From 'Bumps to Bundles'

Perinatal Mental Health
in
NHS Greater Glasgow and Clyde

Research and original report conducted and compiled by Duddleston Harkins Social Research Limited and Progressive Partnership

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1. Acknowledgements and Further Information

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2. Executive Summary

Background and Policy Context

NHS Greater Glasgow and Clyde has robust systems for assessing perinatal mental health (PNMH) and for providing services to women who experience mental health issues during this period. This framework is supported by a number of key policy directives at Scottish Government level including: The Scottish Government's Mental Health Strategy for Scotland (2013-15); The Scottish Government's Reducing Antenatal Health Inequalities; Outcome Focused Evidence into Action Guidance (2011) as well as SIGN 127, 2012; and key strategic localised NHS policies.

However, in this context, there are a range of factors which influence perinatal mental health and the ability of statutory organisations to assess and support women in the perinatal period. These factors include the fear and stigma associated with perinatal mental ill health; poor partner or family support and relationships; socio-economic issues; and culturally sensitive issues for women for whom English is not their first language.

Greater Glasgow and Clyde's Anti Stigma Partnership identified this as one of their key priority areas to be addressed in 2011 and joined with Health Improvement colleagues to drive this agenda forward. To this end, research was commissioned to explore, with women and stakeholders from the statutory and third sectors, what inhibited and what protected mental health amongst women during the perinatal period, and to review existing service provision and provide recommendations for service improvements.

Methodology

A mixed method approach was adopted using qualitative research with women and stakeholders. This consisted of in-depth interviews and focus groups being undertaken across five Community Health (and Care) Partnership sectors: namely, Glasgow City CHP North East sector; Glasgow City CHP North West sector; Glasgow City CHP South sector; Renfrewshire CHP; and Inverclyde CHCP.

111 women and 89 stakeholders, from Glasgow City, Renfrewshire and Inverclyde, took part in interviews and focus groups. These were sampled via a range of methods which included links with statutory sector staff and third sector organisations and communications at community open days.

The overall sample included a broad spectrum of women: from those who were considered to be vulnerable and isolated, to minority groups, to more affluent mothers and to mothers in the general population. The inclusion criteria were women who were either pregnant or had children up to five years of age.

In addition, stakeholders took part in an interview; in a paired interview; or focus group. All stakeholders engaged with women during the perinatal period. The stakeholders included staff from health visiting; midwifery; third sector organisations; social work services; education services; mental health services; health improvement; and interpreting services.

Key Findings

Factors Affecting Perinatal Mental Health

Women can potentially face many challenges to their mental health in the perinatal period. These issues can include: adjustment to parenthood; sleep deprivation; trying to breastfeed; isolation; unrealistic expectations of labour, birth and early parenthood. The stigma surrounding mental ill health is compounded by a further stigma attached to perceptions of failure in the parenting role. This makes it difficult for women to admit that either they are struggling to cope or they are feeling low. All women may be additionally vulnerable where they are living with deprivation. Poverty often underlies poor mental health and in turn compounds the issues which can contribute to mental health problems, such as worries about the cost of housing, childcare, food and amenities and difficulty in accessing services due to transport costs.

Some additional vulnerability was found in the following groups:

- *BME women*, particularly where family support was unavailable, might experience barriers to accessing services due to language; perceptions of services being culturally inappropriate; and difficulties in using screening tools.
- *Young parents,* frequently perceived that they were being judged by service providers and by society in general. This proved a major barrier to engaging with services, particularly statutory services. Additionally, they were often disadvantaged by having little or no peer support and by the breakdown of their relationship with the baby's father.
- *Women who had experienced trauma* (not only childhood sexual abuse and domestic violence but, also, traumatic labour or previous still birth) struggled when becoming a parent due to low confidence and a resurgence of memories and feelings arising from the trauma. These women felt particularly unable to attend community activities.
- *Working women* experienced additional difficulties due to the change from being out at work to being at home. As compared to work, they perceived this change as a loss of control of their lives and a lack of structure to their week. These women had a greater reliance on community activities.

The findings suggest the need for more information and support, both antenatally and postnatally.

Support

Frequently, women named one person as being a key factor in their ability to cope as a parent; usually, this person was a family member, friend, peer or a professional support worker from the third sector or statutory services. Having a support network allowed for practical and emotional assistance and provided the ability to share parenting experiences which, in turn, reduced feelings of isolation or inadequacy. Third sector support organisations were praised particularly due to their service provision being based on an enduring relationship with women. The provision of community groups and activities, which provided opportunities to develop peer relationships, was seen as critical to supporting mental health. However, some women experienced significant financial and emotional barriers to accessing these services and, amongst women and statutory stakeholders, there were low levels of

knowledge of such groups. Often, women and stakeholders cited emotional barriers to accessing services including low self-esteem and low self-confidence post birth. This meant that these mothers were unlikely to go out, attend groups or be in the company of other mothers.

Stigma

The stigma associated with mental ill health, compounded by a pervasive social stigma attached to being seen to 'fail' as a mother, leads to under-reporting of mental health issues. In addition women perceived that disclosing mental health issues could lead to social work services' involvement and potentially to their children being removed from their care. Stigma and misunderstanding was prevalent too among families and communities. Findings suggest a need to raise community awareness of perinatal mental health and, more generally, the struggles and challenges involved with pregnancy and parenthood so that women feel able to disclose issues without guilt, shame or fear of the consequences.

Statutory Maternity Care

Women and stakeholders viewed the role of midwives and health visitors as being of crucial importance. However, in the sample, most women recounted poor experiences of maternity care. A reduction in health visitor home visits appeared to have created issues for women; many remarked on the more limited service and stressed that, due to the lack of an established relationship, they would be unlikely to confide in a health professional. Similarly, stakeholders considered that the amount of time with which they had to engage with women, was increasingly pressurised and they could understand why women perceived this as a lack of care. This had a potential impact on the relationships between these key professionals and women which, in turn, could result in reported under-disclosure of mental health issues. Furthermore, stakeholders stressed the need, given the lack of funding to create separate support services, for intensive support services for the most vulnerable women to be incorporated into mainstream provision.

Current Service Provision, Gaps and Limitations

Effective service pathways are in place for women with severe perinatal mental ill health. However, the participants considered that there were gaps in provision of preventative, early intervention services and particularly those for women experiencing mild to moderate mental health problems. Women and stakeholders spoke of the provision of services which offered social support, such as baby massage and buggy walks, as being critical to both preventing and promoting recovery from, mental ill health. Perceived service gaps were defined by limited flexibility of services; lack of relationships between mothers and health professionals; limited preparation for parenthood; few community based services with health professional involvement; and lack of mental health training for staff, particularly midwives and health visitors. In addition, maternity services' staff frequently expressed a lack of knowledge and confidence in addressing mental health issues with women. Models of good practice, which were flexible, community based and founded on building trusted relationships with women, were recognised as being those provided primarily by the third sector.

Challenges for Services

Major challenges for service providers were the additional stresses experienced by women living with deprivation; by some women from black and minority ethnic groups; and by young women and women who had experienced trauma. In particular, some BME mothers considered that health visitors and midwives did not understand or respect their religious and cultural differences. Some women's lives were greatly affected by poverty and they experienced interconnected issues which contributed to health problems and created barriers to accessing support. In addition, several distinct factors presented significant challenges for services in this area; particularly around inter-agency working. Participants reported confusion or disagreement as to what particular service ought to be the lead agency for cases in which multiple issues had to be addressed. In addition, complex referral pathways and a lack of available time to build relationships with partner organisations often compounded these issues.

Many of the women involved in the research, perceived that, if they were known to be experiencing difficulty, it could lead potentially to social work service intervention. In turn, this led to a fear of children being removed from their care.

In respect of the provision of services, a further challenge was the discontinuation, by both statutory and third sector agencies, of preventative interventions, such as baby massage and free crèche facilities. These services were praised by mothers for providing emotional and practical support and by health professionals for augmenting mainstream services.

Recommendations

The research findings supported and developed the body of literature on perinatal mental health and suggest that women preferred services which were accessible, community based and founded on the building of trusted relationships. The report makes a number of key recommendations:

- Ensure services are accessible, community based, culturally sensitive and are offered at times when women can access them in relaxed, comfortable and informal environments. This ensures that mothers do not feel pressured to attend but allows them to keep in touch informally if they stop attending.
- Develop and extend examples of good practice such as community-led, social support programmes by ensuring, where required, a key worker role to support the most vulnerable.
- Raise community awareness of perinatal mental health issues in order to help reduce stigma.
- Improve awareness of social supports amongst stakeholders and women, including the purpose and benefits of such support. This should be done via a variety of methods including: using local libraries; GP surgeries; health centres; hand held child health records; social media and help lines; and using written and non-written formats, provided in a range of languages.
- Ensure midwives and health visitors have access to training in mental health and inequalities sensitive practice and feel confident to facilitate discussions with mothers about mental health issues.

- Ensure that there are strategies for managing mild to moderate mental health issues and greater staff awareness of referral routes and local resources for women experiencing mild to moderate mental health issues.
- Ensure examples of good practice, such as buggy walks and baby massage, are resourced adequately and produce robust evidence of their effectiveness.
- Share the report in relation to the breastfeeding findings with Maternal and Infant Nutrition Framework Strategic Group, highlighting the unmet need in terms of practical and emotional support for breastfeeding both in the maternity and the community settings
- Work with colleagues in maternity services to improve women's experience of maternity hospitals, in relation to their mental health and wellbeing, paying particular attention to the impact of experiencing traumatic birth.

Conclusion

The key theme to emerge from the research was the need for more effective support for women in the perinatal period through the provision of flexible and accessible services. Opportunity to develop social support is critical to preventing mental health problems and promoting recovery where these arise. There is a therefore a need to compliment clinical interventions with such peer support model approaches.

It is essential that the actions, arising from this research, augment and compliment the approach which NHS Greater Glasgow and Clyde is taking to improve outcomes for families and that these have a positive impact on maternal and infant mental health. It is important, also, that key stakeholders remain engaged to ensure that there are the necessary relationships to drive this work forward.

3. Background and Policy Context

Perinatal Mental Health refers to the mental health of the mother during the period of pregnancy until one year following the birth of the baby. Perinatal mental illness is a serious public health issue with potentially detrimental consequences for the women's life-long mental health and the wellbeing of their children and families. In addition to poorer childhood outcomes, perinatal depression has been linked, also, with depression in fathers and with high rates of family breakdown.

Women are more likely than men to suffer from depression and anxiety and are particularly vulnerable to mental health problems during the perinatal period with post-natal depression affecting up to 20% of such women.

In 2011, the NHSGG&C anti-stigma partnership highlighted that there was an unmet need in relation to PNMH issues and women from more socially and economically deprived areas and, also, that women from minority ethnic backgrounds were less likely to seek out or access informal or formal supports. In order to address this need, links were made with Health Improvement colleagues to drive this agenda forward. A working group was set up to consider the issues and it was agreed that further investigation was needed to highlight the extent of this issues. Funding was obtained from the Anti Stigma Partnership and Health Improvement from the 3 sectors within Glasgow City CHP in order to undertake a piece of research to gain a better understanding of the issues which women faced in the perinatal period. The research was carried out in the NE, NW and South sectors across Glasgow City; Renfrewshire; and Inverclyde.

Duddleston and Harkins (a research company) was commissioned to undertake this piece of work and fieldwork was carried out from March to June 2013**.** Focus groups and 1-1 depth interviews were carried out with 111 women who were pregnant or had a child under 5 years of age and with key stakeholders who had direct or indirect contact with this target group (n=87). They investigated emotional challenges; sources of support; coping strategies; the role of community support; barriers to accessing support; and areas for service improvement.

In his 2006 Annual Report (Health in Scotland, 2006), Scotland's Chief Medical Officer, Sir Harry Burns, emphasised the importance of pregnancy and parenting in defining a range of physical and mental health outcomes. He highlighted the role of parental interaction in the first year of a child's life as being crucial in developing relationships and in establishing positive physical and mental health development. With the introduction of the Early Years Framework (2009), there has been a continuous focus on taking action to work towards Scotland's major public health challenges. These include taking action to ensure that all children receive the best possible start in life. The birth rate, in Scotland, has been rising steadily, up 4.3% between 2002 and 2010. Areas of social deprivation have seen significant increases in births to younger age women and to those more likely to require additional support. In 2011, NHS Quality Improvement Scotland developed the Vulnerable Families care pathway to support the specific aims of the implementation of the Early Years Framework. The pathway's aims are that vulnerable children, from conception to age three, and families, in every part of Scotland, receive equitable, proportionate, effective and timely support.

The Scottish Government's Mental Health Strategy for Scotland (2013-15) focuses on "prevention, anticipation and supported self-management" of mental ill health delivered via a range of improvements and interventions that provide best return against investment over time including evidence based parenting programmes and

early diagnosis and treatment of depression." The strategy acknowledges "The period between pregnancy and 3 years is increasingly seen as a critical period in shaping children's life chances, based on evidence of brain formation, communication and language development, and the impact of relationships formed during this period on mental health. Therefore, it is, also, a critical opportunity to intervene to break cycles of poor outcomes" (Page 19). Women are particularly vulnerable to mental health problems during the perinatal period since it is estimated that the prevalence rate for postnatal depression clusters between 10 and 15% (SIGN 127, 2012).

Perinatal mental health problems include a range of disorders and severities ranging from baby blues (the short-term emotionally labile state experienced by the majority of women following childbirth) to postnatal depression (any non-psychotic depressive illness occurring during the first postnatal year) to postpartum psychosis. The NICE guidelines (45, 2007) on antenatal and postnatal mental health stress the need for patient-centred care which takes into account individual needs and circumstances. Key priorities for implementation include actions taken in relation to the prediction and detection of depression; health professionals discussing the risks associated with treating and not treating the condition; the consideration of self-help strategies and therapy for a women who has developed mild to moderate depression during pregnancy or the postnatal period (including listening visits); and clinical networks being established including a pathway of care for service users and clear referral and management protocols.

The Scottish Government's Reducing Antenatal Health Inequalities; Outcome Focused Evidence into Action Guidance (2011)is based on the premise that poor and unequal access to antenatal healthcare contributes to inequalities in maternal and infant mortality and morbidity and that those, who are at the greatest risk of poor health outcomes, are the least likely to access or benefit from the antenatal healthcare which they need The Guidance states that antenatal healthcare can make a significant contribution to the reduction of health inequalities but it is reliant on improved access; assessment of health and social care need; and equity in the quality of care.

