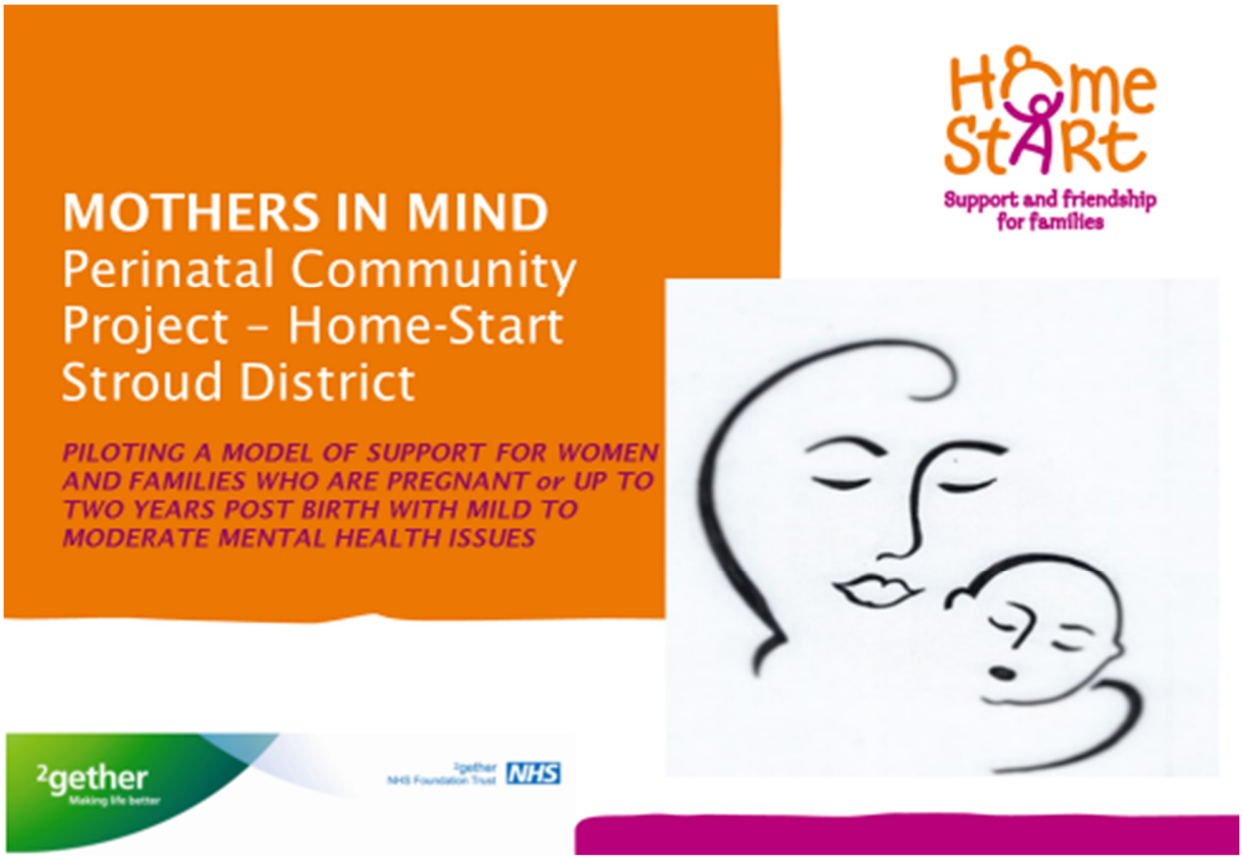

EVALUATION REPORT

MOTHERS IN MIND

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MOTHERS IN MIND

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An Introduction –

Sally Hogg

(Strategic Lead: MABIM, Maternal Mental Health Alliance)

Having a baby is a wonderful experience for most parents. But the transition to parenthood can also be a difficult time – one of huge emotional, social, relational, and physical changes. And for some parents, these changes can trigger or exacerbate mental health problems. When we are experiencing poor mental health, the daily challenges of parenthood can be very difficult.

Around 1 in 10 women – and many men – will experience a mental health problem during pregnancy or the year after their baby is born. These perinatal mental health problems vary greatly in their nature and severity. Many women will experience mild problems, although these can still feel very dark and difficulty at such an important time in that woman and her family's life. For some, the problems are more severe. We know that suicide is one of the biggest causes of maternal death in the first year after giving birth.

Perinatal mental illness does not only affect mums. When a mother is ill, it can have ripple effects on her whole family: Fathers are more likely to have a mental health problem if their partner is ill. And, whilst many women with mental health problems are wonderful mums, being ill can make it harder for women to provide babies with the sensitive, responsive interactions that are so critical to their development. When mums struggle, it brings costs for families, communities and wider society.

None of this is inevitable. We know that, with timely, appropriate and effective care it is possible to prevent or treat perinatal mental illness, and to enable mothers to develop strong bonds with their babies. This is why the Maternal Mental Health Alliance - a coalition of over 80 organisations - work to ensure that all women get the help they need. Our Mums and Babies in Mind project works with local leaders in four areas of the UK – including Gloucestershire - to improve care for mums with perinatal mental health problems and their babies. We capture and share this work to inform and inspire those who commissions and provide services across the UK.

The timely prevention, identification and treatment of perinatal mental illness requires a whole system approach. It involves everyone who works with women to raise awareness about perinatal mental illness, be alert to the signs that a woman is at risk or struggling and help her to secure the most appropriate help. It involves a network of support to be available in an area, from informal mother and baby groups and peer support, through to more intensive and specialist mental health treatment and support, so that all mothers can access appropriate support that meets their needs.

Ever since I joined the Mothers and Babies in Mind project, I've been impressed by the work underway to tackle perinatal mental illness in Gloucestershire. A range of committed and knowledgeable partners from the statutory and voluntary sector are working closely together to drive forward a coherent and comprehensive package of improvements for women and their families.

