Facebook Page "Breastfeeding and Medication" (22) in February 2020. The mothers were asked about their experiences of breastfeeding with a perinatal mental health difficulty and what they would like professionals to know. There were 118 comments within 24 hours.

One mother pleaded for consistency in breastfeeding support;

*"I had one midwife who was amazing very supportive didn't leave until I had the latch perfect, but shift change during the night asked for. Support and the next midwife's answer was if she can't latch it's cause she's hungry I will get you formula. Thankfully, it was my 3rd baby and I just said I don't intent to formula feed I'll just figure it out myself. One doctor who came to check on her she was in NCIU for a week telling me how wonderful it was to be breastfeeding that her health would be so much better for it and to stick to it and ask for support if needed for another to say she would be gaining better, and you'd be home quicker if you just put her on the bottle. It makes me sad that it's not consistent it should be with whatever a mother decides to do full support on that way of feeding being over emotional after birth is bad enough but with constant doubt and professionals contradicting each other its mentally draining, frustrating and too some would completely wipe any confidence out"*

Another pleaded for healthcare professionals to have up-to-date knowledge about breastfeeding (or to know who to refer to):

*"For any health professional to keep up to date with breastfeeding advice. I had a midwife, health visitor, paediatrician & paediatric nurse all look at my daughter for a tongue tie & completely miss it. An IBCLC trained consultant at our children's centre picked it up. After 10 weeks of agony & bleeding nipples, by which time I was combi feeding. After it was sorted & I got the right advice on latch etc it got so much easier.*

*I made a right fuss after I had my second while still in hospital (most of the midwives there now trained properly in finding tongue ties) had it sorted there & then & exclusively breastfeeding until weaning, still on a couple of feeds a day. Wouldn't say it was easy to start with but so much more enjoyable. Boobs are so much easier & cheaper than formula if you put all the Health benefits to one side! "*

Three mothers commented:

"*STOPPING BREASTFEEDING CAN MAKE THINGS WORSE*!"

whilst another added:

"I *feel like this is the ONLY place to start, everything else falls into accordance. If stopping breastfeeding makes things worse which we know it does, then finding a medication which is safe for breastfeeding (and there are so many!!!) follows, with appropriate care for mum and baby whilst still respecting their biological needs*"

However, one commented on the positive effect a knowledgeable practitioner had on her journey:

"I had quite significant PND and anxiety with my 2nd baby, and it made all the difference that the professional I saw (advanced nurse practitioner and prescriber in my GP surgery) was fully clued up on both perinatal mental health and breastfeeding with medications. It made an appointment I was really nervous about much easier and I felt reassured. I knew already about the suitability of medications with breastfeeding but had experienced professionals in the past being really ill informed about breastfeeding, and the last thing I needed at that point was having to fight my corner as I'd had to do before. So, I really appreciated her knowing her stuff. "

In contrast mothers may feel that medication is not the right option for them regardless of information supplied:

*"I chose not to take medication for post-natal anxiety due to fears about side effects for baby, I don't recall any professional saying I couldn't take meds it was the paralysing fear due to anxiety. I've worked within the health visitor arena for 20 years and had come across mums on medication during pregnancy/ breastfeeding, but this did not reassure me. I also spoke to a mental health pharmacist who was helpful but couldn't provide the certainty of 'no risk' to the questions I asked (which of course no one can but my anxiety demanded this). I eventually started sertraline when my son was nearly 2. I was still breastfeeding but was at a desperate point. I have a long history of anxiety prior to pregnancy, during pregnancy I was referred into the hospital consultant which wasn't really needed as the focus was all physical health, I would have been better being referred to talking therapies etc. I strongly feel women should be screened more in pregnancy and given much more info and advice as I found it hard to recognise my symptoms in this period despite my history."*

A multi-disciplinary approach may be invaluable, but the result may not be evidence-based:

"*I was diagnosed with PND after having my daughter 6 years ago. The health visitor noticed the change in me getting worse and also spoke to my partner to find out how everything had been at home and informed him of the signs to look out for. She talked me through the options and booked an appointment at my GP for help to begin treatment. When I told the GP I was breastfeeding, he said I can't take any medication for PND whilst breastfeeding so advised me to stop (my daughter was about 4 weeks old). He prescribed the medication but because of what he said about not being able to take it while breastfeeding I never took them because I didn't know how it would impact my daughter.*

*The GP also advised breastfeeding for initial bonding and colostrum is the main thing so it wouldn't matter if I stopped at this point and formula fed instead. I felt like a failure for not being in a position to feed my baby the way I wanted to, and thought was best, or get better myself."*

## Study Part 2

In a second post (March 2021) the women were asked about their experiences of mental health and medication. A total of sixty-seven comments were submitted, mostly privately to the author, within 24 hours. This is an interesting finding in itself as the previous comments were made publicly on the page. There were comments such as "I didn't want others to know I was taking medication" as if in some respect this was an admission of failure or inadequacy.

There is in addition the anxiety of exposing the baby to the medication through breastmilk and the paralysing fear of long-term damage to the child. This is exemplified clearly by this mother's comments:

*"I chose not to take medication for post-natal anxiety due to fears about side effects for baby, I don't recall any professional saying I couldn't take meds. It was the paralysing fear due to anxiety. I've worked within the Health visiting arena for 20 years and had come across mums on medication during pregnancy/ breastfeeding, but this did not reassure me. I also spoke to a mental health pharmacist who was helpful but couldn't provide the certainty of 'no risk' to the questions I asked (which of course no one can but my anxiety demanded this). I eventually started sertraline when my son was nearly 2 years. I was still breastfeeding but was at a desperate point. I have a long history of anxiety prior to pregnancy, during pregnancy I was referred into the hospital consultant which wasn't really needed as the focus was all physical health, I would have been better being referred to talking therapies etc. I strongly feel women should be screened more in pregnancy and given much more info and advice as I found it hard to recognise my symptoms in this period despite my history."*

Whilst this mother found the reassurance she needed:

*"I had quite significant PND and anxiety with my 2nd baby, and it made all the difference that the professional I saw (advanced nurse practitioner and prescriber in my GP surgery) was fully clued up on both perinatal mental health and breastfeeding with medications. It made an appointment I was really nervous about much easier and I felt reassured. I knew already about the suitability of medications with breastfeeding but had experienced professionals in the past being really ill informed about breastfeeding, and the last thing I needed at that point was having to fight my corner as I'd had to do before. So, I really appreciated her knowing her stuff."*

Compare her reaction to that of a doctor who seemed less supportive of breastfeeding

*"I was diagnosed with PND after having my daughter 6 years ago. The health visitor noticed the change in me getting worse and also spoke to my partner to find out how everything had been at home and informed him of the signs to look out for.*

*She talked me through the options and booked an appointment at my GP for help to begin treatment. When I told the GP I was breastfeeding, he said I can't take any medication for PND whilst breastfeeding so advised me to stop (my daughter was about 4 weeks old). He prescribed the medication but because of what he said about not being able to take it while breastfeeding I never took them because I didn't know how it would impact my daughter. The GP also advised breastfeeding for initial bonding and colostrum is the main thing so it wouldn't matter if I stopped at this point and formula fed instead. I felt like a failure for not being in a position to feed my baby the way I wanted to, and thought was best, or get better myself."*

Another mum just wanted the doctor:

*"To actually stop ... look you in the eye ... and listen! I know they're busy but if they'd actually stopped to look at me ... really look they would have seen I needed support!"*

Being a healthcare professional doesn't decrease the anxiety of mixing medication with breastfeeding:

*"I delayed taking antidepressants for many many months despite clearly needing them. I'm a health care professional and knew the information around their regular use in breastfeeding and relative safety. However, something just couldn't let me take them whilst I was breastfeeding my son. It was always the 'what if' for me that held me back and the guilt I felt thinking he'd also be exposed. I had good support from my GP who called me weekly/fortnightly and would gently discuss medication as well as how I was feeling. About a year later a was breastfeeding my son to sleep in his room, in the dark rocking on our rocking chair when it suddenly dawned on me. "What if I could be a better mum by taking them." The next GP appointment I had we discussed commencing antidepressants and I*

*started on a low dose. I switched a couple of times and upped dosage until stable. I felt ready to wean off and lowered dose with GP support. I think they certainly helped lift me out of the dark place I was in, but it was a fine balance between guilt and effectiveness of the drug"*

### The effect of a new birth on partners

We cannot ignore the impact of the fathers on birth outcomes. There is a 12% increased chance if that the mother will at 32-37 weeks if the father is depressed (23). Paternal depression has an effect on sperm quality, has epigenetic effects on the DNA of the baby and affects placenta function. Then there is the effect on partners who witness a traumatic birth and may suffer post traumatic stress disorder, unrecognised in many because they do not feel that they should exert pressure on their partner and may not even recognise their symptoms as abnormal (24). Much invaluable work has been achieved in raising awareness by Mark Williams (https://www.reachingoutpmh.co.uk/)

## What does it feel like to have depression?

- Feel low, unhappy and tearful
- Irritable
- Tired
- Sleepless
- Appetite changes
- Unable to enjoy anything
- Loss of interest in sex
- Negative and guilty thoughts

How do mothers feel if they don't enjoy being with their baby? Do they have a picture in their heads of a perfect life with a baby that isn't proving to be reality and feel guilty? Depression changes patterns of thought. Mothers may think that they are not a good mother or that the baby doesn't love them and feel guilty for feeling like this. They may think that everything is their fault, lose confidence, feel unable to cope. These negative thoughts may have an impact on breastfeeding so that there are doubts about milk quality and quantity, appropriate sleep, sufficient stimulation or breastfeeding may be a positive reinforcement when everything around feels like failure.

In a study in 2013 (26) 49% of mothers described feelings of anger which isn't always automatically associated with depression and 43% said they found difficulty in leaving the house. Thirty-four per cent admitted that they had hidden their feeling for fear of having their baby taken away from them. The lack of diagnosis will undoubtedly have increased during the pandemic when routine face to face appointments were cancelled or minimised.

The reasons that the mothers in the 2013 survey reported for not disclosing how they felt are disheartening as a healthcare professional. That those who could help were seen as "not friendly" could be taken as "not listening" or "not supportive". That 36% of mothers hadn't even admitted t themselves that they didn't feel their normal selves at a time which should be filled with joy is difficult. Forty-five person of women did share their feelings first with their partner and a further 13% with their mother or other member of the family.