The most recent UK Confidential Enquiry into Maternal Deaths (CEMD) – Saving Mothers Lives (2011) - continued to identify suicide and mental health issues as the second leading cause of maternal death in the UK. Successive Enquiries (2004), (2007), (2011) highlighted the rapid progression from mild symptoms of anxiety and emotional ability to profound psychosis; their reports stress the need for midwives to be competent in the identification of anxiety symptoms. This need, for early detection, is embedded in the key national documents underpinning mental health care in the perinatal period (SIGN 127, 2012), (NICE 45, and 2007).

The Getting it Right for Every Child (GIRFEC) strategy (Scottish Government, 2006) approach provides a consistent way for people to work with children and young people. The strategy outlined how practitioners needed to work together to support families, and, where appropriate, to take early action at the first signs of any difficulty. This requires working across organisational boundaries and putting children and their families at the heart of decision making. The Scottish Government asserts that the GIRFEC approach is being threaded through all existing policy; practice; strategy; and legislation affecting children, young people and their families.

The key principles of Getting it Right for Every Child (2006) run through the Refreshed Framework for Maternity Care in Scotland (RFMC) (2011); this states(page 3) "the Scottish Government is committed to ensuring that all children in

Scotland get the best possible start in life, even before they are born". The framework is based on evidence that investing in early intervention, prevention and support leads to significant savings across public services. The document stresses that effective collaboration and communication between any NHS service, providing maternity care to women and their babies, is essential for person centred, safe and effective maternity care. However, it recognises, also, the range and extent of challenges in translating the framework into practice. These include constrained public service resources; workforce planning and development needs; and information and data issues.

The summary of key quality indicators and outcomes for maternity care include: improved safety of all women and babies; increased early engagement with maternity services; increased integrated workforce planning (prioritising midwifery and public health nursing); improved communication across service areas; increased focus on maternal and infant mental and emotional health and wellbeing; including effective assessment and support services; improved assessment of need and response to women with complex health and social care circumstances; and improved referral to and uptake of parenting support services in the antenatal and postnatal period.

Compassionate Connections is a collaborative project between NHS Education for Scotland and NHS Health Scotland. It aims to support the implementation of the Refreshed Framework for Maternity Care through the development of educational resources which will help to strengthen the impact of maternity care and mitigate health and social inequalities. As well as building on the contribution which members of staff make already towards improving the health and wellbeing of women and their families, the resources will explore the impact of a compassionate person centred approaches to care. In 2011, a learning needs analysis highlighted the need for development in a number of key areas including the impact of inequalities on service engagement.

In Scotland, all pregnant women have a Scottish Woman Held Maternity Record (SWHMR); this is completed primarily by Midwives at the first booking visit at 12 weeks gestation. SWHMR was introduced in 2005; for the first time, all women were asked standardised questions not only about their obstetric history and physical health but, also for the first time, women were asked routinely about their mental health.

4. Literature Review

There is a scarcity of research conducted in Scotland on perinatal mental health; this supports further the need for this research.

Mental health problems, experienced during pregnancy and the postnatal period, impact on foetal development; the infant nervous system; and the parent-infant relationship. These can lead to significant long-term consequences for the child (Coe and Barlow, 2013; O'Donnell et al, 2009; Marryat and Martin, 2010). A review of the research on the effects of prenatal depression on the foetus and new-born suggested that they experienced prenatal and postnatal complications (Field et al, 2006). Also, there is growing evidence that antenatal anxiety has both short and long term consequences for the health of the foetus and the child. The emotional well-being of the mother contributes to the healthy growth of the foetus and the likelihood of achieving full-term pregnancy (Dunkel Schetter, 2011). Furthermore, recent studies indicated that depression, which was co morbid with anxiety, increased the risks (Field, Hernandez-Reif, & Diego, 2006), (Ibanez et al, 2012).

There is a growing body of evidence which suggests that antenatal mental health problems can be, also, a catalyst for future mental health problems and that women, with postnatal depression, have an increased risk of future depressive episodes (Tsivos et al, 2011). Therefore, the perinatal period is a crucial time in identifying mental health problems, and, due to their increased contact with health services, offers an excellent opportunity to screen women. However, barriers to effective screening may include women's attitudes to mental illness and health professionals' anxiety about how to deal with mental illness when they are not specialists in this area. Ross-Davies et al (2006) suggested that, frequently, professionals might underestimate antenatal mental health issues due to a fear of potentially 'opening a can of worms', since they felt ill-equipped to deal with these issues.

What Impacts on Perinatal Mental Health?

The literature includes a range of factors shown to be linked to poor perinatal mental health. These include the change of life brought on by a new baby including the 24 hour responsibility (MIND, 2006); artificial reproductive techniques (Giardinelli et al, 2012); difficulties in regulating the infant's emotions (Gonidakis et al, 2008); previous history of depression (Schmied et al, 2013); poor partner relationship (Schmied et al, 2013); pressures faced and lack of community support (Netmums ,2007); pregnancy and delivery complications (including emergency caesarean section and suspicion of foetal distress) (Blom et al, 2010; Ngoma et al, 2012; Schytt and Hildingsson, 201); and breastfeeding (e.g. Davey et al, 2011; Haga et al, 2012; Dagher et al, 2011), although having a perceived support system has been linked to the initiation and duration of breastfeeding (Brand et al, 2011).

Financial difficulties or being economically dependent on another person (Nicolson, 1998; Ngoma et al, 2012) is linked to poorer mental health and socio-economic deprivation. This is one of the key factors underpinning poor general health in the perinatal period (Scottish Government, 2011).

Early Intervention

Previous research indicated that demographically at-risk pregnant women might benefit from intensive parenting interventions (although this was dependent on factors such as the intensity and frequency of the service and the skills of the service

provider); with early interventions being more effective than those which began in later parenthood. (Barlow et al, 2008). Important factors of such a service were said to be staff having the necessary skills and knowledge to work with parents (and being provided with appropriate training and on-going support); and targeting 'at-risk' communities, within a universal service to assess need. This reduced the stigma associated with targeting. Recommendations, from the Barlow et al report, included moving from a 'late reaction' to social problems towards an early intervention culture; health services placing a focus on antenatal education/preparation for parents; and providing evidence-based preventative early interventions and intensive services for the most vulnerable (such as the Family Nurse Partnership which is currently being piloted in Glasgow). This programme supports at-risk teenage mothers to foster emotional attachment and confident parenting through high-intensity support. It proved particularly successful in connecting with those most disaffected with and distrustful of services.

Stigma surrounding Perinatal Mental Health Issues

The fear and stigma, associated with perinatal mental ill health, is a major challenge in the treatment of the condition. Previous research illustrated how negative perceptions of mental health services could be a clear barrier to service use (Leis et al, 2011), with there being a stigma associated with 'not coping' (Hall, 2006). The stigma and barriers to effective screening for mental health issues amongst perinatal women have led to innovative methods of screening women such as an online version of the Edinburgh Postnatal Depression Scale (EPDS) (Drake et al, 2013). Previous research indicated that the EPDS could be used effectively if: staff had proper support, training and resources; the implementation process was gradual; and staff were able to utilise other skills such as observing the women interacting with their baby, nonverbal communication and using intuition to develop a clinical decision (Milgrom et al, 2011; Vik et al, 2009; Rollans et al, 2013).

Previous research indicated that, although there was fairly high community awareness of postnatal depression, this did not imply necessarily awareness either of its symptoms or risk factors or sources of assistance (Sealy et al, 2009 Highet et al, 2011). Consequently, public education was recommended in order to provide social support and to encourage treatment for symptomatic women and their families.

Informal Sources of Support

Despite attempts by health professionals to detect postnatal depression, some mothers remain reluctant to disclose their true feelings. As such, pregnant women rely often on informal sources such as friends and family, and report low use of formal treatments (O'Mahen and Flynn, 2008; Henshaw et al, 2013). Social support has been linked with good perinatal mental health (Haga et al (2012); Dagher et al, 2011; Emmanuel et al, 2012), and it was suggested that perinatal mental health education ought to be expanded to target social support persons since women consulted them often when determining whether depression existed or ought to be treated (Henshaw et al, 2013).

Service Provision: Health Professionals

Early engagement with health professionals is associated with more positive pregnancy outcomes. However, there is evidence that those women, at highest risk of poor pregnancy outcomes, are less likely to access antenatal care early and/or

have a poorer experience of that care. The Scottish Government HEAT Target for March 2015, states that, by the 12th week of gestation, at least 80% of pregnant women, in each SIMD quintile, will have booked for antenatal care.

The role of the health visitor and the midwife appears to be crucial. Previous research indicated the value of the long-term relationship between GP/health visitor and women, and the problems associated with no one health professional assuming overall responsibility for the care of women with postnatal depression (Chew-Graham et al, 2008). It was suggested that improving the intensity of support by midwives and health visitors might improve outcomes (Marks et al, 2003; Hildingsson, 2011; Lewis et al, 2011; Haga et al, 2012; Taylor and Johnson, 2010; Alerdice et al, 2013). Price et al (2012) reported evidence to support the expansion of the health providers' role of in relation to perinatal depression. It was suggested, also, that home visiting programmes were an effective way of meeting the needs of perinatal women (Leis et al, 2011; Barlow et al, 2008).

The previous research asserted the need for mental health promotion initiatives in primary health care (Loureiro et al, 2009), as well as barriers to mental health treatment at the patient, provider, and system levels. These included lack of time and stigma (Kim et al, 2010; Goodman, 2009). Segre et al (2010) stressed that nurse-delivered mental healthcare might reduce many barriers that prevent the detection and treatment of depression. It was shown, also, that the relationship between the health professional and the woman influenced perinatal mental health (Gurber et al (2012).

However a lack of awareness and understanding amongst health professionals surrounding perinatal mental health could be a huge barrier to service provision. The previous research indicated that, often, health professionals had inadequate knowledge of perinatal depression and anxiety (Chew-Graham et al, 2008; Taylor and Johnson, 2012; McCauley et al, 2011; Wylie et al, 2011). Rothera and Oates (2008) asserted that the improvement of service provision required the development of training and education programmes; care pathways and protocols; and referral guidelines and liaison services.

Managing perinatal mental illnesses involves all levels of healthcare provision (Rothera and Oates (2008), and multidisciplinary teams' early detection and provision of care to women at risk of mental illness was found to be crucial (Ebeid et al, 2010). Therefore, effective partnership working was highlighted as a means of improving perinatal mental health (Yelland et al, 2010); and, in this respect, Loureiro et al (2009) suggested specifically that there ought to be increased collaboration between the health sector and community resources.

Alternative Service Provision

Given the restrictions on resources amongst the healthcare sector coupled with the stigma surrounding accessing mental health issues, alternative service provision, for women experiencing mental health issues, is becoming more commonplace. It was suggested that good practice was represented by community based services rather than in more clinical settings (Harvey et al, 2012; Judd et al, 2011; Field et al, 2000). Important factors included early intervention and prevention; outreach capacity; and an accessible and non-stigmatising location.

Case Study – Family Action Perinatal Project

Family Action (a charity which helps more than 45,000 vulnerable families and children across England a year by offering emotional, practical and financial support) runs the community based Family Action Perinatal Project. The project aims to provide intensive support to improve parental mental health during pregnancy and to ensure the development of a healthy bond after birth. The project works with pregnant women and new mothers, with children up to the age of one, who may be at risk of depression. McCaul and Stokes (2011) discussed the perinatal support project pilot. They asserted that, whilst health visitors provided an essential role in supporting new mothers in the community, there were opportunities for enhancing the support available to women in a way which complemented health visitors' roles. Women were matched with a local volunteer befriender who provided assistance with practical and emotional issues. The project was found to reduce mental health problems in vulnerable women and, as such, was extended. It was suggested that, in relation to perinatal mental health, the health professionals could enhance their support of expectant and new mothers through increased awareness and identification of perinatal depression, and by developing links with community support projects, which could complement their work.

Coe and Barlow (2013) provided further evaluation of the project which, now, in partnership with other agencies including midwives, runs at four sites across the UK. The results were positive, with there being high levels of need and positive outcomes for parents; and midwives and health visitors valuing highly the service being offered. The authors concluded that the project appeared to fill a gap in service provision with women who had mild to moderate ante and post natal depression. In addition, they suggested that there was scope for the project to work with women earlier in the antenatal period where the impact might be even greater.

It was suggested often that Infant massage had benefits for both the mother and the infant. There is inconsistent literature on infant massage, although, overall, it indicates that the classes do appear to have some benefits for mothers and infants. However, it is recommended that there ought to be further research and evidence. The benefits include improvements in the mother-infant interaction and physical contact and reductions in depression scores (Underdown et al, 2006; Onzawa et al., 2001; O'Higgins et al, 2008; Oswalt et al, 2009; Feijo et al, 2006; Fuijita et al, 2006).

Support for Vulnerable Groups

There appears to be a link between women who have experienced some form of abuse and poorer perinatal mental health. In particular, these women often suffer from posttraumatic stress disorder during the perinatal period (Seng et al, 2008; Roller, 2011; Howard et al, 2013).

Black and Minority Ethnic (BME) women are another potentially vulnerable group who experience barriers to accessing perinatal support and mental health services (Redshaw and Henderson, 2013; O'Mahony and Donnelly, 2012; Onozawa et al, 2003). Indeed, women from BME communities are seven times more likely to die in childbirth than women in other groups (Scottish Government, 2011). In particular, Asian women appear to be vulnerable to perinatal mental health issues (Abbasi et al, 2013; Dhillon and Macarthur, 2010). Gulamani et al (2013) conducted a literature

review of postnatal depression in Asian countries and concluded that culture played an important role in perinatal mental health. The evidence suggests, also, that these women may be less likely to utilise mental health services, or to discuss depressed mood with health professionals (Liu and Tronick, 2012; Goyal et al, 2012).

Previous research indicated that, in order to improve service provision, health professionals needed a greater awareness and understanding of the Asian culture (Baldwin and Griffiths, 2009; Hanley, 2007). Downe et al (2007) examined screening tools for depressed mood for South Asian women and found that women preferred face-to-face interviews to self-complete questionnaires. Also, they found that none of the tools (including a translation of the EPDS) were evaluated sufficiently for clinical practice and, therefore, raised questions about the use of language-based tools to measure postnatal depressed mood in this population.