It is great that Home-Start are playing a key role in this. As this report describes, voluntary sector support is an valuable part of the local offer – helping women to understand and access specialist mental health services, providing additional social

and emotional support to women during and after their treatment, and filling gaps for those who are struggling but do not need or want professional services.

This report clearly describes how Home-Start volunteers can spend time building relationships with women, and providing compassionate, personalised and responsive care. They have the time and flexibility that many professionals crave, but are unable to provide. The time they spend supporting women in their homes helps to make life easier for these women and enables them to find the time they need to care for themselves, and to enjoy their children.

In this report, Celia describes how her Home-Start volunteer enabled her to have a shower. As a mum of two small children, I know how important these seemingly trivial things can be to our emotional wellbeing and readiness to face the day ahead! I truly believe that care is contagious; when someone keeps us in their minds and meets our needs, we are better able to care for others. When stresses of everyday life are made easier for mums, there is more space in our minds to reflect and resolve our own worries, and to keep our children and their needs in mind.

All services have limited time and opportunities to make a difference to the lives of women and their babies, and stretched resources to do so. Therefore it is important that we learn, together, about how best to provide effective support that is accessible and acceptable to women and makes a difference to their quality of life and outcomes.

The work detailed in this report has generated valuable learning about what does, and does not, work for women and their families. The approach of developing, and continuously improving services based on insights from women is one to be commended.

Through this project Home-Start have started to tackle a number of issues that research tells us can be barriers to women getting the help they need – issues such as workforce knowledge and skills; stigma; and the accessibility of provision. The learning generated will be valuable for all working in this area and I'm sure that the whole local system will continue to learn from and build on the messages in this report.

Perinatal Mental Health

Sally Hogg
Mums and Babies in Mind
#MABIM @salhogg

Acknowledgements

We would like to thank the Gloucestershire Clinical Commissioning Group, 2Gether NHS Foundation Trust, Four Acre Trust, The Coventry Building Society, The Summerfield Trust and our main core funders that made this project possible.

Thank you to the Midwives, Health Visitors, 2Gether Trust staff and other referral agencies who supported the project. To the Gloucestershire Perinatal and Infant Mental Health Network, and in particular, its Chair Helen Ford (Senior Commissioning Manager) who made this project possible.

To Jayne Harris who was seconded onto the project by the 2Gether NHS Foundation Trust and who took up post as a high intensity practitioner in September 2016 and who has written one section of this report that appertains to this CQUIN part 5 and a further report linked to this project that appertains to CQUIN part 6. Also to Nathan Gregory (Performance and Development lead for Gloucestershire Localities) who chaired the working group that oversaw the Implementation CQUIN Group for the project.

To Donna Morris and Claire Louise Symonds of MPCP (Mindfulness Parenting Community Project based in Bristol) for their part in developing a specialist mindfulness parenting course as part of the Mothers In Mind Project (in partnership with the Oxford Mindfulness Centre).

To the staff, trustees and volunteers of Home-Start Stroud District for their commitment and enthusiasm to the delivery of this pilot and the extra work that it generated for them. Particular thanks are due to Alison Coates who supported the scheme to collate feedback from families and helped with the development and collection of data for the project as a whole.

Of course, we would like to thank the families who have helped us shape this project and its recommendations. They bravely gave us so much valuable personal information. Their commitment to helping families have better support and understanding of their perinatal mental health challenges in the future was inspiring and empowering.

Also to the MABIM project lead Sally Hogg for her knowledge and expertise and taking the time to help us launch the project back in the summer of 2016 and in writing an introduction to this report.

Lastly to the creator of *Hurrahforgin* Katie Kirby who kindly allowed us to use some of her illustrations and cartoons in our project literature and who so very eloquently expresses, with wry humour, the realities of parenthood in a bid to debunk the myth of the perfect parent.

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Executive Summary and Recommendations

The Mothers in Mind Project was delivered in the Stroud District of Gloucestershire. Its aim was to explore what an *ideal* model of community support for women experiencing *perinatal* anxiety and depression from pregnancy up to two years after birth would look like incorporating the views and experiences of women affected by poor mental health.

It sought to address the issues of stigma and better professional understanding of perinatal mental health and helping to develop better pathways between specialist mental health services and localised community support.

Central to this pilot project was the provision of specially trained volunteer befrienders supporting families in their homes on a weekly basis.

Since the start of the project, April 2016, the Maternal Mental Health Alliance has continued to successfully drive a national agenda to improve specialist perinatal mental health services across the UK and there has been a significant national shift in interest and acknowledgement of the importance of better supporting perinatal mental health.

Locally, Gloucestershire's Clinical Commissioners and the ²gether NHS Foundation Trust were successful in securing funding of £1.5 million over 3 years from NHS England for the development of a Specialist Perinatal Mental Health Team.