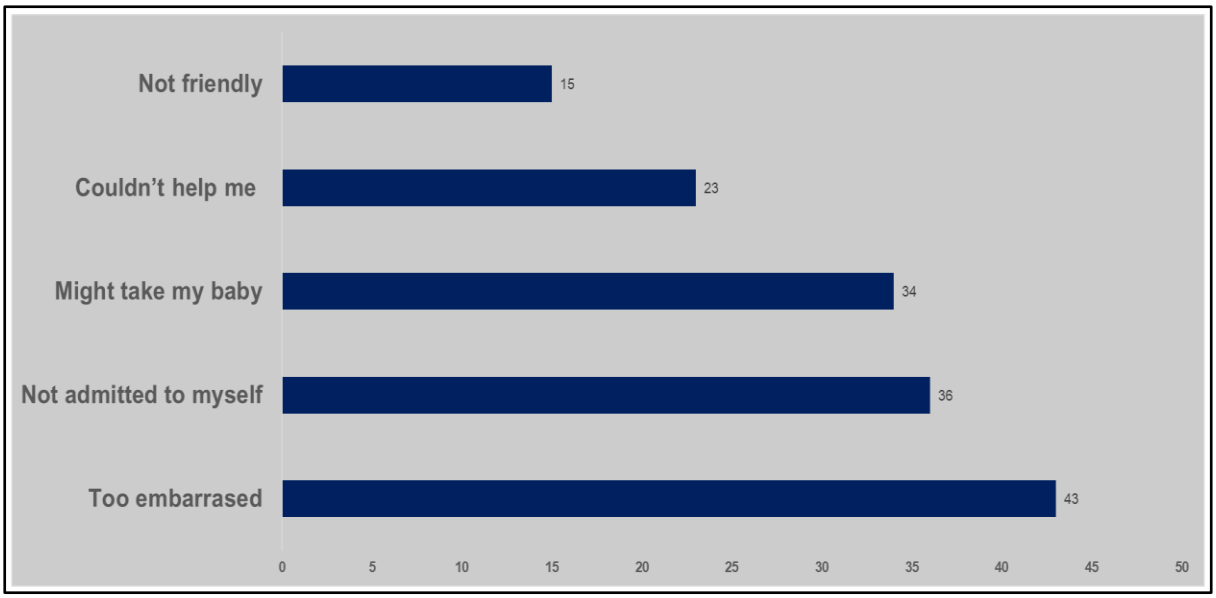


Fig 2. Reasons given by mothers for not disclosing their mental health issues with healthcare professionals (25)

Over 36% of women said that relationship worries had an impact on the way they felt. In addition, of those surveyed, seven out of ten women said that their relationship with their partner had been affected by their illness and 59% cited low sex drive as one of the key ways they were affected. We cannot ignore the concerns of the mothers with mental health complications. These are problems which none of us are immune too. Mental health is rather like a petrol gauge: on good days the positivity is full, on bad days it is "running on empty".

## The effect of the pandemic.

The office for national statistics (ONS) published data in May 2021 on the increase in depression during the pandemic (26). It showed that 43% women aged 16 to 29 years reported experiencing depressive symptoms, compared with 26% of men of the same age. How many of those were breastfeeding? Life as a new mother during this time has been particularly difficult with limited face to face contact with health professionals including health visitors, no access to baby and toddler groups and limited social contact even with family. The contacts to the Breastfeeding Network (27) Drugs in Breastmilk Service involving mental health anecdotally increased during the time March 2020 to May 2021. Many of the mothers also reported that they had forgotten to mention to the doctor that they were breastfeeding, having not been pro-actively asked by the doctor. Messages to check left with the surgeries were often reported not to be returned, presumably because of the workload of general practice during this period. The mothers resorted to asking on social media for the advice of other mothers and found their way to the information service. The messages to Breastfeeding and Medication (22) (both operated by the author) reflected similar queries.