The European Perinatal Health Report (Euro-Peristat, 2010) outlines how "the UK stands out from its neighbours with a high proportion of very young mothers (5%)". The literature identified the difficulties which adolescent mothers encountered as a result of the combined stress of adolescence; parenthood; maintaining peer relationships; and establishing positive relationships with their infants. Meltzer-Brody et al (2012) found that the risk factors for postnatal depression amongst adolescents included antenatal depression; social support; and trauma history.

Anderson et al (2002) explored the vulnerability of postnatal depression amongst financially, educationally, and socially advantaged women and concluded that, regardless of demographic advantages, screening measures ought to be a universal standard of care for all women. The most recent UK Confidential Enquiry into Maternal Deaths (CEMD) – Saving Mothers Lives (2011) continued to identify suicide and mental health issues as the second leading cause of maternal death in the UK. Also, it cautioned that since half of these suicides were by white, employed, married women, living in comfortable circumstances, risk of suicide ought not to be equated with socio-economic circumstances. Generally, however, previous research indicated that poor perinatal mental health was associated with lower socio-economic status (Segre et al, 2007; Goyal et al, 2010; Matijasevich et al, 2009; Darcy et al, 2011) and, consequently, it was suggested that strategies to reduce maternal depression ought to be targeted at women with low incomes.

5. Methodology

NHS Greater Glasgow & Clyde commissioned Duddleston Harkins Social Research Ltd and Progressive Partnership to conduct research into women's mental health during the perinatal period. This involved identifying what inhibited and what protected mental health amongst women during the perinatal period; reviewing existing service provision; and providing recommendations for improvements. Qualitative research was undertaken with women and stakeholders working with the client group across the following 5 chosen Community Health Partnership areas:

- Glasgow City CHP North East sector
- Glasgow City CHP North West sector
- Glasgow City CHP South sector
- Renfrewshire CHP
- Inverclyde CHCP

The project investigated emotional challenges; sources of support; coping strategies; the role of community support and barriers to accessing support; and areas for service improvement.

The study adopted a qualitative approach consisting of in-depth interviews and focus groups with 111 women, who were pregnant or had children up to 5 years of age, and 89 key stakeholders.

The research steering group (consisting of representatives from the Health Improvement Teams; from the five area teams and the Mental Health Improvement Team; and the Nurse Consultant from the Mother and Baby Mental Health Unit with input from the Public Health Resource Unit) was set up to assist in coordinating the overall research project and to provide support for the researchers, namely, Judith Harkins and Leah Turner.

Each of the five areas had a nominated lead from health improvement whose responsibility was to set up a local steering group. The local steering group attendees included representatives from health visiting; community midwives; social work; local community projects; third sector organisations; children and families' teams; and education services. Each local steering group met to discuss the research objectives; the specific areas of concern for their area; and any additional suggestions on recruitment and engaging the client group.

The North East and North West sectors decided not to focus on any particular subgroup and, instead, considered that isolation and poverty, experienced in the general population, were significant areas for investigation. The South sector focused on Black and Minority Ethnic (BME) women in order to investigate their particular issues and needs. In Renfrewshire, the focus was on mothers from deprived areas (which included very vulnerable mothers who had experienced abuse and/or suffered from post natal depression) and mothers, from more affluent areas, who, were in employment before having their child/children. It was thought that these mothers might experience a range of different challenges and barriers which needed to be researched further. Inverclyde focussed on the issue of child protection and the stigma surrounding engaging both with social work and mental health services. Therefore, the overall sample included a broad spectrum of women from those, who were considered to be vulnerable and isolated, to minority groups, to more affluent mothers, and to mothers in the general population. The Appendix illustrates the demographic profile of the women.

Advice was sought regarding ethical approval. In this regard, the group was advised that this was not required under the UK Health Departments' harmonised Governance Arrangements for Research Ethics Committees which came into effect in September 2011. At all times, the priority was the respondents' wellbeing and it was emphasised to respondents that they were free not to answer any questions, with which they were uncomfortable with, and were free to terminate the interview at any point. Since there might be a perceived need by respondents, the researchers carried contact details for Breathing Space and Steps for Stress for their use. The researchers used, also, their intuition and experience to guide the interviews, and to ensure that they did not probe too deeply on any personal or sensitive issues which the respondent appeared to be struggling with. There were no problems encountered during the interview process.

Stakeholders

The local steering group suggested a list of potential stakeholders who ought to be involved in the research and helped either to organise focus groups with such stakeholders or provided Judith and Leah with contact details. Potential respondents were assured that their responses would be kept confidential and that the report would be written at a global level rather than at a local level. Verbal or written informed consent was gained from all respondents.

Between February 2013 and June 2013, a total of 89 stakeholders took part in an interview, paired interview or focus group. All stakeholders including staff from health visiting; midwifery; third sector organisations; social work services; education services; mental health services; and health improvement and interpreting services were engaged with women during the perinatal period,.

The in depth interviews were approximately 30-60 minutes in length and focus groups lasted for approximately one hour. The Appendix includes the topic guide.

Women

The researchers and the steering group developed research materials which comprised of a consent form; information sheet; topic guide; and profiling questionnaire. The inclusion criteria were either pregnant women or who had children up to 5 years of age. It was decided not to include fathers in the research. The steering group acknowledged the dearth of resources available to support fathers but, given the limited resources for this research and the range of issues to be explored, it was agreed that the best and most effective use of the research was to focus on women since, most frequently, they were the primary carers.

The women, included in the research, were pregnant or had children aged five years or less. This included women who had experienced or were experiencing mental health problems; women living with deprivation; more affluent women; and women with a range of additional vulnerabilities. These included addiction issues; experience of gender based violence or childhood sexual abuse; current or previous physical health conditions; and experience of miscarriage or stillbirth. Women were not recruited by virtue of their mental health status; on the contrary, some women disclosed information about mental health issues during the course of the research process.

Due to the sensitivity of the topic and the potential vulnerability of women during the perinatal period, there were a number of challenges related to the recruitment and engagement of this client group. As such, a variety of recruitment methods and

approaches were utilised to gain access to and recruit these women. These included gaining professionals' and community groups' permission to conduct mini focus groups with women attending their parent and baby related classes (e.g. baby massage, baby library sessions). In an attempt to recruit less engaged women, a number of 'community days' were organised (with the help of community organisations). This involved recruiting, in the street, women who met the criteria to participate in the research and were prepared to take part in a short interview with a researcher who was located in a nearby venue.

A combination of these methods resulted in a total of 111 women participating in the research.

Action Research

In addition to the researchers undertaking interviews and focus groups with women, they recruited women recruited to help with the research. The premise was that a woman, who had experienced the perinatal period with its associated challenges, would be effective in engaging with other such women and gaining their perspectives. The action research consisted of the following:

- Two BME women recruited to undertake individual interviews with BME women;
- Two third sector family support volunteers interviewed women whom they had befriended; and
- Two third sector organisations hosted focus groups where a woman conducted the group alongside a researcher.

Gathering Locally Relevant Information

The research included five CHP areas (North East, North West and South Glasgow CHP sectors and Renfrewshire CHP and Inverclyde CHCP) from across Greater Glasgow and Clyde. The research allowed for all areas to be dealt with separately, responding to their specific needs by tailoring the research to each area. However, the research indicated, generally, that women, across all areas, had very similar needs, issues and challenges. Therefore, the research results span all five areas and provide a robust picture of women's experiences during the perinatal period.

However, particular areas did focus on specific issues. For South Glasgow, the focus was on BME women and affluent women's needs whereas, in Renfrewshire, the focus was on those living with deprivation. The findings from these audiences, as detailed in the report, ought to be considered at a broader level e.g. not only specific to the location in which the fieldwork took place. It may not be the case, that, in our sample, the issues highlighted by, for example BME women or working women, are related to their geographical area. On the contrary, across the five areas, similar issues may be faced by BME women or working women.

Analysis

The key factors, driving the analysis, were grounded in the research aims and objectives and sought to explore key issues surrounding perinatal mental health. The following were the various stages to the analysis.

- The researcher wrote a short summary of the focus group/interview once it was completed. This summary included comments and tentative conclusions/interpretations of the data.
- Next, the focus group or interview was transcribed and the researcher coded the data in order to answer key questions. In addition to examining the content of the transcript, the researcher noted the relative frequency with which different issues were raised and the intensity with which they were expressed.
- Then, the researcher created an analysis matrix which included common themes; recurring words or phrases; and links between ideas. The common themes were the type of support provided to women; coping strategies; barriers to accessing support and services; stigma; the role of maternity care and health visiting; gaps in service provision; good practice; and suggested improvements to services.
- Finally, the researcher completed the analysis by identifying patterns; common themes; deviations from patterns; and any factors which might explain them.

6. RESULTS

A. Challenges and Risks

Key findings

- The perinatal period is a potentially challenging and vulnerable time for women; this can be compounded by a range of existing vulnerabilities. Women face challenges such as adjustment to parenthood; sleep deprivation; isolation; and unrealistic expectations of labour, birth and early parenthood. The findings suggest a need for more information and support in the antenatal period in order to prepare women and their partners to progress their expectations.
- The stigma surrounding mental ill health makes it often difficult for women to admit they are struggling to cope or are feeling low. Additionally, in some cases, there is a lack of encouragement or understanding from family to discuss these issues. Also, there is the perception of support services (particularly social work) and the perceived fear, of such support services being a vehicle for removing children from the care of "unfit" mothers, presents a real barrier. Often, women maintain a pretence of feeling and coping well which exacerbates the problem.
- Breastfeeding is a crucial factor which impacts on mental health and wellbeing. Many women expressed a real desire to breastfeed but found that there was insufficient support from staff in hospitals and on discharge. The failure to breastfeed led to feelings of guilt and inadequacy amongst new mothers and highlighted a need for more practical breastfeeding support.

A primary research aim was to identify risks to perinatal women's mental health. The range and extent of identified risks highlighted the vulnerabilities which mothers faced in the perinatal period and, also, the range of support services required to mitigate these risks. Being a new parent is perceived to be a challenging experience for anyone, given the range of emotions experienced along with recovery from labour; the issue of breastfeeding; sleep deprivation; and personal identity issues (e.g. adjusting to being a mother rather than a professional woman). However, these issues can be heightened and compounded by a range of social issues and personal circumstances (e.g. unemployment; domestic violence; addiction; poor parenting; childhood abuse; and previous history of mental health issues) which place some women at particular risk. Furthermore these risks are compounded by living with deprivation. For example:

It's normally a cluster of factors; it's not just one thing. It's addiction issues, abuse in childhood, poorly parented themselves…you add that to the very real vulnerability faced in the postnatal period hormonally…it's easy to see how all these factors can come together and make anyone vulnerable to mental health issues. (Stakeholder)

Personal Challenges

Women experience a range of personal challenges in the perinatal period. A significant challenge is adjusting to becoming a mother, with some women reporting feeling lost and abandoned once their baby was born. The change in focus (both by health professionals' and family members) from the pregnant woman to the baby, once it was born, was a major adjustment. Mothers spoke, also, about losing a sense of who they were:

I felt the focus automatically switched to the baby who was obviously fine and what was needed but I had a difficult labour and section and I needed some support too. (Mother)

I did feel a bit like, 'now I'm just a mum', I realise it is a massive deal being a mum but I feel like I have lost a bit of who I am as a person. (Mother)

In terms of the physical consequences, sleep deprivation was a further challenge. , Women became extremely emotional and sensitive, and they had a heightened perception that they were struggling to cope or that their problems were insurmountable. For example:

It's when the tiredness kicks in that you're really vulnerable, you become like a zombie. I think when that happens; everything else starts to take its toll. (Mother)

A particularly vulnerable time for women appears to be a few weeks after the baby is born, when their partner returns to work and visits from family and friends stop. Women reported feeling very isolated, under pressure and overwhelmed. Feelings of isolation appeared to be heightened by the fact that women were not yet attending any activity based or social groups. For example:

After dad goes back to work and the minute they're alone with a baby that's when the pressures pile on…it's definitely not right away which is the most vulnerable time - maybe after four weeks or so. (Stakeholder)

Unrealistic Expectations

Women's' unrealistic expectations of labour and early parenthood were considered to be exacerbated by a perceived lack of information and support provided during pregnancy in relation to preparation for parenthood. Further issues included women's strict birthing plans and general anxieties about labour. It was suggested that women should be provided with more information during pregnancy in order to prepare them (both practically and emotionally) for labour and parenthood. For example:

I think women have an idea of the 'perfect' family life in their head and when it doesn't end up like that feel like they have failed. (Stakeholder)

The antenatal period is the time to get the message across because we know that when women are pregnant, they are really open to information. (Stakeholder)

Stigma associated with 'not coping'

A clear finding was the tendency for some women to hide their insecurities or problems in order to appear as if they were coping well with parenthood and were "a good mother", in order to avoid the stigma associated with either the baby blues or post natal depression. For example:

You bury your head in the sand, because it's taken as a sign of weakness if you say 'I'm not coping'. (Mother)

I think there's just a stigma attached with post natal depression, you feel like a failure as a woman and a mum. (Mother)

Often, women experienced guilt as they were either not managing well or not enjoying the experience as much as they expected to (another problem associated with unrealistic expectations of parenthood). For example:

You are told about this overwhelming feeling of love that you get when your baby is born. I was waiting for it to happen and I never got that feeling. (Mother)

As well as maintaining a pretence for family and friends, women reported their fear of health professionals or services (particularly social work) perceiving them as an inadequate or incompetent parent and, subsequently, removing their child. For example:

When the ladies came to talk about the group…the way they pitched it was 'if you have postnatal depression, come to this group and we will help you'. I thought don't say that! It's a shame because nobody picked up the leaflet because that would be admitting that they had a problem. So you expect to turn up and see the police at the door to take away your child because you can't cope. (Mother)

This perception is a significant challenge to perinatal mental health and, also, to women's engagement with support services and groups.

In some cases, problems were exacerbated by their partner's or family's perception that feeling down was a normal part of early parenthood which would pass. This could lead to a failure to recognise symptoms of postnatal depression. As such, the woman was discouraged often from seeking help or support. This was coupled frequently with a perception that, routinely, services removed children from mothers who seemed to be failing to cope. For example:

My partner said 'you can't admit that' (post natal depression) or go to that group. *Supposing they send social services round to the house? (Mother)*

My mum said 'just hang off, you'll be all right, everyone feels down for a time when they have had a new baby'. So she made me feel like I was over-reacting and I didn't need help. That set me back. (Mother)

Breastfeeding

The difficulties and challenges in relation to breastfeeding, and subsequent feelings of pressure or guilt, if mothers were unable to breastfeed successfully, were significant research findings. Although all demographic groups raised the matter of breastfeeding, more affluent women had a greater tendency to express the desire to breastfeed.