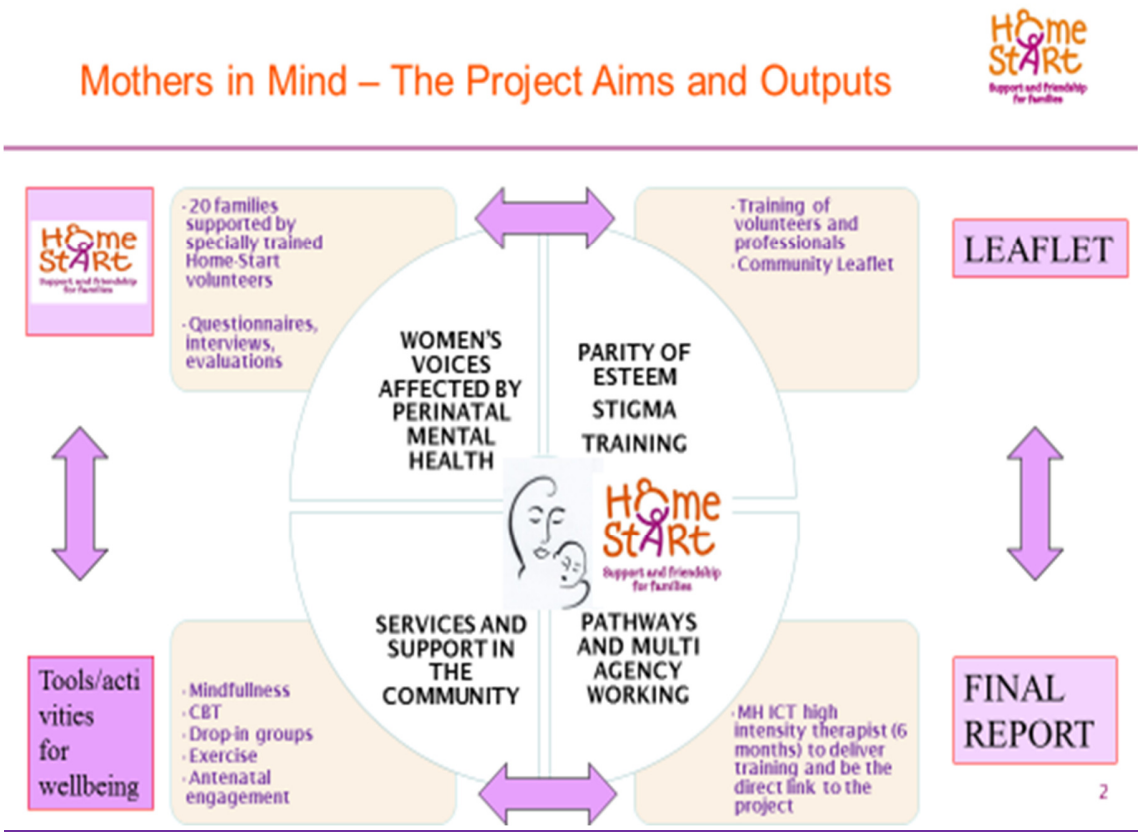
With these positive developments, it is perhaps even more pertinent than ever that the findings and reflections from this project are reflected upon in order to further develop a fully holistic model of support for women facing perinatal mental health challenges in Gloucestershire.

The Project

The overall aims of the project were:

- To explore how to better support women and their families affected by poor mental health in the first two years of their child/dren's lives.
- To develop a pathway with the ²Gether NHS Foundation Trust into and out of mental health intermediate care team/Let's Talk Service and improve the links and access to advice for volunteers and professionals working with women in the perinatal period.

- To reduce stigma and increase awareness of perinatal mental health challenges across the District. This included developing, printing and circulating a leaflet across the locality.
- To create training opportunities for Home-Start volunteers and professionals working with families affected by perinatal mental health challenges in the Stroud District.
- To develop and explore drop-in groups as a source of support for women affected by perinatal mental health issues and to look at other sources of peer support.
- To develop and explore different types of wellbeing workshops/courses as part of a community support package.
- To collect data from women of their own experiences of perinatal mental health and the services they had used.
- To make a recommendation at the end of the project of what an ideal local community model of support would look like and one that could be rolled out to other localities within Gloucestershire.
- To explore provision for dads in the perinatal period.



The role of a home-visiting-volunteer in perinatal support

In the twelve month period of the project, Home-Start Stroud District received 72 referrals for women affected by perinatal mental health issues[1]. This represented nearly 75% of our overall scheme's referrals where our only universal criteria is that there must be a child under the age of five in the family and that they live in the Stroud District of Gloucestershire[2].

To support a family for one year through the monitored home visiting of a fully trained and supervised volunteer costs approximately **£1400 p.a.**

That's £120 per month

Which is £30 per week

Which is £15 per hour (That's a total cost of £15 per hour face to face support)

Our evaluation clearly shows that this model of support is highly cost effective and It should be seen as a crucial component of any model of community perinatal support. It ensures non-time limited non-stigmatised intervention for vulnerable families. Providing both practical and emotional support in the family home.

Well-trained supervised volunteers can provide a link between specialist mental health services and also primary health care services by gaining familiarity and insight into a mother's emotional wellbeing and enough trust with the family to support them to seek specialist support. Furthermore, once a referral has been made, volunteers can practically support families to attend appointments. Once specialist treatment has ended volunteers can continue to support families to use tools and strategies to maintain better mental health and build long-term resilience.

Home visiting breaks the barriers that high anxiety levels and low mood can impose on a family. Many respondents to our questionnaire spoke of not being able to go to a baby or toddler group without the support and presence of their volunteer. This

[1] The perinatal period for the Mothers in Mind Project was extended to include up and until a child's 2nd birthday (see page of 7 of main report)

[2] In April 2017 following funding from the Clinical Commissioning Group, Home-Start extended its borders to include the Gloucester parishes of Kingsway and Quedgeley. However this geographical area is not included in the Mothers in Mind Project.

creates a gateway for women to start making friends with other mothers and building up activities they are able to do outside of the house.

Women cited the flexibility, non-judgemental, practical and empathic side of Home-Start support as having been some of the aspects of support that make it so useful. Having someone to talk to and a listening ear were also re-occurring responses.