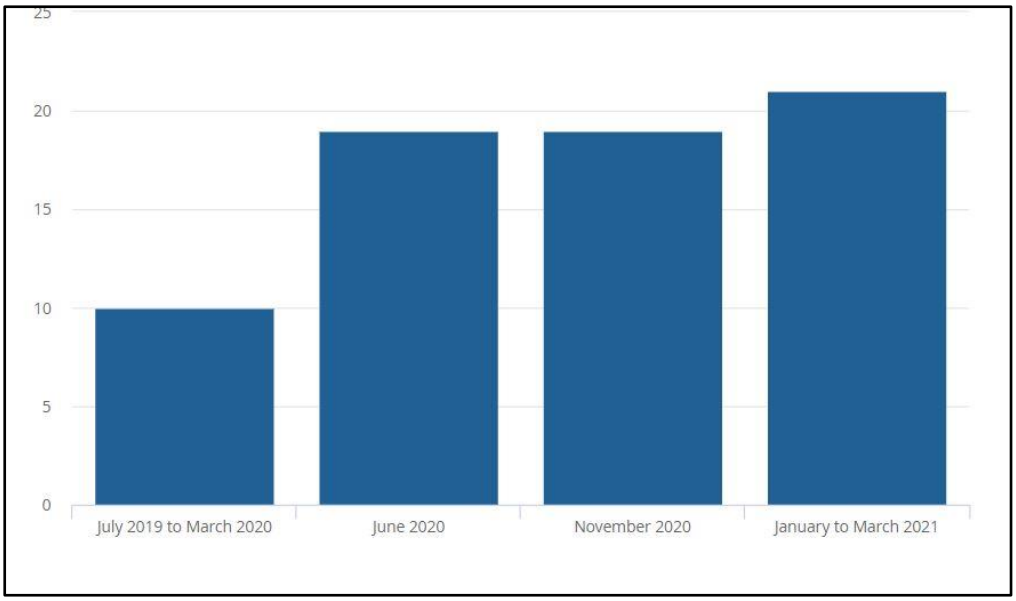


Fig 3 Percentage of adults with depressive symptoms, Great Britain, July 2019 to March 2021 (26)

## The safety of drugs to treat anxiety and depression for a lactating mother

Although most selective serotonin reuptake inhibitor (SSRI) and serotonin-norepinephrine reuptake inhibitor (SNRI)antidepressants are not licensed to be used during breastfeeding we have knowledge of the pharmacokinetics of the drugs and small studies which show that they are generally compatible with breastfeeding. Addition information is available from other sources including BfN (27), Breastfeeding and Medication (22), UKDILAS (28), Hale (29), Lactmed (30), Jones (31), Brown (32). NICE guidelines on Maternal and Child Nutrition PH11 (33) recommend that prescribers consult additional sources and not just the BNF.

In January 2021, the MHRA launched the Safer Medicines Consortium (34) which identified that "*There is, therefore, a need for reliable and consistent information about medicines used before or during pregnancy and breastfeeding for women and the healthcare professionals who advise them." The vision of the consortium is that "All women will have access to accurate and accessible information to make informed decisions with their healthcare professional about taking medicines before or during pregnancy or breastfeeding*.".

In a paper published in 2003 (35) Anderson concluded that medication shortens duration of breastfeeding because of specific advice or subtle cues by health care professionals. In a literature search he had found 100 possible individual reports of adverse events in babies associated with passage of medication through breastmilk. None were definitely linked, 53 were possibly and 47 probably. Of these 37% cases were in newborn, 63% in babies under 1 month of age and only 22% in babies more than 2 months. There seems to be a presumption by professionals, mothers, families and society that formula has benefits over breastmilk with a trace of medication in, that adverse events are likely and serious. There is a reticence to use professional judgement and go outside the license application. This leaves the mother with the dilemma – to interrupt or stop breastfeeding to take the medication or to delay medication.