Many women expressed a personal desire to breastfeed for the baby's health, describing it as a proud accomplishment. Conversely, women spoke of feeling guilty and inadequate at being unable to breastfeed and often accused themselves of 'giving up'. For example:

I didn't breastfeed with my first child as I couldn't, it was too painful. I felt very guilty. By my third child, I loved and enjoyed breastfeeding as I had support and wanted to do it. I felt very proud for not giving up. (Mother)

I definitely had low points. I had to stop breastfeeding as she wasn't putting on weight, and that was earlier than I had intended to. The first few months were a bit of

a blur and a struggle. I remember thinking I was a failure 'cause I wasn't breastfeeding. (Mother)

Some women highlighted either the pressure which they faced to breastfeed whilst in hospital or said that, whilst providing guidance, staff were rough and insensitive. For example:

I wanted to breastfeed but she was really sleepy but I almost felt like the midwives were forcing me into it. They were pushing her onto me and I felt they were being quite rough. I had said I wanted to do it but they were really forcing it on me. So they weren't helping, they were making me feel uncomfortable. (Mother)

A common finding was women expressing a desire to breastfeed but experiencing a lack of support from hospital staff and on discharge. They reported that, rather than offering practical and emotional support, hospital staff were "ticking boxes" in relation to breastfeeding. A further issue was some health professionals not listening to the mother's requirements or queries; this meant that trust and confidence in health professionals started to break down. However, some women did relay receiving effective support and encouragement from health professionals and that their hospital stays were extended until feeding was established. For example:

Breastfeeding was just a total stress. I was determined I wanted to do it but got no support at all in the hospital. The midwife was fabulous once I got home but by then, it was too late. I was so disappointed about that. I wanted practical help such as how the baby should latch on, but all the midwife was concerned about was ticking the box to clarify if I was breastfeeding or not. They were obsessed by the paperwork. (Mother)

I wanted to breastfeed but it took ages for feeding to be established. So I was in the hospital for 5 days, but they were really good with me. They really helped me. They didn't want me to go home until feeding was established. (Mother)

Overall, it appears that breastfeeding is an important factor impacting on perinatal mental health. There appears to be a greater need for breastfeeding support both in hospital and on discharge in order to encourage more mothers to initiate and continue breastfeeding.

Risks linked to Services

Some risk factors for perinatal mental health appear to be related to perceptions of the services and care provided by the health professionals. These issues are discussed fully in section E below.

B. Support

Key findings

- Support for women included informal support from either family members or friends or other parents; or professional support from either a key worker or community organisation or health professional. Women spoke very highly of the emotional and practical support which they received from one key confidant, and praised, also, community groups and projects for the support, including peer support, which they offered. A crucial coping mechanism for mothers was respite; this allowed them some time to themselves.
- Often, vulnerable women, who were engaged with third sector organisations, relied heavily on this support. However, there are limited organisations of this kind and they have finite resources.
- Some women appeared to experience multiple and complex barriers when attempting to access support and services. Emotional barriers included low self-esteem; lack of confidence; and fear of being judged. This made mothers unlikely to go out or attend groups on their own. The accessibility of some locations was a further barrier, as were financial constraints.
- A primary research finding was lack of awareness and understanding amongst some stakeholders and mothers of available support services. This impacted on any onward referral.

The research highlighted the importance of support for mothers as a means of either preventing or combating low mood/depression. Mothers spoke frequently of the invaluable practical and emotional support received; this made parenthood a much more pleasurable and rewarding experience. Generally, support took the form of informal (such as family and friends), or more professional sources (such as key workers in community organisations or family support workers) if mothers lacked this informal support. Professional support, in the form of health professionals and community/voluntary organisations, is discussed later in the report.

What appeared critical was the mother having one key person in her life that she could trust for help, support and care. Often, this person was the mother's partner or own mother; however, more isolated parents spoke of a key person in an organisation being a 'godsend'. This highlights the benefits of mothers having a significant person; a fact highlighted by stakeholders in relation to the gaps in service provision (see D below).

Generally, respondents relied on their partner, family and friends for invaluable support and care. This support ranged from practical help in relation to raising their children; emotional support through difficult periods; and providing respite or simply being there. Respondents mentioned, also that this key person helped to raise their confidence and self-esteem, and their belief that they could cope as a mother. This support was particularly crucial for single parents. For example:

If it wasn't for my friend, I don't think I would have made it. The support from her has been amazing. She made me get up and get on with it, and took me to some groups where I could meet other people. There's no way I could have done that myself. (Mother)

In the sample, vulnerable mothers who were engaged with third sector organisations had established positive relationships with them. Third sector staff were praised highly and relied on for advice; information; and general support. The need for there

to be an established relationship between the staff member and mother was highlighted as being crucial for the mother to be honest about any issues, and for the staff member to monitor the mother's mood and behaviour and pick up on cues. For example:

It was Sarah (community worker) who actually made me realise that something wasn't right and I needed to speak to someone. The health visitor didn't pick up on it but Sarah knew that I wasn't myself and I did end up being diagnosed with post natal depression. (Mother)

Mothers highlighted the importance of respite and the chance to be "more than a mum for a while". Obviously, this necessitated mothers having someone to care for their children. This was generally a family member, although some mothers had accessed respite care through a free crèche or babysitting service provided by a voluntary organisation; this was a highly valued service. For example:

You need that respite and a wee bit of time to yourself, so you don't have to be a mum all day every day. (Mother)

However, this aspect of service provision is costly and comparatively rare with volunteer programmes which offer respite care and crèche facilities operating only in certain communities.

Peer Support

A vital source of support was attending various community-based groups (such as mother and toddler groups, baby massage etc.) alongside other mothers. Reported benefits included: gaining emotional support; using mothers as a "sounding board" and source of advice and guidance (rather than a health professional); reducing feelings of isolation and being alone in their parenting struggles; and providing opportunities for themselves and their children to socialise. For example:

It's like therapy because everybody goes through the same stuff, so you know you're not the only one. It's different from getting advice from a health visitor or a midwife because mums tell you the truth. (Mother)

I'm a huge fan of mentoring and befriending and peer support that is self-led. It is important for the mum to be able to access a forum for support and contact with other mothers if she wants to. (Stakeholder)

Barriers to Accessing Support

A main research objective was to investigate the barriers experienced by mothers when accessing any type of support. For some mothers, they appeared to face an insurmountable number of barriers. For example:

For those really vulnerable and disadvantaged families, there are so many barriers that it's difficult for them to get out of the door sometimes. (Stakeholder)

Mothers experienced many emotional barriers to accessing support. These ranged from lack of confidence and self-esteem; fear of being judged as an incompetent parent; and a lack of a perceived need for help. A fundamental barrier for mothers was having no-one to attend groups or services with. Having a mentor or peer to attend the group/service on the first few occasions was suggested as a means of encouraging mothers to attend. For example:

It's a big thing for them to come into a group that's secure and nobody will judge them so I think many mums don't bother or simply can't overcome that hurdle. (Stakeholder)

A lot of women with complex needs don't like going into groups so getting them into something that you know will really support them is so difficult….It's maybe about mentoring them into groups. (Stakeholder)

Physical Barriers

Further barriers to attending services and groups were linked to accessibility such as the location of venues being unsuitable (e.g. requiring mothers to travel on two buses with their children; this was raised as a particular barrier in the Inverclyde area where services were more dispersed). Further barriers were the logistics of having other children to be cared for and the cost of attending particular classes (such as baby massage or baby sensory) including entry and travel costs. For example:

It took a lot for me to start attending classes. When I thought about what it would take for me to get to a class, it just put me off even going. I have to get a buggy down three flights of steps then it is either a 45 minute walk to the class or wait for a bus that doesn't already have a buggy on it. Then add the cost of the bus and the class - it really put me off. (Mother)

A further barrier was the time of some classes. Early morning classes were an issue for those who struggled to get their children ready for 9am. Others mentioned a lack of evening classes (in particular antenatal or first time parenting classes) when partners or family members were more likely to be able to attend as support.

Language and cultural barriers are discussed in section F below which outlines the particular needs and experiences of some BME mothers.

Awareness of Services

Perhaps, the most significant barrier to mothers, attending services and groups, was the lack of awareness, both by mothers and stakeholders, of such groups in the local area, some mothers mentioned health visitors providing a list of local groups and services. However, more commonly, mothers said the health visitor had not provided any such information. The lack of awareness was seen to be exacerbated by the short term nature of many support services due to funding issues. For example:

My health visitor didn't have a clue about classes on in the local area. I had to Google and find out myself. So many people are not aware of what's out there. They should have a list somewhere of all the classes. (Mother)

Various projects come and go and it's difficult to know what's available at a particular time, and if it's difficult for me as a professional, it must be many times harder for families to understand. (Stakeholder)

Other Barriers

A further barrier was groups being perceived as either being too tailored or exclusive to a specific group, or not specific enough. Mothers, from potentially vulnerable groups, complained often that more mainstream provision did not suit their needs or circumstances, e.g. young mothers feeling uncomfortable attending groups mainly

comprising of older “more competent” mothers. However, certain groups were seen to be too specific and excluded other mothers. For example, breastfeeding support groups were available only for breastfeeding mothers and some mother and toddler groups had a religious slant. Also, some women had preconceived ideas of what the groups involved and this discouraged them from attending. For example:

A lot of the playgroups (here) are quite religious groups….I know some of the parents said the other parents were making them feel awkward, and it being made out that there’s something wrong because they’re not religious…. (Mother)

C. Role of Maternity Care and Health Visiting

Key findings

- Views on maternity care and health visitors varied quite significantly, and were related often to the mother's relationship with the health professional. Some stated that the time spent with their midwife or health visitor and the support offered contributed greatly to their general wellbeing. However, in our sample, the majority of mothers related poor experiences with maternity care; these were linked mainly to the lack of time and visits made by midwives and health visitors post birth. Coupled with the feeling that visits were rushed, this contributed to mothers feeling anxious, uninformed and frustrated.
- The structure of the visit itself played, also, a part, since mothers experienced a lack of continuity of contact which resulted in repetition during visits and, at times, important information 'slipping through the net.' There was, also, a sense amongst the women of a lack of genuine care provided to mothers, with more focus on ticking boxes and paperwork. Stakeholders echoed these views by stating that increasing case loads and bureaucracy had changed their focus of visits.
- Health visitors appeared to play a pivotal role for the most vulnerable mothers, with women responding better once they had an established relationship and trust with a key worker. Due to the lack of resources and of health professionals' increasing workloads, it is becoming more commonplace for community organisations to assist in this area.

The care and support provided by midwives emerged as an important research finding. Often, mothers reported in detail the care which they had received during pregnancy and birth, in particular, and the impact this had on both their mental health and self-perception as a mother. Some mothers reported positive experiences, highlighting that the non-judgemental support and information, which they received, had made becoming a mother less stressful than anticipated. For example:

…the midwife was excellent…Very caring and attentive - made the experience a lot less stressful. (Mother)

However, it was more commonplace for mothers to highlight limitations with the service.

Lack of Visits/Time

A significant perceived limitation on service provision was both the number and duration of appointments with the midwife/health visitor. Some midwives and health visitors voiced their frustration at their reduced contact with women. They considered this to have had a detrimental impact on their relationship with the mother and their ability to pick up on changes in the mother's behaviour. For example:

We used to have so much time to spend with the women so we could get to know them and they could get to know us. Now, there's so much paperwork to be done at each visit and so many visits to fit into each day, we've lost that connection and it is definitely having an effect on how we are able to pick up on things, and detect things early. (Stakeholder)

Generally, mothers appeared to receive reassurance, information and advice from such visits and, thus, complained that visits and appointments were "few and far

between". Additionally, some mothers considered that their concerns and experiences were viewed to be unimportant. For example:

I used to feel better after a visit from the health visitor, more reassured. But the visits were few and far between and then I would start getting anxious again. (Mother)

As midwives and health visitors had such a busy schedule and so much to cover in each appointment, some mothers perceived that there was a lack of real interest in their needs. There was frequent mention of such staff "ticking boxes" and prioritising completing paperwork over having an informal chat with the mother. This meant that mothers were unlikely to confide in a health professional. In particular, the EPDS was viewed to be a tick box exercise. Often, mothers considered that their relationship with the health professional was not established enough for them to want to admit any perceived weakness or that they were struggling to cope. Consequently, women reported lying on the EPDS form so as to appear to be coping better than they were. It was suggested that, by initiating a more informal conversation, the health professional might encourage the mother to open up and express her true feelings. For example:

I remember I wasn't feeling too great but I just ticked all the boxes anyway because I didn't want her to start asking me questions. If it was more of an open conversation, you may be more likely to open up and confide. (Mother)

Lack of Continuity

Women and stakeholders alike acknowledged the problems created by lack of continuity in the relationship between the service and the mother. Midwives stated that it was difficult to gain a sense of the mother's circumstances and mental health and to detect any emerging issues. For example:

It's very difficult. They're supposed to get 3 visits and the way the workload is, they're not always visited by the same midwife so we often miss things because these women aren't getting visited the way they should. We're busy and not spending the same amount of time in the house that we used to….you maybe only see the mum for 15 minutes whereas in the old system, you would see them throughout their pregnancy and you could more notice changes. (Stakeholder).