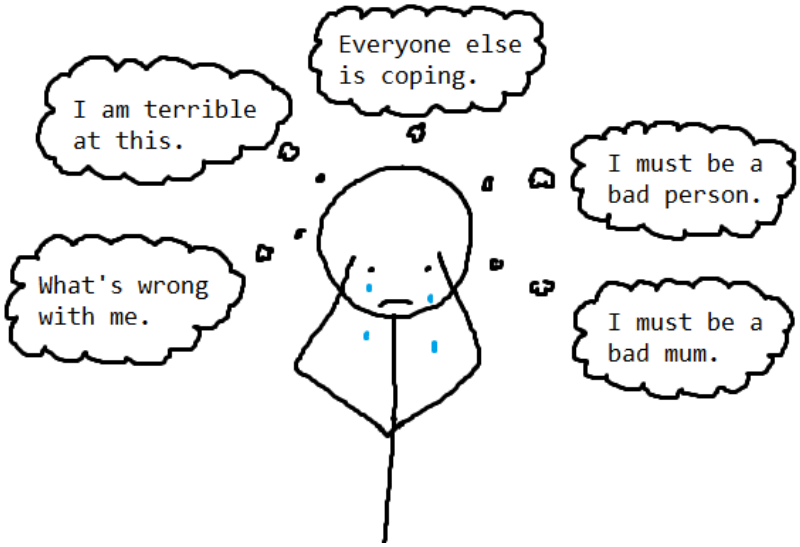
78% of women supported through home visiting who did the PHQ9 screening for depression scored between moderate and severe depression. 97% of the same cohort of women who did the GAD7 screening for anxiety scored levels between moderate and severe anxiety. We were surprised by this having thought that the majority of our cohort of women supported would be scoring in the mild to moderate ranges for both depression and anxiety. This would indicate that the intensity or level of perinatal mental health issues being supported through universal community support is significantly higher than might be presumed.

Through the project our referrals from midwives went up significantly on the previous year. The project helped us develop a really good working relationship with the local midwives and we will ensure that this continues to be developed into the future. It also meant that we received around fifteen ante-natal referrals which meant we could develop a relationship with the families before the babies were born.

Our working relationship with health visitors has always been strong and positive in the Stroud District. Historically we have received up to 70% of our referrals from them and a health visitor is always invited to attend our volunteer training course to inform new volunteers about the role of the health visitor and what can families can expect from them.

We only received one referral from a mental health professional which would indicate an ongoing gap between specialist statutory services and community support. [2]gether NHS Foundation Trust staff need to be aware (and make better) use of the services available through community and voluntary organisations.

Stigma and Attitudes to Mental Health and talking to professionals



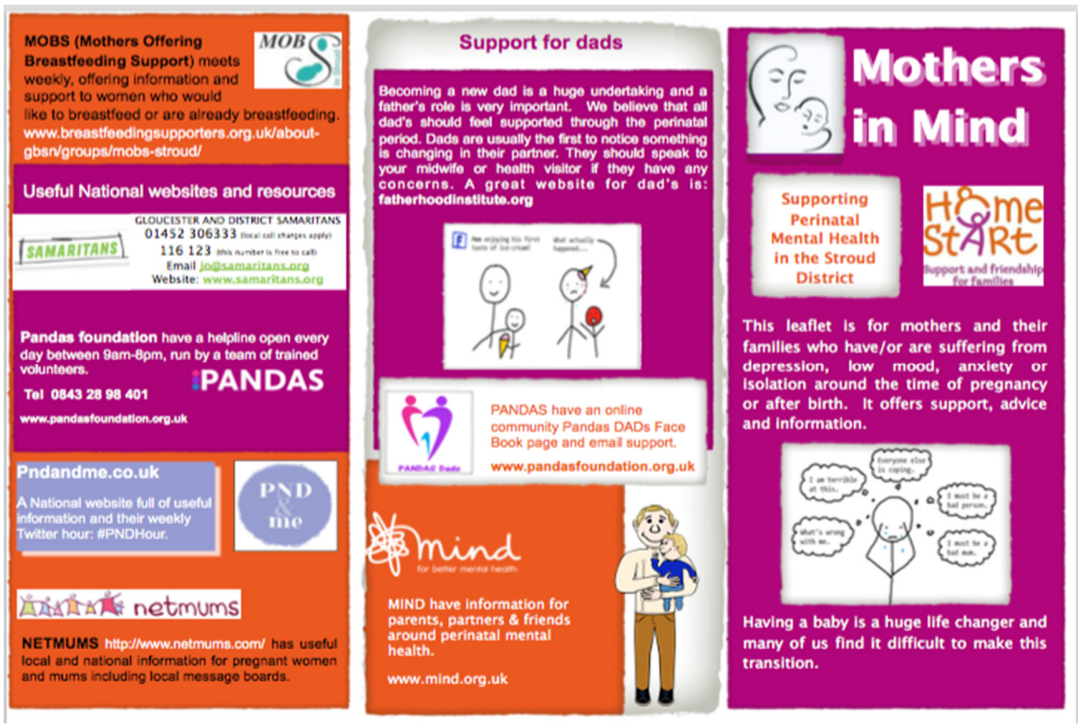
Although 90% of women who responded to our questionnaire agreed that it was important to address the stigma around talking openly and honestly about mental health, 77% of them admitted that they had put on a mask to hide their own level of perinatal mental health challenges.