| Drug | Pharmacokinetic data | Compatability |
|---|---|---|
| **SSRIs** | | |
| Sertraline | plasma protein binding 98%, relative infant dose 0.4-2.2% | compatible with breastfeeding |
| Paroxetine | plasma protein binding 95%, relative infant dose 1.2-2.8% | compatible with breastfeeding |
| Citalopram | plasma protein binding 80%, relative infant dose 3.56% - 5.37% | compatible with breastfeeding |
| Fluoxetine | plasma protein binding 94.5%, relative infant dose 1.6% - 14.6% | compatible with breastfeeding if mother has used it before or if initiated when baby > 6 weeks |
| **SNRIs** | | |
| Duloxetine | plasma protein binding >90%, oral bio-availability >70%, relative infant dose 0.1-1.1% | studies limited in number but adverse events not noted |
| Venlafaxine | plasma protein binding 27%, oral bio-availability 45%, relative infant dose 6.8-8.1%. | Withdrawal after delivery if taken in pregnancy likely. Observe for jitteriness, respiratory distress, cyanosis, apnoea, seizures, temperature instability which may represent discontinuation syndrome. Compatible with breastfeeding |
| **Tri-cyclics** | | |
| Amitriptyline | plasma protein binding 94.8%, relative infant dose 1.08-2.8% | undergoes extensive first pass metabolism. Compatible with breastfeeding but avoid co-sleeping |
| Imipramine | plasma protein binding 90%, relative infant dose 0.1-4.4% | compatible with breastfeeding |
| **Other drugs** | | |
| Mirtazapine | plasma protein binding 85%, oral bio-availability 50%, relative infant dose 1.6-6.3%. | Studies in doses up to 45mg but limited in number. No adverse effects noted. Compatible with breastfeeding but avoid co-sleeping |
| Propranolol | 90% plasma protein bound, relative infant dose 0.3-0.5%. | undergoes first pass metabolism and compatible with breastfeeding |
| **Benzodiazepines** | | |
| Diazepam | plasma protein binding 99%, relative infant dose 7.1, half-life 43 hours | single occasional use probably compatible with breastfeeding for panic attacks but best avoided due to risk of accumulation |
| Lorazepam | plasma protein binding 85%, relative infant dose 2.5%, half-life 12 hours. | preferable to diazepam if use of a benzodiazepine essential. Observe baby for drowsiness and poor feeding |
| **Hypnotics** | | consider how mother will deal with her milk supply overnight and who will look after the baby whilst she sleeps. Missing a feed increases risk of mastitis and use for more than a couple of days risks lowering milk supply |
| Zopiclone | plasma protein binding 45%, half-life 4-5 hours, relative infant dose 1.5%. | Matheson (1990) studied 12 babies whose mothers were given 7.5mg zopiclone in the early post-natal period. None showed any adverse effects but were not allowed to breastfeed for 10 hours |
| Zolpidem | plasma protein binding 93% , half-life 2.5-5 hours, relative infant dose 0.02% - 0.18%. | undergoes extensive first pass metabolism, |
| Temazepam | plasma protein binding 96% half-life 8-15 hours | In a study of 10 mothers (Lebedevs 1992) levels were undetectable in 9 babies and no adverse effects were noted. |
| Nitrazepam | plasma protein binding 96% half-life 30 hours, relative infant dose 2.9%. | In a study of 9 women no adverse effects were noted in the babies (Matheson 1990). |
| | | |

Fig 4 Pharmacokinetics of drugs commonly prescribed for perinatal mental health issues ( data taken from 27-32)

## Conclusion

The responses of the mothers to the questions on social media are educational in themselves as they provide a 360-degree view of what patients feel about the support of professionals for mothers who are breastfeeding and have mental health issues

The aim of breastfeeding support is to empower the mother to feed her baby in the way that she has chosen for as long as she and her nursling choose. Empowerment is about increasing confidence. However, with perinatal mental health issues the confidence of the mother may be diminished and failing. Many mothers have described the difficulty of calling a professional, making an appointment and discussing their feelings. To be challenged as to why they are still breastfeeding, to be told that breastfeeding doesn't matter disempowers them further. Yet this is the situation that is encountered on a daily basis (14). The mothers have not sought confirmation of their chosen feeding method, be their nursling 6 weeks, 6 months or 6 years; they have visited the health professional for treatment for their mental health issues

In 2018 the Maternal and Mental Health Alliance produced a report called Mums and Babies in Mind (36). It supported local leaders to improve services and care pathways for mums with mental health problems and their babies. The aim was to improve:

- Understanding perinatal and infant mental health and their relationship with infant feeding
- Understanding how to empower individual women to make and achieve the feeding choices that are best for them (taking account of their mental health)
- The ability to support women – wherever they are in their feeding journey – in a way that protects and promotes their, and their babies' mental health.