Mothers, too, discussed the importance of establishing a trusted connection with their midwife or health visitor so that they felt comfortable in discussing any concerns or problems. Consequently, the tendency for mothers to see a different midwife or health visitor on each occasion was said to reduce significantly the chance of mothers confiding in them. At times, this made mothers more wary of the purpose of the visits (viewing them more in terms of surveillance than support). For example:

I had a different midwife every day. There was no continuity. If it was the same one, I might have had more confidence to say I was struggling. (Mother)

Care in Hospital

Some mothers spoke at length about the unsatisfactory treatment which they received in hospital after having their baby. The few days, after giving birth, was perceived to be a critical and potentially vulnerable time when mothers relied on practical help and emotional support. These mothers said that they did not receive this from hospital staff. The fact that, often, mothers were discharged quickly after delivery, and before feeding had been established and mothers had received simple

parenting advice (such as bathing the baby), appeared to compound this feeling. For example:

I think they need to do more in hospitals because it can be a horrific experience for mums….you feel like you're just shoved in and shoved out. They couldn't get you out of there quick enough. (Mother)

Midwives considered that some mothers were discharged prematurely from hospital (due to resource issues) which "set women up for a fall". They stated that everything could appear well immediately after the baby was born, and that, more commonly, it was two or three days later when problems could arise. For example:

We're supposed to encourage our mums to leave within 6 hours…We're not doing these women a service by doing that. We encourage them to stay until they feel safe, they have established their breastfeeding or…until they feel well enough to leave. (Stakeholder)

Midwives expressed particular concern about those mothers who had had traumatic birth experiences being discharged quickly (These mothers are discussed in chapter H.) Since they considered that they needed a verbal debrief on their labour to understand why particular actions were taken. They believed many mothers returned home traumatised, with real concerns and fears about future pregnancies. For example:

A lot of them need debriefed – somebody to go over and talk about it with them, make them understand 'this is where things started to go wrong and this was what was done and this is the end result' but a lot of mums go home traumatised because nobody has spoken to them about it…that can make such a huge difference, cause these are the girls that are going to start developing problems with their mental health. (Stakeholder)

Importance of Role of Health Visitor in reaching Vulnerable Groups

There was a common consensus that the health visitor role was pivotal in relation to engaging with the most vulnerable mothers who were unlikely to access any form of support or even leave the house. This was because it was a universal service (and thus nonthreatening) and, perhaps, would be the only professional whom the mother engaged with. Given the vulnerability of these mothers, it was perceived to be crucial that, once access was given, the health visitor had adequate time for a quality interaction with the mother. Another recommendation was appropriate mental health training for health visitors, and the provision of a more intensive health visiting service (akin to the Special Needs in Pregnancy (SNIPS) project). This was illustrated by:

For those really vulnerable women, we just need to make sure the health visitor is aware of them….They are the ones that can make a difference. (Stakeholder)
A good health visitor is worth her weight in gold…I would increase the number of health visitors and make sure they had proper training for the mental health needs of this group. (Stakeholder)

Community Organisations bridge the Gap left by Reduced Midwife/Health Visitor Service

Stakeholders, from all disciplines, recognised the challenges faced by the reduced midwife and health visitor service, with community and voluntary organisations being said to "attempt to bridge the gap" for more vulnerable families. Health visitors spoke of making more referrals to such services when, previously, they would have managed the mother's needs within their own caseload. For example:

Since the health visiting review, the focus is now on families most in need so public health work has been reduced, in terms of inputting to groups, the resource just isn't there…and I don't think it's going to get better any time soon. Its agencies, out in the community, that are picking up the pieces now. (Stakeholder)

D. Current Service Provision

Key findings

- Effective service pathways are in place for women with severe perinatal mental illness but participants considered that there were gaps in provision of preventative, early intervention services and those for women experiencing mild to moderate mental health problems.
- Maternity staff expressed frequently a lack of knowledge and confidence in addressing mental health issues with women.
- Compared to statutory services, third sector organisations seemed to provide services which met women's needs more effectively in that they were flexible; community based; and founded on building relationships with women.
- Women and stakeholders experienced difficulty in finding information about community and statutory services.

Effective service models had certain characteristics in common. These included accessibility of support; informal setting; relationship building; continuity of one key contact; provision of respite; and peer support across all key milestones. However, it was evident that services which possessed these characteristics had limited resources or were at full capacity. Each sector and community had either different local services or different names for the same groups. Examples (as opposed to an exhaustive list) included library sessions for babies and toddlers; breastfeeding support group; playgroup; Triple P classes; baby massage; drop-in clinics; and parent and toddlers' groups. Only one emotional support group was referenced in our sample. This established community service was run by volunteers with input from health visitors and was hugely valued by its members. For example:

(It) is a fantastic group…At the beginning, it's just enough to come along and listen and realise we're just all the same and no-one is actually doing anything wrong….You sit and talk and realise 'I felt like that, I'm not an alien, I'm not crazy and my baby isn't going to be taken away from me'…You meet friends. You meet other people who are like you. The kids love it, they don't want to leave. Everyone here is a shoulder to cry on…I love coming here on a Tuesday. I've often thought 'just make it to Tuesday and you'll be okay'. (Mother)

Service Pathways

NHS Greater Glasgow and Clyde (NHSGGC)'s provision of screening and services is as follows;

- All women are screened for mental health problems at booking visit; on postnatal wards; and by health visiting throughout the first three months following childbirth. In accordance with the recommendations of the Confidential Enquiry (2003, 07 & 11), SIGN 60 & SIGN 127, NICE 45, Mental Health Care & Treatment Act (2003), all women are actively encouraged to attend a variety of mother infant interaction activities and specific parenting session if required.
- NHSGGC hosts the Mother & Baby Mental Health Unit, a six bedded unit which provides a specialised inpatient service for mothers who are experiencing severe mental illness, either in the late stages of their pregnancy or with their baby up until the age of 12months. The unit serves the West of Scotland.

- A specialist Perinatal Mental Health Community Outreach team provides a maternity liaison service to Glasgow City's maternity units; outpatient clinics; and, via home treatment, for women who either have or have had a history of moderate to severe mental illness. It is planned that this service be expanded to cover the NHS GGC area.
- Community Mental Health Teams provide input for women with severe or enduring mental health problems.
- Primary Care Mental Health Services provide input for women with mild to moderate mental health problems.

The research highlighted that staff were not always clear about where women, with mild to moderate mental health issues, ought to be referred and what processes ought to be followed. Staff expressed, also, frustration that they could not seem to access the services which they considered that the women required. For example:

Referrals just get fired back so what are we supposed to do? (Stakeholder)

Confusion about how and where to refer women led to some stakeholders being demoralised and feeling that they had not done enough for the women in their care. This was compounded by a lack of confidence and knowledge in addressing the issues themselves. For example

A lot of the time you feel like you've reached a big wall. We've got limited resources within ourselves about how to deal with it. It's very hard; you can recognise a problem but you don't know how to manage it. (Stakeholder)

There is that level of "please don't open that can of worms because I really don't know where to go with this" so you want to listen but to actually ask too many in depth questions, you're opening yourself up to questions that you actually don't know the answers to which is worse than offering that ear to start with when you really can't help after that. (Stakeholder)

Stakeholders, who had engaged with either the Mother and Baby Unit or the Perinatal Mental Health Community Outreach team or the Community Mental Health Teams were very positive about the support provided to women whose needs were considered to be critical. However, it was recognised that, due to a lack of resources and capacity, not all cases were taken on. For example:

The perinatal mental health service is fantastic if you're at crisis point….but if you're not at crisis point and you want to prevent them from getting to crisis point then it's a nightmare. (Stakeholder)

Key Gaps

The research highlighted areas of effective, flexible provision of preventative support to women in the perinatal period. Often, this provision took the form of a voluntary organisation which offered the women a range of services including peer support; respite; and practical help. However, this provision was limited and operated only in some communities. Identified gaps are detailed below.

Early Intervention and Professional Services for Mild End of Spectrum

Stakeholders expressed concern that "there was nowhere to go" for mothers who needed some extra support to prevent their mental health issues escalating in

severity. The benefits of proactive support were highlighted as a means of either preventing more severe mental health problems or the escalation of other social issues which, then, could lead to child protection concerns. For example:

A little bit of proactive support to help them through a difficult spell would help prevent more severe problems further down the line. There needs to be a pretty serious risk before services kick in and that's the wrong point to intervene when you should be more targeting early intervention. (Stakeholder)

Supportive Community Services

There was a perceived lack of flexible support services which recognised the particular needs and circumstances of the mother, and where women choose how they engaged with the service. Given the variable circumstances of women experiencing perinatal mental health issues, it was considered that there ought to be a menu of services. Better investment, in voluntary and community services and peer mentoring models, was suggested as a means of overcoming the gaps left by midwifery and health visiting. Such services (many of which had been cut) were praised highly for offering both professional and peer support. A common suggestion was that these services ought to be re-introduced. For example:

It's about a menu of services, a different range of services depending on need…so women have the opportunity to make that connection...There definitely has to be more support services out there, especially if they want mums out [of hospital] sooner and sooner and different types of initiative will suit different people. (Stakeholder)
We need to look at building these things up because we know statutory services can't do it anymore. (Stakeholder)

Given problems with short term funding, the need to build sustainable services that are evaluated to evidence their outcomes (both hard and soft) was highlighted:
We need to get better at evidencing what we do, so we can prove to funders the benefits of our service. (Stakeholder)

Effective service delivery appeared to involve a service provided accessibly in a community setting with which women could engage voluntarily. Sometimes they would go along to the social worker or the health visitor because they had to or they were obliged to, whereas when they were engaging with us, we would say 'we're non-statutory we can't make you come, you come because you want to'.

Another element of good practice was services delivered in partnership between the community and statutory health professionals. Some health professionals spoke of such previous services which they had run in the community in an attempt to overcome barriers to engagement for the most vulnerable and disengaged mothers, whereby mothers were more relaxed and, thus, were more likely to confide in the health professional. However, again due to both resource issues and health and safety concerns, nowadays, midwives and health visitors are unable generally to be involved in such groups. For example:

More peer support type groups with an input from a professional so mothers can access both at the one time, there's midwives there, there's mums and dads there so they can all mix…Have somewhere where mums can then go where they can still get professional advice if they needed but they can access other things as well. (Stakeholder)

Crèche facilities and volunteer groups, which offered respite care, were regarded as invaluable; these either allowed the mother proper time to commit to group activities or, simply, provided 'me time' for the mother. Crèche facilities offered by voluntary organisations appeared to have been reduced drastically due to the financial downturn. For example:

The crèche is fantastic…the kids look forward to coming here and it gives me an hour during the week where I can talk about how I am feeling without juggling the kids at the same time. That makes such a difference. (Mother)

Given the current financial climate, many stakeholders acknowledged that having separate support services for the most vulnerable parents was unrealistic. Consequently, it was suggested instead that intensive support be provided through mainstream services, for example, by extending the Special Needs in Pregnancy (SNIPS) model to general health visiting. For example:

I don't know if there's scope for having a SNIPS like service within health visiting…where they don't do the routine work but deal with the very vulnerable cases…early identification and making sure there are supports in place. (Stakeholder)

The need to consider the mother's reasons for non-attendance at services was considered, also, to be best practice, rather than closing the case once the mother has defaulted on several appointments. In some cases, one to one support, provided at home, would appear to be the best option for the mother. For example:

We try to do home visits from the nurse for those who are significantly depressed, who default appointments, then we'll try and be assertive as we can be without the door being slammed in the nurses face. Sometimes that has to be taken on a case-by-case basis, but just being prepared to go that extra mile I think helps people, letting them know that you're there for them. (Stakeholder)

Need for Key Workers to Journey through Services with Women

Often, vulnerable mothers required contact with multiple services and organisations; this could be a further source of stress. A perceived gap was the lack of a key worker, who was fully aware of the mother's story, to guide the mother through the different services and to prevent mothers from falling through gaps in service provision, when referrals are not acted upon. For example:

Although there are so many difficulties for women, the answer is a lot simpler. It's about there being someone there to walk through it with you. (Stakeholder)

Some community and voluntary organisations offer this key worker role for mothers. The SNIPS service attempts, also, to ensure that women are not left unsupported to access such services. Community projects, which offered a full programme of support groups, classes, clinics and mentoring, were shown to be successful at building a trustful relationship with mothers; providing support at pivotal stress points; and ensuring the women had a continual point of contact to reduce the risk of problems escalating. For example:

It's the wee things that can make such a difference. Before I became involved with the family, they would spend every day indoors. I help the mum to dress her five kids

and then we take them to the park…she couldn't do that without me and it has helped so much. (Stakeholder)
This model relies on the staff member having the time and skills to engage with the mother to build a trusting relationship.

Lack of Training on Mental Health among Staff

There appeared to be a lack of mental health training for staff working with women in the perinatal period so that they were able to recognise symptoms; respond to initial concerns; signpost where appropriate; and understand how mental health issues could translate to behaviour (e.g. such as lack of energy, motivation and self-confidence to attend appointments). For example:

I think if I had all the time in the world I still don't know enough to support them so it goes back to training; I need to know what I'm going to say to the ladies. (Stakeholder)

Including Partners and Family Members

Partners were perceived to be a forgotten group who, also, needed support, partly to raise their awareness of perinatal mental health issues and, partly, for more general support to make them feel more involved in their child's care. For example:

Something that I would put high up on the agenda is working with partners and family members – that's hugely neglected….so involving partners in a meaningful and fundamental way because they're observing their partner in a really difficult place and don't know how to manage it. (Stakeholder)

Engagement and Information Provision

Social media was mentioned frequently as a means of engaging with mothers, particularly the most unengaged. For example:

Social networking is the way to go – maybe we should have a midwife Facebook page? (Stakeholder)

Some women, particularly those from more affluent areas, referred to NHS Health Scotland's Ready Steady Baby app.

A helpline, operated in partnership with health professionals and community organisations (and peer volunteers), was viewed as another effective method of reducing isolation amongst mothers. For example:

A helpline…somewhere where they can pick up the phone when they're at their most vulnerable and access someone that can answer their questions…there would be anonymity with a phone line…everything is confidential and done at their pace. (Stakeholder)

The health visitor, providing a booklet on services in the local area, was another suggestion, although concerns were raised about the resources required to keep the directory up to date. For example:

The idea of a directory is good but the difficulty is, historically they're not usually up to date and who takes responsibility for that? (Stakeholder)

E. Challenges for Services

Key Findings

The research revealed a number of challenges for services. These are as follows:

- Confusion or disagreement as to what particular service should take ownership of the woman's case when there are multiple issues to be addressed.
- Concerns amongst women about the removal of children from their care.
- Preventative services, such as baby massage and free crèche provision provided by both NHS and third sector, are disappearing.
- Ineffective partnership working between services is compounded by complex referral pathways.
- Increasing time pressure presents challenges to engaging successfully with women and partner organisations.