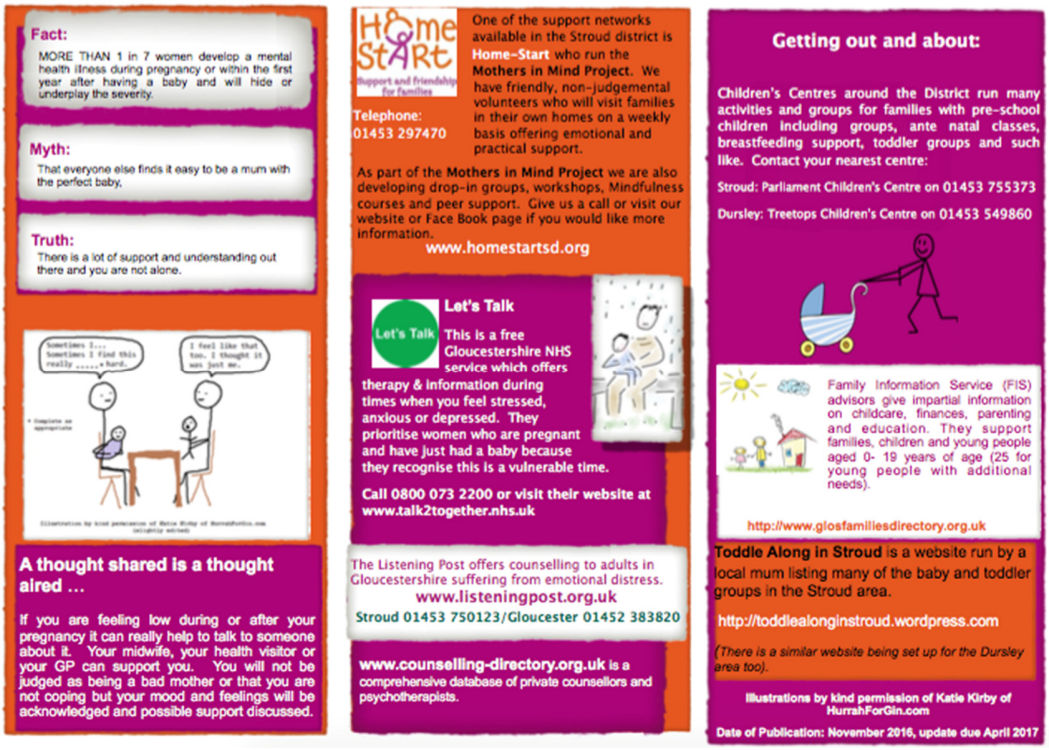
50% admitted that the reason they had never told a professional about how they were really feeling was because they had believed they might have taken their baby away. The level of stigma attached to poor maternal mental health must not be underestimated by anyone who might have contact with a mother in the ante or post-natal period and ways of breaking down this stigma should be a central component of any training to frontline staff (and volunteers) supporting families.

Only 54% of women felt able to be open and honest with a professional about their mental health. The 46% that were not able to be totally open and honest about their mental health cited (apart from having their child(ren) taken away) lack of trust, not knowing what would happen if they did tell and a fear of being judged negatively. The myth of 'the perfect parent' pervades the consciousness of many of the mothers we talked to, creating a greater sense of isolation, anxiety and failure. Professionals and society as a whole must work harder to breakdown these false images which are impossible to live up to.

Women who had felt able to speak to a professional about their mental health did so because they were asked a direct question and they trusted the professionals enough to be honest with them. Where services do not enable enough time for a relationship to develop between a health professional and a mother they are minimising the potential of an honest dialogue. Home-Start volunteers are perceived by families as being neutral, non-statutory and the non-time limited nature of their relationship with a family mean that they can gain the trust of a vulnerable mother. This point is crucial in underlining the importance of the role of the trained home visiting volunteer in bridging the gap between women seeking specialist support where necessary or receiving gentle weekly support from a volunteer

Leaflet





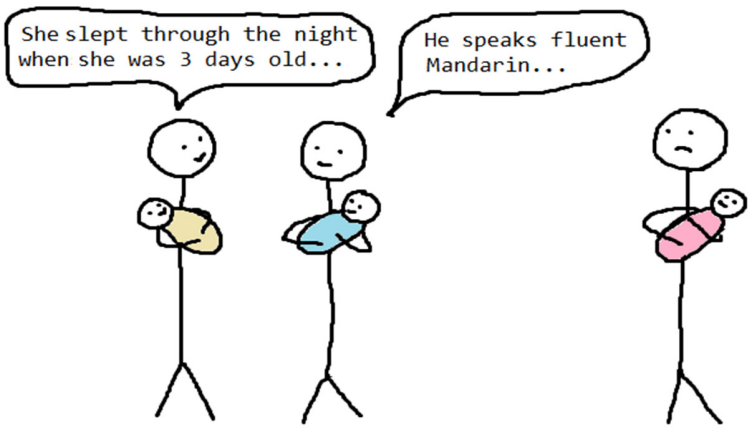
We created a leaflet, with our focus group that talks about perinatal mental health, its prevalence, local services, national websites and information for dads. We distributed it across the locality and the feedback was excellent. We felt that this was a simple but effective part of our project that can be easily replicated in all localities of Gloucestershire.

Women's Drop-in Groups

Through running a focus group of mothers and developing a six week pilot drop-in group, we collected some very useful feedback through the wealth of lived experience and enthusiasm of women who have been through their own perinatal mental health challenges and want to support other women.

The drop-in group was successful in creating a safe weekly space for women (already supported by Home-Start). The lack of a specific start and finish time was welcomed by women as well as the small size of the group and that the group was supported by Home-Start volunteers who brought their families along to the group. One volunteer facilitated group discussions in a gentle non-intrusive way that was well received by the women who attended.

We were able to report back to the Clinical Commissioners that this was a unit from our model of community support that we were very keen to continue to develop and have now received funding from them (for twelve months) to facilitate two weekly drop-in groups that will run across the District for 6 weekly sessions. We are recruiting for a new member of staff to run and develop this project. Referrals for the group will be able to be made by all professionals. We also hope to invite, when appropriate, professionals to pop in and discuss various aspects of supporting mental health. The perinatal primary mental health liaison post suggested by Jayne Harris as part of her recommendations on training health visitors and Home-Start volunteers (CQUIN 5) might be ideal to take up this mantle.



Online Peer Support

There are obvious practical benefits to the use of online peer support for mothers unable to access local services either because of rural isolation or their own mental health challenges that make getting out of the house so difficult. There is also the 24 hour element of online support that might be beneficial for women affected by poor sleep patterns or their baby's disturbed nights.

Our focus group members looked at national websites and organisations offering peer support and were positive about what they found. On the leaflet that we produced for the project we chose some links to National websites as recommended by our focus group. Again, a leaflet in each locality produced on a yearly basis can point families to useful websites, online support and telephone helplines.

Importantly online peer support and websites can provide information and support for partners of women affected by perinatal mental health or for the one in ten men who will themselves have some level of mental health challenge as a result of becoming a parent.

There was recognition that online information and support can be accessed by parents without having to identify themselves and this was felt to be a valuable aspect of this area of support.

We will be considering whether to develop a closed Facebook page as part of our Mothers in Mind Drop in Groups which would be carefully moderated.