In several areas of the country the author is aware of projects where the mental health team and the infant feeding supporters work together, (having had combined workshops), so that mental health and breastfeeding are supported together in whichever way the mum wishes. She may be supported to:

- receive additional breastfeeding support whilst having her anxiety/depression acknowledged, to be treated with a medication compatible with breastfeeding,
- to stop breastfeeding if that is what she chooses

but throughout to be listened to and empowered through talking therapies or upskilled health practitioners.

Mental health and infant feeding should be addressed as one field. Many mothers experience anxiety and depression in the early postnatal period, possibly many more than are ever documented. By understanding that advising a mother to stop breastfeeding in order to take medication may be taking from her the only thing that she feels positive about. It also removes the activity of oxytocin which helps reduce stress and anxiety and finally influences the return of menses.

Mothers are very clear about what they want from professionals and their voice is clear.

- Listen
- Be empathetic
- Don't judge
- Use evidence-based sources

- Refer to others who know about breastfeeding
- Accept that the importance to breastfeeding to the mother may not align with your own but she wants help with her mental health rather than a breastfeeding discussion unless she asks for that.

This is a challenge for all healthcare professionals but possibly reflects how we would want to be treated if we were in this situation. By having breastfeeding support and mental health support working together for the benefit of the mother can only maximise recovery potential and a positive family. It is a challenge to change long-term working practices but women are clearly asking for professionals to listen more and value their decisions.

## References


1. The Benefits of Breastfeeding NHS https://www.nhs.uk/conditions/baby/breastfeeding-and-bottle-feeding/breastfeeding/benefits/ accessed May 2021
2. National Institute for Health and Care Excellence (NICE). Maternal and child nutrition public health guideline PH11, updated 2014. https://www.nice.org.uk/guidance/ph11
3. Rollins NC, Bhandari N, Hajeebhoy N, et al. Why invest, and what it will take to improve breastfeeding practices? Lancet 2016; 387: 403– 504.
4. World Health Organization. The optimal duration of exclusive breastfeeding. Report of an expert consultation, 2001. https://apps.who.int/iris/bitstream/handle/10665/67208/WHO_NHD_01.08.pdf?ua=1 accessed May 2021
5. Department of Health. Breastfeeding: public health policy and advice, 2016. https://www.health-ni.gov.uk/articles/breastfeeding (accessed May 2021).
6. Hoddinott P, Tappin D, Wright C. Breastfeeding: clinical review. British Medical Journal 2008; 336: 881– 7.
7. Renfrew MJ, Pokhrel S, Quigley M, McCormick F, Fox-Rushby J, Dodds R, Duffy S, Trueman P,William A. United Nations Children's Fund (UNICEF). Preventing disease and saving resources: the potential contribution of increasing breastfeeding rates in the UK, 2012. https://www.unicef.org.uk/wp-content/uploads/sites/2/2012/11/Preventing_disease_saving_resources.pdf
8. Hansen K Breastfeeding: a smart investment in people and in economies. Lancet 2016; 387(10017):416
9. McAndrew F, Thompson J, Fellows L Infant Feeding Survey 2010. Leeds: Health and Social Care Information Centre. 2012. https://sp.ukdataservice.ac.uk/doc/7281/mrdoc/pdf/7281_ifs-uk-2010_report.pdf
10. Breastfeeding at 6 to 8 weeks after birth: annual data https://www.gov.uk/government/statistics/breastfeeding-at-6-to-8-weeks-after-birth-annual-data accessed May 2021
11. Victora CG, Bahl R, Barros AJ (2016) Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. Lancet 387(10017):475–90.
12. Brown A Why Breastfeeding Grief and Trauma Matter 2019 (Pinter & Martin)
13. Beck CT. Postpartum depression. Stopping the thief that steals motherhood. AWHONN Lifelines. 1999 Aug-Sep;3(4):41-4.
14. Brown A, Finch G, Trickey H, Hopkins R, A lifeline when no one else wants to give you an answer'. An evaluation of the Breastfeeding Network drugs in breastmilk service 2019 https://breastfeedingnetwork.org.uk/wp-content/pdfs/BfN%20Executive%20summary.pdf