Balancing Support and Risk

Given the vulnerability of many women, who experience social problems alongside mental health issues, there is often a need for social work involvement or for assessments to be carried out in order to determine whether or not the home environment is safe for the child. Stakeholders felt strongly that, although this assessment was often necessary, it created a distrust and fear between the women and service which often limited the effectiveness of the support provided. Mothers echoed this fear, often coupling either social work involvement, in particular, or any discussion of child protection with their child being removed. Often, this meant that women did not access support or hid their problems. This issue of managing support and risk is a huge barrier to be overcome in ensuring that the best service and outcome is provided to both the mother and child. As well as social work, voluntary organisations faced, also, this barrier if conducting any form of assessment with the mother. For example:

It's a huge challenge managing support and risk…women can be very reluctant to engage at the pregnancy stage because there's an assessment…regardless of who you work for they think 'I'm not telling you what's going on because I know what you're going to do'…and you try to tell them, if you tell us now, here's all the support we can get you. (Stakeholder)

If you reach a level of vulnerability where there is a child protection agenda, that simply by default becomes the agenda, and despite everybody's best efforts, can often add to that stigmatisation…so how can we engage with them in a way that keeps them safe and keeps their children safe, and nurtures them rather than them being in fear of the system? (Stakeholder)

Evidencing Impact

Aspects of service provision, which may represent best practice, include those which intervene early and which provide practical and emotional support. Outcomes from these services may be more difficult to evidence since they may be preventative in nature and, often, are evidenced by 'softer' outcomes (e.g. increased self-esteem and confidence; increased social networks). Both stakeholders and mothers felt strongly that services, such as baby massage, had clear benefits for women (such as

reducing isolation; providing peer support; and supporting secure attachment). However, there was a perception that such services might have been withdrawn because there was insufficient evidence about their effectiveness. Stakeholders' highlighted frustration that, often, services were crisis driven, with support provided only when vulnerability reached a certain threshold. Also, a fundamental gap was seen to be the lack of early intervention work, conducted now by statutory services, such as social work and health visiting. For example:

I don't think it's recognised the value these things have. Services which improve mental health, they're seen as a nice add on rather than a very crucial thing. We all understand the value of these things but that doesn't translate into services. (Stakeholder)

Perceptions of Key Services

A crucial barrier faced by social workers, in particular, is the service being perceived as a threat by mothers who do not recognise their role in terms of providing support but, instead, focus on their assessment of risk to the child. It was suggested that, often, social work involvement could heighten rather than alleviate mental health issues. The fact that, nowadays, social work focused on the most vulnerable families was said to add to this perception, with universal services (such as health visiting) being viewed as more neutral. Voluntary organisations were viewed, also, as being more accessible and less stigmatized since mothers could choose often whether or not they wanted to engage. Appropriate training, to equip voluntary staff with the skills and knowledge to address mental health issues, was seen to be a priority. For example:

There's not the same stigma engaging with a voluntary service as there is with social work…so there should be more support for groups like ours and training for our staff so we know where to signpost people if there are major problems as the voluntary sector is definitely a less threatening environment. (Stakeholder)

If there was more capacity within the health visiting service, it would make such a difference to that woman's journey…it's a universal service so it's non-stigmatised. (Stakeholder)

Range of Challenges and Risks to Women's Mental Health

As mentioned previously in relation to risks and challenges to women's mental health, it is comparatively rare for women to experience mental health problems in isolation. More often, they experience multifaceted problems with mental health problems being due often to a range of social issues. Then, these are compounded by the challenges of the perinatal period. This is not to exclude less 'high risk' women who experience, also, mental health issues but, generally, women face a range of challenges to their mental health.

This provides a significant challenge for organisations since multifaceted issues amongst women result in a range of services being involved in their care; problems with ownership and partnership working including which issue should be given priority (i.e. addiction or mental health?). A woman's chaotic lifestyle may make it difficult to attend services, and a woman's reluctance to engage due to stigma and fear of children being removed. These are only some of the issues facing services which make it difficult to engage successfully with women and achieve a positive outcome.

Partnership Working

Given the range of needs of women in the perinatal period, particularly when coupled with other vulnerabilities as described above, there is a fundamental need for effective partnership working between the range of organisations and services involved in providing care and support. For example:

Because of the complex problems, no one agency can do it on their own. We need to speak to each other and see how we can pull together. (Stakeholder)

The research uncovered many barriers faced by organisations when attempting to work in partnership. Ultimately, this limited the effectiveness of the service and support provided. A basic problem appeared to be referral procedures to particular services, and the outcomes of referrals meaning that, often, women were left without a service provider, having "slipped through the net". Many stakeholders felt strongly that patient care was compromised by the issues of ownership and only allowing a woman a certain number of attempts to engage before closing her case. Improved communication between services was suggested as a means of partly overcoming this barrier. For example:

We need to think about how we join these things up, and that is particularly missing in mainstream mental health services….If we refer someone they can wait a while to be seen and then they miss a couple of visits and it's case closed. And there's no linking up to say 'how do we capture this woman'. (Stakeholder)

A further barrier was differences in understanding between some services (e.g. addiction and social work; mental health; and social work) in relation to prioritising which specific issue was most prominent to the women and ought to be addressed first. For example:

If we try to access mental health services, we hit barriers because of the drug use. So that for us is a real barrier as you can't really separate the two. (Stakeholder)

I feel really concerned that women who have got an enduring mental health problem or their pregnancy or birth has just triggered one suddenly becoming involved in the child protection process…No matter how sensitively social work handle an investigation it's going to be alarming and we find ourselves in conversation with our colleagues in the mental health service that it's about the fact the process is actually making the person's mental health worse. That's not what any of us want so for me it's about how can we join up and practice more effectively? We're never going to take away the fear of child protection from people…but I just feel we could do it so much better. (Stakeholder)

Further barriers included resources issues meaning that services had little time to dedicate to liaising with other services (which was described as a false economy since it led to duplication of work); the pressure to meet targets; confidentiality issues; and lack of knowledge amongst stakeholders as to what other services were available in their local area, or what services they could refer women to. For example:

Time and resources are the issue. There are a huge volume of cases to work through, and I worry that the targets we have to meet impact on the quality of interaction with patients… So the time then to think about partnership working is so limited. (Stakeholder)

Effective Partnership Working

Despite these barriers, the research did reveal instances of good partnership working such as between midwife, health visitors and GPs; midwife and voluntary organisation; health improvement and voluntary organisations; and primary and secondary care mental health teams. The use of multi-disciplinary strategy groups allowed, also, for effective partnership working. For example:

We tend to alert GPs and health visitors. We have monthly meetings with the health visitors so those who we think have issues, we'll discuss with them earlier rather than later. (Stakeholder)

Factors, which allowed for effective partnership, included information sharing both about patients/clients and about their services, forming good working relationships; having shared purpose and values; and having an interest and motivation to work in partnership. For example:

We have done educational seminars with the health visitors from time to time to keep them updated with what we do and also to try and foster improved working relationships with them. (Stakeholder)

F. Vulnerable groups

This section gives a brief overview of the needs of some vulnerable groups and may be of interest to people working with such groups.

Black and Minority Ethnic (BME) Mothers

In the sample, there were 43 black and minority ethnic women of whom 28 were Pakistani and 6 were African. The majority were married, unemployed and aged between 30-39 years old and most had been born outside the UK.

Cultural and Language Barriers
An important research finding was the cultural impact on parenthood. In the research, some mothers perceived the way, in which children in the UK were raised, to be different from their own cultural values. Consequently, they perceived this as a barrier to attending mainstream groups (such as aqua natal classes) or forming effective relationships with health professionals. For example:

I don't have the same values or background so couldn't understand the culture. (Mother)

They just don't understand our culture. (Mother)

Some women considered, also, that it was inappropriate to share personal problems with strangers. For example:

I wouldn't talk to the health visitor about family issues. It was my problem and I didn't want to share my business. (Mother)

Some women commented on the number of different health professionals involved in the perinatal period (an issue commonly expressed by the majority of women in the research).

Stakeholders perceived some BME women to complete the Edinburgh Postnatal Depression Scale from a different perspective; this could lead to misdiagnoses. For example:

BME women do answer the questions differently; you can tell they take a different meaning from the questions just from how they answer them. (Stakeholder)

Language was a barrier, with women reporting problems through conveying their feelings via an interpreter. Some women pretended that they understood the health visitor in order to limit the repetition of the information and their discomfort. For example:

I got a leaflet about mother and toddlers' group but didn't understand what it was about....I didn't ask for any further explanation as didn't want to look stupid so I just didn't go. (Mother)

Some mothers considered that health visitors and midwives did not understand or respect their religious and cultural differences. They suggested that staff be given culturally sensitive training so that they could develop a better understanding. It was suggested that pairing staff with mothers from similar backgrounds was another

method by which staff might better understand and empathise with them. For example:

Members of staff need to be trained on how to talk to mums and build a connection that is linked to your culture…and to ask how you feel towards your pregnancy and baby. (Mother)

Lack of Support Network

Overall, in the sample, the BME women did not have the same level of support network as many of the women who described their ethnicity as white British. Most stated that their mother and extended family were in their country of origin. Consequently, their support network consisted of their partner and his family (which, at times, could be a source of stress) and, sometimes, one other friend or sibling. Some women had no support network at all. In many cases, the mother lived with her parents in law; often, this was described as controlling, stressful and suffocating. For example:

Living as part of an extended family was draining as there were constant visitors in the beginning. I felt as if I had no control which was difficult to deal with. (Mother)

In the research, BME women reported frequently the degree to which they were just 'expected' to be the housewife, and received limited help from their husband. For example:

I don't feel at all supported. I have no support from my husband; he could do a lot more. I feel quite alone. (Mother)

However, in the sample, some BME women experienced positive support from family, friends or their partner, and they attended local playgroups or groups. For example:

My friends and family supported me… I had such supportive networks within my family. (Mother)

Mothers living with Deprivation

Deprivation was found to underpin many of the issues affecting women's mental health in the perinatal period. Most of the women, participating in the research, lived in areas of multiple deprivation and many of these women's lives were affected greatly by poverty. Consequently, they experienced interconnected issues which contributed to health problems and created barriers to accessing support.

These issues included: lack of money to pay for activities such as groups; and the cost of public transport. For example;

A lot of the classes are quite expensive so that excludes people. There have to be classes made available for all. (Mother)

Stress and anxiety caused by financial worries; lack of a support network or opportunity for respite; and feeling judged or 'looked down on' by health professionals. These led to missed appointments. For example:

I don't really rate them [health visitors]. They don't come in to provide support; they come in to judge you. (Mother)

Lack of confidence to interact in group settings:

I had no confidence at all. I didn't do anything for the first 12 weeks because I was paranoid about my baby crying and people looking at me thinking I was a bad mum. (Mother)

And a lack of knowledge of available services:

I have no idea what help is out there…I wouldn't know where to start (Mother).

Some of the most vulnerable women, in this group, were affected particularly by concerns about the involvement of social work services and the removal of children from their care. For example:

I still get women coming up to me saying "I'm frightened that the social work are going to come and take my baby away" and that's particularly first time mums….Then they don't get the treatment they require. (Stakeholder)

Amongst this sample, there was a particular reliance on, and praise for, third sector services with staff from these organisations being pivotal in reducing isolation and providing practical support. For example:

I couldn't have done it without them [voluntary organisation]. They have been there whenever I needed them, because I don't have anyone else. (Mother)

Affluent, Working Mothers

Twenty relatively affluent women participated in the research. These women had taken time out from work to have children.

Isolation was a significant issue for these women since, previously, they had generally experienced a successful career; felt in control; were independent and led busy lives. Although often they had a partner and family support, they still felt lonely when on maternity leave, particularly when they did not attend any groups or activities. For example:

Maternity leave is very lonely when you are used to being out at work, and all your peers are still working and have their careers. (Mother)

Some of these women expressed jealousy towards their partners who continued to go to work and had, also, the benefit of coming home to their new family. For example:

I sometimes think it is easy for him (partner) because nothing has changed. He is still doing the same job and has the same routine to an extent. (Mother)

There seemed to be a stronger reliance on groups amongst these women, with their often researching such groups themselves. Frequently, these mothers attended groups as soon as possible, with some speaking of almost replacing their job with the routine of attending groups. Providing structure to the week appeared to be fundamental to them as were the benefits of speaking to other like- minded mothers. For example:

After the initial drama of having the baby and getting into a routine, I didn't know what to do with myself so I joined every class going…I think I treated having a baby like having a job, and having that structure.. (Mother)

These mothers are used often to having control of their l lives, their bodies and their work. Consequently, when they become a parent, they struggle sometimes to adjust. There tends, also, to be a higher expectation placed on achieving the 'perfect family life'; this can create anxiety. For example:

You go from having a very responsible job to feeling very vulnerable and being at the mercy of the midwife who you need help and support from. (Mother)

During the perinatal period, a significant milestone for any working mother is returning to work. Concerns included reprising the same role which they were doing prior to parenthood; being able to return to work on a part time basis; coping financially on a part time wage; and worries about not spending as much time with their child. Mothers spoke about these concerns "ruining their maternity leave", a time when they ought to have been enjoying their baby. Stakeholders acknowledged that, due to financial issues, many mothers had no choice but to return to work. For example:

I really worried about going back part time as I work 12 hours shifts so how am I going to find and pay for childcare? And then if I have another baby, I won't be able to survive on part-time maternity money, so you're worrying about all these things when you should just be able to enjoy your baby. (Mother)

I think given the recession and the financial difficulties these families face, it's putting a lot of pressure on women because they have to go back to work (Stakeholder)

In general, these women had a reliable support network such as their partner, close family or friends. This offered these women some beneficial respite. For example:

I think my family made the difference, because they would say 'we'll take her for a few hours and have a bit of time for yourself'. That definitely helped. You feel horrible saying that but you need a bit of time. (Mother)

Stakeholders acknowledged that, although these women faced particular challenges, they did not tend to experience the same complexity of problems as other women who, for example, might be living with poverty; addiction issues; housing concerns; or lack of family support. There was a perception that this group's challenges and issues were more contained.

Younger mothers

The research included 14 young mothers aged 21 years old or younger. None were in employment; around half were co-habiting or had a partner, with the other half being single.