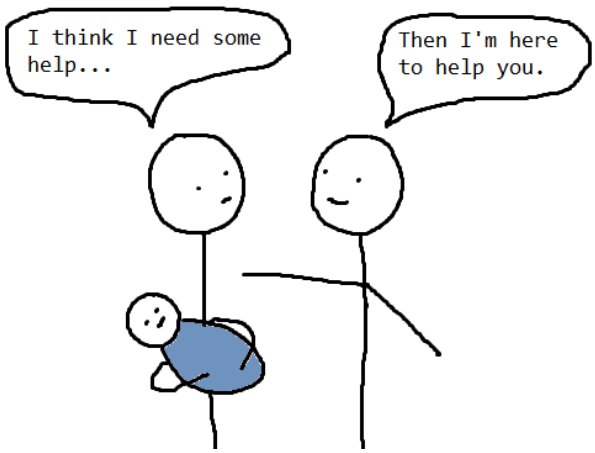
Mindfulness

As part of the project we ran a 10 week mindfulness parenting course. We were interested to explore how mindfulness might be integrated into a holistic model of ante and post-natal support. We also ran an introductory workshop for our volunteers into how mindfulness can support positive parenting and better mental health.

The course was facilitated by the Bristol based MPCP (Mindfulness Parenting Community Project). The aim of the course was to support vulnerable parents to manage their own mental health and to connect with the joy of parenting.

We recruited 15 parents to attend the course. 10 attended the first session. However, we quickly learnt that January, February and March are not good months to run a course that involves the expense of a funded crèche. The course was beset by participants' children being ill with various seasonal viruses. This meant that parents had to miss sessions which meant some gave up coming because they missed sessions early on in the course and therefore did not make enough connection with the group and its facilitators in order to feel the need to continue.

However, those that did complete the course gave very positive feedback. We are awaiting a full evaluation of the course from the Oxford Mindfulness Centre who match-funded the Mothers in Mind Project to participate in the running and evaluation of this course.



CBT Wellbeing groups

One aim of the pilot was that the groups would be run in line with the Improving Access to Psychological Therapies (IAPT) Cognitive Behaviour Therapy (CBT) treatment model so that in future it could potentially be replicated across the county within the IAPT treatment programme. It was part of the role of an accredited IAPT CBT Therapist appointed to deliver the Changing Minds in Perinatal Mental Health training, to co-facilitate the group and be a direct link with HomeStart.

The conclusions from the pilot is that it would not be viable for IAPT to offer specific perinatal treatment groups as part of their group treatment programme.

A full by report by Jayne Harris can be found in the evaluation but in summary it was found that it would not be viable nor helpful for IAPT to offer specific perinatal treatment groups in the future.

Recommendations from Jayne's report are:

Improving the Pathway

The pathway into IAPT from Community and Voluntary Services is via self-referral. Home-Start workers are in an ideal position to support self-referral only if they have a good understanding of what IAPT may be able to offer and the assessment process. It has been known for Home-Start volunteers to organise their weekly visit to look after children to enable women to attend IAPT appointments which may be on the phone or face to face. Home-Start has also helped with transport to appointments.

It would be helpful if [2]gether NHS Foundation Trust services were aware of all the community and voluntary support which is available for women who may be engaged with [2]gether NHS Foundation Trust for treatment. The new Specialist Perinatal Mental Health Service may help by educating secondary care colleagues.

Furthermore, if there was a nominated person in the MHICT, they could maintain contact with those community and voluntary sector organisations and could also act as a point of contact for staff in MHICT staff who want to refer women for extra community support. This role does not currently exist as it cannot be accommodated using existing MHICT resources.

Any future plans for community projects aiming to support women during the perinatal period could benefit from promoting a coordinated approach between providers of community support from the wide range of agencies and charities supporting women at this time. This could form part of a role of a Perinatal Primary Mental Health Liaison worker as described in the recommendations for Part 5 of the [2]gether NHS Foundation Trust Quarter 4 CQUIN report

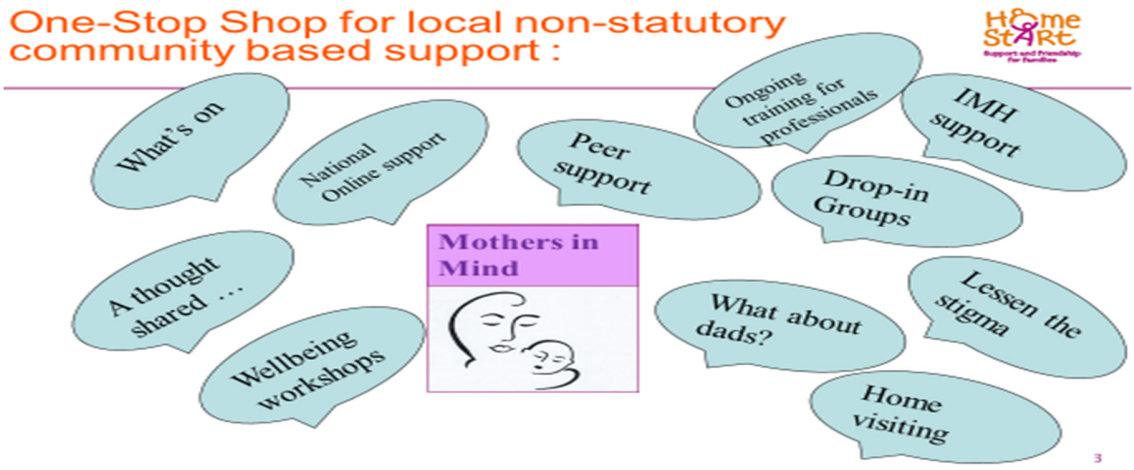
Recommendations

Our Recommended Model of locality based community support:

Specialist community perinatal mental health services should be backed-up by holistic locality based support that includes peer support networks and groups run by the community and voluntary sector. This implies a continued financial commitment by Gloucestershire Clinical Commissioners to help support a spectrum of innovative practice in each locality

Development of support in each locality needs a coordinated approach from all agencies and charities supporting women at this time and better referral pathways and communication between mental health intermediate care team (MHICT), primary health care workers including health visitors, midwives and GPS and all agencies working with pre-school families.