15. RCOG Maternal Mental Health – Women's Voices 2017 https://www.rcog.org.uk/globalassets/documents/patients/information/maternalmental-healthwomens-voices.pdf
16. MBRRACE-UK Saving Lives, Improving Mothers' Care 2021 https://www.npeu.ox.ac.uk/mbrrace-uk/reports accessed May 2021
17. Yelland, J., Sutherland, G. & Brown, S.J. Postpartum anxiety, depression and social health: findings from a population-based survey of Australian women. BMC Public Health 2010; 10, 771.
18. Sharifi F, Nouraei S, Shahverdi E. The Relation of Pre and Postnatal Depression and Anxiety with Exclusive Breastfeeding. Electron Physician. 2016;8(11):3234-3239.
19. Borra C, Iacovou M, Sevilla A. New evidence on breastfeeding and postpartum depression: the importance of understanding women's intentions. Matern Child Health J. 2015 Apr;19(4):897-907.
20. Byrom, A, Thomson, G, Dooris, M, Dykes, F. UNICEF UK Baby Friendly Initiative: Providing, receiving and leading infant feeding care in a hospital maternity setting—A critical ethnography. Matern Child Nutr. 2021; e13114.
21. Brown A, Rance J, Bennett P. Understanding the relationship between breastfeeding and postnatal depression: the role of pain and physical difficulties. J Adv Nurs. 2016 ;72(2):273-82.
22. Breastfeeding and Medication Facebook https://www.facebook.com/breastfeedingandmedication
23. Liu C, Cnattingius S, Bergström M, Östberg V, Hjern A. Prenatal parental depression and preterm birth: a national cohort study. BJOG. 2016 Nov;123(12):1973-1982..
24. Williams M. Fathers Reaching Out - Why Dads Matter 2020. :https://dadmatters.org.uk/wp-content/uploads/2020/09/MARK_WILLIAMS_FATHERS_REACHING_OUT_PMH_REPORT10_SEP_2020-2.pdf
25. Perinatal Mental Health Experiences Of Women And Health Professionals https://maternalmentalhealthalliance.org/wp-content/uploads/Boots-Family-Trust-Alliance-report.pdf (accessed May 2021)
26. Coronavirus and depression in adults, Great Britain: January to March 2021 ONS May 2021 https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/coronavirusanddepressioninadultsgreatbritain/januarytomarch2021
27. The Breastfeeding Network Drugs in Breastmilk Service https://www.facebook.com/BfNDrugsinBreastmilkinformation/
28. UKDILAS – NHS information service on drugs in lactation, part of the Specialist Pharmacy Service. https://www.sps.nhs.uk/articles/ukdilas/ Freely available factsheets and telephone service
29. Hale TW Medications and Mothers Milk – a book or subscription service. Springer Publication
30. LactMed – a free searchable database part of NCBI https://www.ncbi.nlm.nih.gov/books/NBK501922/
31. Jones W Breastfeeding and Medication 2018 Routledge
32. Brown A and Jones W (Ed) A guide to supporting breastfeeding for the medical professional, 2019 Routledge
33. NICE PH11 Maternal and Child Nutrition (recommendation 15) 2014
34. Safer Medicines in Pregnancy and Breastfeeding Consortium information strategy Jan 21 https://www.gov.uk/government/publications/safer-medicines-in-pregnancy-and-breastfeeding-consortium/safer-medicines-in-pregnancy-and-breastfeeding-consortium-information-strategy
35. Anderson PO, Pochop SL, Manoguerra AS, Adverse drug reactions in breastfed infants: less than imagined, Clin Pediatr (Phila), 2003;42(4):325–40

36. the Maternal and Mental Health Alliance. Understanding perinatal and infant mental health and their relationship with infant feeding. https://maternalmentalhealthalliance.org/projects/mumsandbabiesinmind/