There were mixed opinions amongst young parents as to the need for more information and support from health professionals. On the one hand, some expressed a need for more information on preparing for labour and wished for a longer stay in hospital. On the other hand, some recounted negative experiences such as feeling judged and disrespected by their health professional, with it being assumed that, due to their age, they would be an incompetent mother. In these

cases, young mothers were relieved to be discharged from hospital quickly after giving birth. For example:

I couldn't wait to get out so I could just get on with it on my own without their judgements and preconceptions that I wouldn't be able to do it. (Mother)

Young mothers spoke of experiencing stigma both from the community and health professionals; this caused distress and led to a reluctance to attend services and join groups. Consequently, this meant that young parents missed out often on the benefits gained from maternity care and peer support. Due to the fear of being judged, there was, also, a reluctance to open up to their midwife or health visitor. For example:

The number of people who look at you when you're walking about. Even before I was offered the antenatal classes, I knew I wasn't going because the young mums I knew say they got looked at like they were stupid wee lassies. (Mother)

I think it's a bit discriminating how all the midwives slag off the younger mothers. I found that sad. It doesn't matter what age you are, whether you make a good mother or not. My health visitor doesn't like me, so I don't feel I can talk to her about my problems. (Mother)

Young mothers, who were, also, single parents, described the difficulties faced in being solely responsible for their baby at such a young age, and the negative emotions experienced when they were left by their partner or had problems in their relationships. For example:

Being a single mum is so hard because you have no time for anything. I have found it a struggle because I don't get a lot of help. It's all left to me. (Mother)

This sample was recruited partly through third sector organisations. There tended to be a reliance on these organisations, with young mothers building a trusted relationship with staff and relying on them for support. As such, third sector members of staff were able to detect problems (including symptoms of postnatal depression) and could attend groups with young mothers to help them develop self-confidence. For example:

It was the help I got from here (third sector organisation). It was with them speaking to me about it that I realised I had it [postnatal depression]. (Mother)

For me it was my confidence. It was so hard for me to go [mother and toddler groups]. I was so scared because I didn't know anybody, but she came with me the first few times and that made all the difference. (Mother)

A common experience amongst young mothers was isolation due to many of their friends ceasing contact once they fell pregnant. Perhaps, due to this lack of peer support and particular challenges which they faced, many (particularly single mothers) relied heavily on their family for both practical and emotional support. For example:

When she was born, my mum was a god send. Really if it hadn't been for her, I wouldn't be where I am now. She would have probably been in care. (Mother)

They often say that their friends have cut them off, because they're now not able to participate in the things that they used to…so participation in normal teenage behaviour is cut off from them now. (Stakeholder)

Stakeholders highlighted the lack of services for this group, including primary care mental health and support services. In particular, there was a perceived lack of transitional support services for the 16-18 year age group. For example:

Primary mental health for 16 – 18 – that's a clear gap. More services for underage mothers and better social work support. (Stakeholder)

Young mothers are often at a transitional phase moving into the adult work….transitional support is difficult to access…The barrier to get into social work seems to rise after 16; you have to have very severe problems to be given priority. (Stakeholder)

Mothers who've experienced Trauma

The research identified a number of women (approximately 12) who had had traumatic experiences in their past such as childhood abuse; previous stillbirths; multiple miscarriages; domestic violence; abandonment by their partner; and traumatic births. All had an impact on their experiences of pregnancy and early parenthood. In addition, some women had issues with their family or home life or experienced a real lack of family support; and, also, suffered from depression, anxiety and other mental health issues. Consequently, they found it extremely difficult to adjust to parenthood. They perceived often that there was a lack of support during their pregnancy both at the hospital and post birth. For example:

The lack of support and contact from my family really upsets me…I'm so hurt and it sends me on a downwards spiral. I think all of that and the lack of support for me was a catalyst to my depression. (Mother)

A lot of the mums we're seeing have long-standing mental health issues relating to incidents that have happened throughout their childhood. (Stakeholder)

Mothers reacted to their anxiety, depression and past experiences in completely different ways. Some did not want to hold, feed or change their baby whilst others became very overprotective of their child, believing that no one else (including the father) could care for their child as they could. For example:

I loved being pregnant and loved my baby so much I think that's where my problems started. I had a really bad childhood. I was abused a lot and saw a lot of things a child shouldn't have to see, so I shut everyone else out.....When he was born, I wouldn't let anybody else do anything. (Mother)

Often, these women lacked confidence which meant that attending groups was a challenge too difficult to overcome. Frequently, the group environment was intimidating for these women, indicating the need for one to one support, at least initially. Establishing a relationship and trust with a key worker would appear crucial so that they can confide how their past experiences may have influenced their behaviour. Some women stated they would be more likely to attend if they had someone to accompany them. However, they needed often to see real benefits in attending the group before making a commitment to do so. For example:

I was offered a (third sector group) but I wasn't confident enough to go along to a group. So I didn't go to antenatal classes either…I needed someone to come and see me on my own. (Mother)

As, frequently, these women found pregnancy, labour and/or early parenthood challenging; they required additional support and reassurance. However many did not receive this, and had little confidence or strength to request it. Due to their past experiences and lack of confidence and trust in people, there is an even greater need for support services.

Some mothers had experienced traumatic labour which had impacted negatively on their relationship with their baby during the crucial first few days. Participants indicated that a conversation or debrief with a health professional about their labour and birth might have helped to process what happened and allow them to move on. Some mothers said they were not provided with any information on their labour and had many unanswered questions; others felt that the trauma had discouraged them from having other children. Those, who were having a second child, were very apprehensive about giving birth again. For example:

I nearly died as I developed sepsis after my C-section. The stress...it was horrendous. I think all of that contributed to the post natal depression…I think more midwives and doctors have to…say 'you can come back and talk to us about what happened during your labour and we'll explain it all', if you have questions that are left unanswered, you can start doubting yourself as a person and as a mother….I'm taking about getting closure for what happened. It doesn't take away from what's happened because it is traumatic and it is upsetting, but….it helps if you can understand it a little bit better. (Mother)

The research included mothers who had experienced loss of a baby (either through miscarriage, still birth or post birth); this resulted in heightened anxiety. They tended to be very anxious about their pregnancy and needed additional reassurance and support which most felt was not provided. In instances, where they had received additional support, this provided reassurance. For example:

I was very nervous as my previous pregnancy was a stillborn. I had a fear of it happening again. I was mentally exhausted – I wanted the best for my child….I needed some extra help and support. (Mother)

7. Developing Recommendations: Workshop with Stakeholders

An interim debrief presentation was presented to a range of stakeholders involved in the research.

Key Findings

- Common themes, suggested by stakeholders, were the need to:
- Normalise the need for support during parenthood (advertising campaigns, role of schools, early intervention);
- De-stigmatize postnatal depression;
- Ensure peer support, both antenatal and postnatal;
- Provide training, education and support for staff involved in the care of perinatal women;
- Sustain funding for good quality third sector organisations – increasing the range of services; focusing on early intervention; and
- Improve partnership working and sharing of good practice between organisations.

Attending the session were 26 stakeholders from a range of statutory (22 attendees) and voluntary (4 attendees) services including health visiting; health improvement; mother and baby mental health unit; midwifery; psychiatric nursing; education services; public health; and voluntary sector family support projects.

The debrief session involved a verbal presentation of the interim results and identifying key challenges and issues. Then, the attendees formed smaller groups which were given the task of suggesting ways in which some of the challenges could be addressed and which team, department, or type of organisation ought to take responsibility for driving the action forward (see Appendix). They were asked, also, to identify the top priority actions to be taken forward from the research.

Suggested Priority Actions

20 attendees provided their three priority actions; these were grouped into the themes below.

Early Intervention: **Support Services and Education in the Antenatal and Postnatal Period provided by Voluntary Organisations**

Respondents indicated the need for more and better antenatal education and services for women (particularly provided by voluntary and community organisations) which, then, would lead to postnatal services. Topics to be covered by such classes included the normalities of parenting and difficulties adjusting to parenthood; postnatal depression; and planning coping strategies and support required in the postnatal period. Another suggestion was Early Intervention, consisting of parenting education provided in schools, which emphasised the realities of child rearing, as was the need to include other family members.

Further Education, Training and Support

A common suggestion was for staff and agencies to receive training and support around perinatal mental health, specifically in relation to identifying mental health issues and signposting to services. It was suggested, also, that this training be provided at the student level for midwives and health visitors as was the need to prioritise and release staff for training. A further priority action was improving

professional confidence and understanding the promotion of positive mental health to prevent over reliance on medicalization.

Peer support

Stakeholders suggested the need to build capacity for a robust peer support programme from pre-birth which would continue to post natal services.

Funding

There was highlighted the need for sustainable, strategic funding for projects which offered support and continuity. This included additional funding for existing services and, thereby, creating a menu of services for women.

De-stigmatizing and Normalising Perinatal Mental Health Issues

It was suggested that the postnatal need for parents to be supported ought to be normalised with the default position being an expectation that they would experience some degree of depression or adjustment problems. Other suggestions were de-stigmatizing postnatal depression through an advertisement campaign and having positive promotional material and opportunities to promote positive mental health.

Better Partnership Working and Sharing of Good Practice

Partnership working was raised as a priority area; this would lead to better referrals, between GPs, health visitors and midwives to appropriate services. Other suggestions were closer joint working with voluntary sector groups; more partnership working pre-birth; and sharing good practice. A further suggestion was the need to ensure the maintenance of the links of communication between the stakeholders involved in the current research and to ensure a co-ordinated approach to driving the research forward.

Further Priority Actions

A list of further suggestions provided by stakeholders is as follows:

- Better marketing to sign post clients/patients to groups and peer support
- Community development prior to setting up groups
- Further research to see what is working and provide this across the board
- Looking closely and objectively at identified good practice
- Better support to women after delivery in hospitals (breastfeeding; birth experiences; expectations; services; groups)
- Advertising groups as information stations
- Family support workers in all establishments
- Improved communication between professionals and clients regarding the available services
- Incentives i.e. crèche
- Resources and time for midwives and health visitors
- Universal services for expectant parents and parents
- Review maternity services

8. Discussion

This research provides a wealth of information on factors informing perinatal mental health among women living in the NHS Greater Glasgow and Clyde area. This research is noteworthy and valuable, given the limited research conducted in Scotland in this area. Overall, the results confirm and extend much of the previous literature on perinatal mental health whilst making suggestions for improvement in practice.

What Impacts on Perinatal Mental Health?

The literature highlighted various factors impacting on perinatal mental health. These included adapting to the change of life brought on by a new baby (MIND, 2006); being economically dependent on another person (Nicolson, 1998); previous history of depression (Schmied et al, 2013); lack of community support and pressures leading to feelings of loneliness and isolation (Netmums, 2007); lack of partner support or poor relationship with partner (Schmied et al, 2013; Schytt and Hildingsson, 2011); and financial difficulties or worries (Schytt and Hildingsson, 2011; Ngoma et al, 2012). This research supported many of these findings, with mothers highlighting challenges including feeling lost and abandoned once the baby was born; losing a sense of who they were; and adjustment to the responsibility of parenthood. Given the range of challenges faced by women, this supports the need for patient centred care (as highlighted by the NICE guidelines and the Refreshed Framework for Maternity Care) and the improved assessment of need and response to women with complex health and social care circumstances (as outlined in the Refreshed Framework for Maternity Care).

The experience of pregnancy; labour; and birth (including infertility treatment; fear of childbirth; and emergency caesarean sections) can impact, also, on perinatal mental health (e.g. Giardinelli et al, 2012; Schytt and Hildingsson; Blom et al, 2010; Ngoma et al, 2012). In this research, women recounted extremely traumatic birth experiences which had led to anxiety and concern. These suggested a need for better support for women following birth (including de-brief of their labour) to prevent mental health issues from escalating. However, NICE (NICE 45, 2007) found no evidence to support routine single-session debriefing after a traumatic birth.

Most of the research highlights the vulnerability of mothers of lower rather than higher socioeconomic status (e.g. Segre et al, 2007; Goyal et al, 2010). Reducing Antenatal Health Inequalities highlights the importance of equity in quality of care, particularly for those with health and social care needs. In particular, the NCT Evidence Based Briefing Paper (cite original source) stresses the particular vulnerability of women with stressful psycho-social circumstances.

This research indicates, also, that deprivation is a key factor impacting on perinatal mental health. As well as having a direct impact on mental health, poverty appears to compound other vulnerability factors and, for example, making women, who are, even more susceptible to mental health problems. However, more affluent mothers emerged, also, as a target group in need of support. Although they tended not to face multifaceted problems, they faced other challenges relating to their change in role, purpose and sense of self from working female to stay at home mother. In a similar vein to Reducing Health Inequalities, this highlights the need for stakeholders to be aware of and consider such challenges when screening for mental health issues amongst this target group and prioritising the need for staff to better understand social inequalities.

As in previous research (Davey et al, 2011, Haga et al, 2012), the challenges to perinatal mental health, associated with breastfeeding, were significant research findings. The importance of support in relation to breastfeeding, either from health professionals or informal sources, appears paramount. Women complained frequently about the lack of breastfeeding support. This suggests a clear need to support new mothers to develop effective breastfeeding techniques (Brand et al, 2011) and to ensure that, after birth, they have adequate support to establish and, then, to continue breastfeeding. There would appear to be a role both for midwives and breastfeeding support workers/volunteers; a service, which has been cut drastically due to funding issues, appears to be a key gap in service provision. This may impact both on breastfeeding rates and perinatal mental health.

Many women appeared to have unrealistic expectations of labour and parenthood, leading to an extremely difficult first few months since they were unprepared for the demands of a new baby. Previous literature indicated the need for parenting classes which educated women on the realities of motherhood and the demands on their time; sleep; and emotions (Taylor and Johnson, 2010). This appears to be an important implication for practice.

Sources of Support

The research revealed that many mothers relied on informal sources for practical and emotional support. In many cases, having one trusted person appeared to mitigate the negative impacts of other potentially vulnerable circumstances. This was reported in previous literature (O'Mahen and Flynn, 2008; Haga et al, 2012; Dagher et al, 2011), with women confiding in friends and family about symptoms (Henshaw et al, 2013). The current results indicated women being discouraged by friends and family from seeking support due to stigma and fear of social work involvement. In line with previous research (Henshaw et al, 2013), an implication for practice would be to involve family members and friends (in particular, the key support person) in perinatal mental health education.

As in previous literature (McCaul and Stokes, 2011), a significant research finding was the effectiveness of peer support. Rolling out peer support models to other services and areas would appear to be a priority.

Stigma

The stigma, surrounding perinatal mental health and the associated fear with admitting such issues or engaging with health or support services (Lies et al, 2011, Hall, 2006, Antenatal Health Inequalities), is well documented in the literature. In this research, women reported feeling like "a bad mother" and some were concerned about social work involvement and their child being removed from their care. This prevented women from seeking support before issues reached a critical stage.

Research highlighted, also, a lack of awareness surrounding the symptoms and the risk factors of postnatal depression and sources of assistance (Sealy et al, 2009; Highet et al, 2011). Furthermore, this research suggests the need to raise community awareness of perinatal mental health and, more generally, the struggles and challenges involved with pregnancy and parenthood so that women feel able to admit their issues without guilt or shame.

As highlighted in the literature, there appear to be various barriers to treatment at the patient, provider and system levels; these include referrals not being acted on (Kim et al, 2010). In this research, referral protocols were perceived to be a barrier with increased staff understanding of how to access services for women appearing to be a priority for future action.