The following model of locality based community support takes into consideration all the learning, evaluation and feedback received as a part of the Mothers in Mind Pilot Project:



An existing community organisation already working with ante and post-natal women acts as a **locality lead for Mothers in Mind** holding information appertaining to perinatal support in the locality that it covers and developing services that meet the needs of women and their families affected by perinatal mental health as described in this evaluation.

Each **locality** of Gloucestershire is different in its geography, demography and in size. Birth data shows us a huge difference in numbers of births in each locality; Gloucester being the largest had 2732 births and The Cotswold 457 births in 2015/16. Each locality already has existing services and groups that understand the community that they serve. Some localities will currently have better developed services than others. Each locality will already have an organisation that could, with additional funding, build upon existing services to take on the Mothers in Mind role in their community.

Depending on the locality we would recommend that, ideally, the Mothers in Mind model should include:

- Each Gloucestershire locality could develop a **'community leaflet'** similar to the Mothers in Mind Leaflet developed for the Stroud District that explains the range of perinatal mental health conditions, their prevalence, who to contact, online support and any other local activities. In a rural community the leaflet can act as a central hub of information both for families and for professionals.
- The organisation develops and runs a service offering **specially trained home visiting volunteers** who provide an important bridge for women accessing specialist services by encouraging women to seek professional help and providing practical non-time-limited weekly support to enable women to attend appointments and groups whilst also providing practical and emotional support in the home.
- The organisation acts **as a central point of information for professionals seeking to support families in the community** either in parallel to specialist support or as a step-down. This includes helping early help hubs to make appropriate referrals for families affected by perinatal mental health.
- The organisation could also work alongside and act a central **point of contact** in the locality and have access to support and advice from the proposed perinatal primary mental health therapist post (if this role is created (as recommended in CQUIN 5)).
- Similarly, the organisation has a **point of contact** and access to support and advice from the [2]Gether Trust's newly developed specialist perinatal health team with a reciprocal point of communication between the specialist team and each locality's Mothers in Mind service.
- The organisation **runs drop-in groups** for women affected by perinatal mental health with occasional input from a specialist perinatal mental health worker, health visitor or midwife. The drop-in groups would also develop opportunities for **peer support**.
- The organisation runs **wellbeing workshops** where there is an identified need, both ante and post-natal, including CBT, Mindfulness and other approaches to better supporting anxiety and depression. This could be done in coordination and consultation with health visitors and midwives.
- The organisation **works to de-stigmatise and educate the locality** as a whole on perinatal mental health **and** to better understand how to support families affected by mental health challenges.
- The organisation **seeks to develop ways to better support dads** within its parenting support mechanisms and inform other services how to create and run inclusive services for partners.

Further General Recommendations:

All professionals and volunteers should have specialist training in perinatal mental health.

All professionals and volunteers working with perinatal women should have a good understanding of specialist service pathways and also a clear understanding of the spectrum of community services available to better support women, their children and partners.

Pathways between specialist secondary care, primary care and the voluntary and community sector should be strengthened and improved. In particular there needs to be an increase in awareness and recognition from specialist mental health professionals about the sources of support available in the community and their important role in providing a holistic package of support for women and their families.

At the heart of any development in perinatal services there should be a clear understanding of why women find it hard to talk openly and honestly about their mental health and have strategies in place to overcome these barriers.

Health visiting and midwifery teams should allocate time to their staff in order to contribute to any local voluntary or community activities being developed including ante and post-natal groups or courses in order to foster a holistic multi-agency way of working.

Fully trained home visiting volunteers provide an important bridge for women accessing specialist services by encouraging women to seek professional help and providing practical support to enable women to attend appointments and groups. They can also offer cost-effective non-time limited practical and emotional support in the home. In localities in Gloucestershire where there is no provision for this kind of community support, Commissioners should consider supporting new initiatives to create them.

Home Start
Support and friendship for families

Context and Background

Perinatal mental health

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. The word 'perinatal' signifies a period of time and there are a range of mental health problems that can affect women during this time, including anxiety disorders, depression and postnatal psychotic disorders.

The word 'perinatal' has taken over prior descriptions of early maternal mental health issues as it encompasses both ante and post-natal. However, the words post-natal depression (or PND) are still used to describe perinatal mental health issues in popular culture and our media. It should not be assumed that the general public are familiar with the term 'perinatal'.

For the Mothers in Mind project, we extended the official perinatal time period to include pregnancy (from 3rd trimester) through to the 2nd birthday of a child. This was because experience showed us that the standard definition would exclude a lot of vulnerable mothers from the project; our initial evalution project (Corgier, 2015) identified that many mothers continue to suffer from some level of poor mental health after the first birthday of their child and that some do not seek help until after the first birthday of their child. The Royal College of Psychiatrists cites that 1 in 4 women will still have mental health challenges when their baby reaches its first birthday. (Royal college of Psychiatry, n.d.)