Early Intervention

Previous research indicated the link between maternal mental health and child development outcomes (O'Donnell et al, 2009; Marryat and Martin, 2010) and, also, that services, which began earlier, were more effective than those which began in later parenthood (Barlow et al, 2008). This research highlighted the need for early intervention services, beginning in pregnancy, which provided emotional support and practical parenting education, and enabled a relationship to be established between women and service. This supports the premise of the Refreshed Maternity Care framework which is based partly on evidence justifying investment in early intervention and on Reducing Antenatal Health Inequalities which indicates the need for investment in early intervention and prevention. Implications for good practice include such services being community based, in an accessible and informal setting, and providing continuity of contact with staff.

Midwife and Health Visiting Services

The value of the health visitor and midwife, as a means of providing antenatal and parenting education, and as a key person with whom to engage and establish a trusted relationship, is highlighted both in previous literature and this research. Changes to the role of the midwife and health visitor have been shown to have an impact on the diagnosis and management of postnatal depression (Chew-Graham et al, 2008). Similarly, this research indicated problems caused by reduced contact such as the women feeling uncomfortable about confiding in the health professional, and the health professional being less able to pick up on cues and changes in behaviour. Mothers reported feeling unsupported and anxious, due to the lack of time and visits, and, in some cases, there being a lack of genuine care with more focus on "ticking boxes" and paperwork. Conversely, those, reporting positive experiences with their midwife or health visitor, considered that the time spent was crucial to their wellbeing. The lack of continuity of contact was seen to result in repetition during visits and, at times, important information 'slipping through the net.' Stakeholders stated that increasing case loads and bureaucracy had changed the focus of their visits and they highlighted the need for mental health training and more support services to make referrals to. Stakeholders reported often feeling as if they had let the woman down since they felt unable to take effective action.

Previous literature emphasised the need for midwives and health visitors to provide intensive and longer term support for the most vulnerable women alongside ensuing that staff had the appropriate training; support; and resources to conduct such services (Barlow et al, 2008; Hildingsson, 2011; Haga et al, 2012; Marks et al, 2003; Alderice et al, 2013; Lewis et al, 2011; Price et al, 2012). Furthermore, this research supports these findings, with stakeholders stressing the need, given the lack of funding to create separate support services, for intensive support services to be incorporated into mainstream provision. Another perceived benefit was the universal nature and lack of stigma surrounding the midwife and health visitor service. Reducing Antenatal Health Inequalities describes as pivotal universal antenatal healthcare is described as pivotal.

Home visiting programmes appear to be valuable (particularly for the most vulnerable women); this is a finding which supports previous research (Leis et al, 2011; Barlow et al, 2008). Stakeholders spoke of the need for a 'softly softly' approach, visiting the mother in her own home to establish a trusting relationship before encouraging the woman to engage with other services or attend any type of group support. Often, there was a need, on the first few occasions, for the keyworker to attend the group alongside the mother; this was considered to be an effective way of overcoming the barrier to attendance. Reducing Antenatal Health Inequalities highlighted the importance of continuity or care and the relationship between staff and women.

Skills of Service Provider

Previous research highlighted the importance of the skills of the service provider (Barlow et al, 2008). This was true, also, in this research, with mothers reporting that the health professional's attitude and skills were crucial in establishing a trusted relationship, where they were able to discuss their concerns and value the advice provided.

An issue, related both to the skills and attitude of the midwife and, also, to the stigma surrounding perinatal mental health, was the use of the EPDS as a screening tool (Drake et al, 2013). It was shown previously that the EPDS could work well if members of staff were trained properly and supported, and the health visitor had appropriate time to spend with the mother (Vik et al, 2009; Milgrom et al, 2011). In this research, women described the EPDS as a 'tick box' exercise; this was perceived as a major limitation to its utility. Some professionals admitted that they feared asking particular questions in case they 'opened a can of worms' and uncovered issues which they were unable to deal with, either due to a lack of mental health training or a lack of services for referrals. The current SIGN (year) guidelines state that there is insufficient evidence to recommend the use, in either the antenatal or postnatal period, of the EPDS as a sufficiently accurate tool Instead, it is suggested that the EPDS is used as a tool which may be beneficial in facilitating discussion of emotional issues and in facilitating on-going clinical monitoring.

This research indicates a clear need for this area to be improved in the form of new procedures; training; and support for staff to probe and uncover mental health issues (such as taking note of nonverbal communication and using their intuition, Rollans et al, 2013). However, if they do uncover a need, health professionals need to feel confident that there are appropriate services in place. Furthermore, this highlights the need for more extensive support services for women.

Lack of Understanding and Knowledge amongst Health Professionals

Lack of relevant training and understanding of perinatal mental health appears to be a significant barrier to women accessing effective treatment; this supports the previous literature (Wylie et al, 2011; Chew-Graham et al, 2008; Yelland et al, 2010; McCauley et al, 2011; Rothera and Oates, 2008). Compassionate Connections (NHS Education for Scotland, 2011) highlights the learning needs of staff working with the target group; these needs include knowledge and understanding of the experience of inequality and discrimination on service user engagement; and assuming a non-judgemental approach. Further key findings were the lack of awareness of available support services in the local area (including inclusion criteria) and referral procedures to health services. A required improvement is mental health training for health professionals so that they are able to screen accurately; diagnose; and make referrals to appropriate services. This supports, also, the Refreshed Maternity Care

Framework which indicates that staff should be provided with the necessary training and development and support.

Partnership Working

Previous research highlighted the importance of effective partnership working in the management of perinatal mental health, given the complexities of the condition and the need for multi-agency service provision (Rothera and Oates, 2008; Yelland et al, 2010; Loureiro et al, 2009; Ebeid et al, 2010). The Refreshed Maternity Care Framework highlighted, also, the need for improved communication and collaboration. In addition, Compassionate Connections revealed knowledge, understanding and respect to be a learning need in the role of multi-agency partners' staff. This research highlights, also, the importance of such partnership working to provide a more seamless service for women in the perinatal period. It highlights, also, barriers such as lack of time and resources; ownership issues; and referral pathways. The referrals process was a commonly cited barrier and confusion surrounding ownership and a lack of feedback and communication resulting often in women falling out of the system. Child protection was a further issue which stakeholders perceived as exacerbating mental health issues. The research highlighted the need for mental health services and social work to work better in partnership in order to reduce feelings of anxiety within the mother.

Quality of Care in Hospital

A clear research finding was the reported lack of quality care in the maternity hospital. Often, this led to women experiencing anxiety about coping with their baby and, particularly so, following a traumatic birth experience. Women said they were made to "feel like a number"; discharged too early; and received a lack of practical and emotional support from hospital staff. Stakeholders acknowledged that the system could 'set women up for a fall'. This research indicates clearly the need for better support and care in hospital and on discharge. It suggests, also, the inclusion of debriefing women on their labour in order to prevent mental health issues from escalating (although, as mentioned previously, this is not in line with the NICE guidelines).

Alternative Service Provision

The research highlighted instances of good practice in relation to accessible, community services as was demonstrated in the previous literature (Harvey et al, 2012; Judd et al, 2011; Coe and Barlow, 2013). It is recommended that more such services are funded, particularly those with midwife or health visitor involvement (models which were praised, also, in the literature (e.g. McCaul and Stokes, 2011) since these would appear to constitute best practice and to provide the women with both community and health professional support. Services, such as infant massage; stress management; breastfeeding support; and buggy walks were perceived to improve perinatal mental health. The benefits of infant massage were shown, also, to some extent in the literature (Underdown et al, 2006; Onzawa et al, 2001; O'Higgins et al, 2008). This research suggests that ensuring access to these support services would play a key role in improving perinatal mental health.

BME Women

A key target group in the research was BME mothers, specifically those of Asian descent. Previous literature (e.g. Dhillon and Macarhur, 2010; Abassi et al, 2013) highlighted how Asian women could be particularly vulnerable to perinatal mental health issues. The Refreshed Maternity Care Framework recommends that practice should accommodate cultural and religious practices. Mothers highlighted cultural differences as a barrier to establishing a trusted relationship with a health professional and attending mainstream support groups. Suggested improvements are the inclusion of some level of continuity in culturally sensitive training for health professional staff.

Face to face interviews rather than language based tools were suggested as more appropriate screening methods (Downe et al, 2007) with the NCT Evidence Based Briefing Paper (Healthcare Commission, 2008) highlighting the particular vulnerability of BME women in terms of misdiagnosis of mental health issues. Furthermore, this research endorsed this view in questioning the appropriateness of the EPDS as a screening tool for BME women. In general, language barriers were raised as a significant limitation to women engaging effectively with services (This issue was raised, also, in Reducing Antenatal Health Inequalities which prioritised workforce communication skills, particularly for those women who did not have English as their first language). A clear implication for practice is to ensure that women are provided with written information (including details of services and local groups) in their own language. Similar to other mothers, social support was a significant factor associated with a reduced likelihood of depression (Dhillon and Macarthur, 2010; Hanley, 2007). As the majority of BME sampled women were perceived to be first generation, the issue of extended family could be a source of stress, conflict and pressure which represented another challenge to the mother's mental health. In these circumstances, frequent visits from a health professional would appear to be extremely valuable.

9. Research Limitations and Suggestions for Further Research

Research Limitations

A key limitation was that the research being skewed to services which were active and interested in the research area (both in terms of steering group membership and participant sampling). This meant that the research might reflect the views of the stakeholders most involved with the client group, and the most effective services in this area. Similarly, the research involved mothers who were more engaged with services. Although attempts were made to fill this gap through the use of community days (which involved street recruitment), there was still a sense that women, least engaged with services, might be under-represented in the sample. The research findings, relating to BME women, may be representative only of the research sample which consisted mainly of Asian women who had been born outside the UK. It should not be extrapolated that these findings would be echoed amongst samples from different ethnic groups or amongst UK Asian women.

Further Research

A further priority area would be to examine community awareness of perinatal mental health in the NHSGGC area and the mechanisms to reduce stigma, by such as exploring the effectiveness of using new media. It would be beneficial, also, to undertake research with fathers in order to investigate the mental health needs of this group and to explore their role in supporting women.

10. Recommendations

- Ensure services are accessible; community based; culturally sensitive; and are offered at times when women can access them in relaxed, comfortable and informal environments. This ensures that mothers do not feel pressured to attend but allows them to keep in touch informally if they stop attending.
- Develop and extend examples of good practice such as community-led, social support programmes by ensuring, where required, a key worker role, to support the most vulnerable.
- Raise community awareness of perinatal mental health issues in order to help reduce stigma.
- Improve awareness of social supports amongst stakeholders and women, including the purpose and benefits of such support. This should be done via a variety of methods including: using local libraries; GP surgeries; health centres; hand held child health records; social media and help lines; and using written and non-written formats, provided in a range of languages.
- Ensure midwives and health visitors have access to training in mental health and inequalities sensitive practice and feel confident to facilitate discussions with mothers about mental health issues.
- Ensure that there are strategies for mild to moderate mental health issues and greater staff awareness of referral routes and local resources for women experiencing mild to moderate mental health issues.
- Ensure examples of good practice, such as buggy walks and baby massage, are resourced adequately and produce robust evidence of their effectiveness.
- Share the report in relation to the breastfeeding findings with Maternal and Infant Nutrition Framework Strategic Group, highlighting the unmet need in terms of practical and emotional support for breastfeeding both in the maternity and the community settings
- Improve women's experience of maternity hospitals, particularly in relation to their mental health and wellbeing.
- Explore the mental health impact of experiencing traumatic birth.

Conclusion

Throughout the research process a range of themes were identified. These were lack of awareness of services to refer to; strict referral procedures; a lack of tailored services for specific groups e.g. young parent, BME groups; language barriers; and the vulnerable time when partners went back to work and visitors stopped which could lead to isolation. In addition, it was difficult to evidence softer outcomes such as baby massage and buggy walks etc. Social supports are very important since it would be helpful to have early intervention from key workers; a range of social activities/ interventions; and parenting classes' pre-post birth. There is a need to compliment clinical interventions with peer support model approaches.

It is essential that the actions, arising from this research, augment and compliment the approach which NHS Greater Glasgow and Clyde is taking to improve outcomes for families and that these have a positive impact on maternal and infant mental health. It is important, also, that key stakeholders are engaged at an early stage of the process to ensure that there are the necessary linkages in terms of what will be most useful for NHSGGC's strategic direction in the area of perinatal mental health.

The findings and associated recommendations from the report will be presented to a number of forums and strategic NHS Greater Glasgow and Clyde structures and will also be presented at the Annual Scottish Faculty of Public Health Conference in November 2013.

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Appendix 1 – Participating Mothers' Demographic Information

	North East (Sample: 21)	South (Sample: 23)	Renfrewshire (Sample: 27)	North West (Sample = 38)	Inverclyde (Sample = 2)
Age					
Under 18					
18 – 20	2	1	3	2	1
20-29	12	9	12	11	1
30-39	6	12	10	20	
40+		1		5	
Refused / No response	1		2		
Ethnicity					
White Scottish / British	16	4	24	20	2
White Polish	1	2		1	
Asian			1	1	
Indian					
Pakistani	2	15	1	11	
African	2		1	4	
Caribbean					
Black					
Arab		2		1	
Employment status					
Employed	12	4	11	14	
In education	1	1	1	2	
Unemployed	7	18	15	22	2
Other					
Refused/No response	1				
Marital Status					
Married	10	19	11	22	
Co-habiting	4	1	9	7	1
Single	5	2	6	6	1
Widowed					
Divorced				3	
Separated		1			
Refused/No response	2		1		

Appendix 2 – Research Steering Group

The research steering group comprised of the following NHS Greater Glasgow and Clyde staff;

- Heather Sloan, Health Improvement Lead, Mental Health Improvement Team
- Ruth Donnelly, Health Improvement Senior, North East Sector Health Improvement Team
- Pauline Walmsley, Health Improvement Senior, North West Sector Health Improvement Team
- Jacalyn McIlwham, Health Improvement Practitioner, South Sector Health Improvement Team
- Anne Burns, Health Improvement Lead, Renfrewshire CHP Health Improvement Team
- Brain Young, Mental Health Improvement Lead, Inverclyde CH(C)P Health Improvement Team
- Elaine Clark, Nurse Consultant, Mother & Baby Mental Health Unit

With support and input from Susan Fleming and Margaret McGranachan, Public Health Researchers, Public Health Resource Unit.