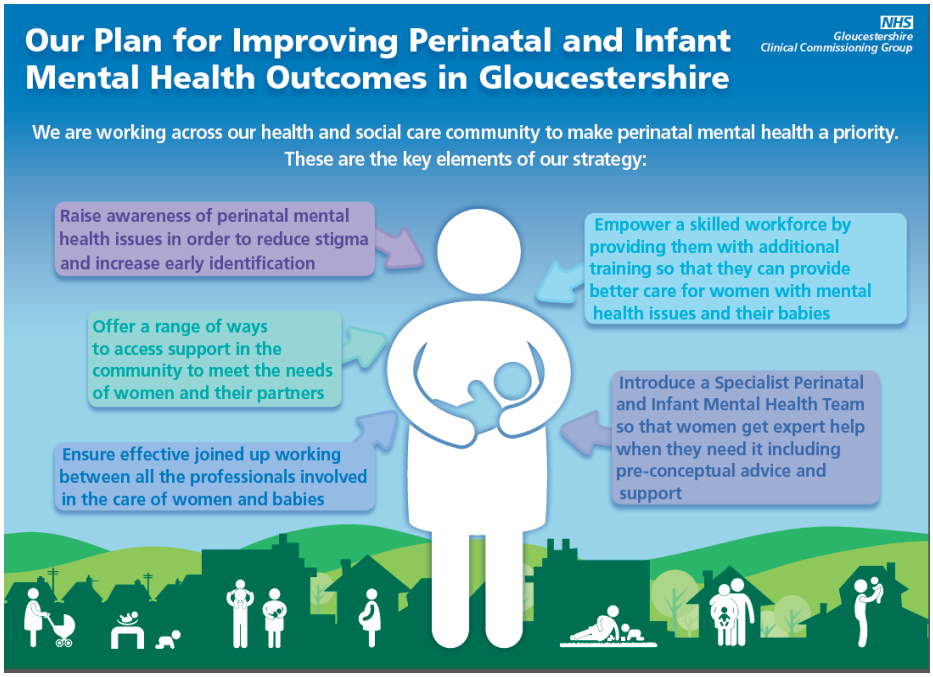
Perinatal mental health problems affect up to 1 in 5 women at some point during pregnancy and for the first year after birth (Royal college of Obstetricians and gynaecologists , 2017) However prevalent, it still holds a heavy weight of stigma, and women are reluctant to seek support for fear of being judged as an unfit mother. It is the most common major complication in pregnancy with women more likely to be hospitalised with a mental illness in the two weeks following birth than at any other point in their lives.

Postpartum psychosis affects 1 in 500 new mothers – it is twice as common as Downs Syndrome (Rai, 2015) and yet is relatively unknown and remains a leading cause of maternal death (Knight, 2015).

The National Institute of Clinical Excellence guidelines (NICE, 2014), calls for extra support for women who have experience of, or are at risk of, mental health problems before, during and after their pregnancy.

Perinatal mental health problems carry an estimated cost to the UK of about £8.1 billion per year according to a recent report (Bauer, 2014) (LSE 2014). The report estimates that 28% of these costs relate to the mother and 72% relate to the child. If not treated effectively, perinatal mental illness can impact on foetal development, how a mother cares for her baby and adverse longterm outcomes for children.

Context



Following the County's commitment to improving services for women affected by perinatal mental health (see info gram) and Home-Start Stroud District's desire to see a better model of community support, the Gloucestershire Clinical Commissioning Group, the [2]Gether NHS Foundation Trust and Home-Start Stroud District combined resources to pilot the Mothers In Mind Community Project.

The project forms part of the [2]Gether NHS Foundation Trust's *2016/17 CQUIN Part 6 description indicator* to develop and pilot a pathway in conjunction with community services (Home-Start) and mental health services (Mental Health Intermediate Care Team). An implementation plan (see appendices) was developed and this final report is produced as part of the CQUIN (part 6) containing recommendations for a community model of perinatal mental health support.

As an organisation dedicated to early intervention Home-Start Stroud District were conscious that a significant proportion of women being referred had some level of perinatal mental health challenge which affected their own wellbeing and their ability to parent. Many of these women were not seeking any form of specialist support, either through choice or through not being offered it. The small proportion of those who did seek help often found there was very little out there to support them and the services that were available were often difficult to access and appointments impossible to attend because of young children. We were also repeatedly being told by families that GPs, health visitors, midwives and other professionals were missing opportunities of hearing and supporting these women to seek specialist help. This mirrored the work that the NHS's Campaign 'making every contact count' (NHS, 2016) has tried to highlight in order to improve practice. That is for professionals to take every opportunity to allow people to speak openly and honestly about their mental health.

Our project has sought to give a voice to those who are or have been affected by poor maternal mental health and to explore their experiences, both positive and negative, including what gaps they perceive currently exist in provision and what could be developed to create a community model of holistic non-stigmatised support. Our recommendations are based on the qualitative data that we have collected over the course of the year through questionnaires, face-2-face interviews,

a focus group, pilot drop-in groups and the ongoing review process carried out with families as part of their core home visiting offer.

The project has also explored our central assumption that our befriending volunteer home-visiting model of support is key to any community model of perinatal support because it can support specialist intervention from both primary and intermediary mental health care and can provide the long-term non-threatening accessible support needed by families to overcome and recover from the difficulties of poor maternal mental health.

"Home-Start complements what we do … they do the bit that is hard for us, e.g. the big blocks of time." *Health visitor*

Furthermore, central to this project was a need to upskill both professionals and volunteers working with families and to increase their understanding of services available. From our evaluation report of 2015, we had already consulted with local professionals working in family support, including health visitors, social workers and children centre workers and there had been a unanimous call for more training around perinatal mental health.

This training element of the project overlaps with part 5 of the CQUIN which specifically looked at developing and piloting a CBT training programme for health visitors. A preci of this area of work is included in our section on training and Jayne Harris's recommendations and conclusions following her running two 'Changing Minds' courses for local professionals and Home-Start volunteers are reflected in the recommendations of this report.

1. Home Visiting

Central to the project was to explore and evaluate Home-Start's model of weekly home visiting support by specially trained volunteers to 20 families whose lives were affected by poor perinatal mental health. This part of the project was funded through Gloucestershire's Clinical Commissioning Group. In the Royal College of Obstetricians and Gynaecologists' recent report (Gynaecologists, 2017), one of their recommendations was that commissioners should consider introducing clinically supervised and trained local peer support networks and groups in partnership with the community and voluntary sector, which many women find particularly helpful in their recoveries.' We believe that Home-Start's model of trained volunteer befriender clearly shows in practice how important this recommendation is as being a crucial factor in any model of community perinatal support.

Referrals:

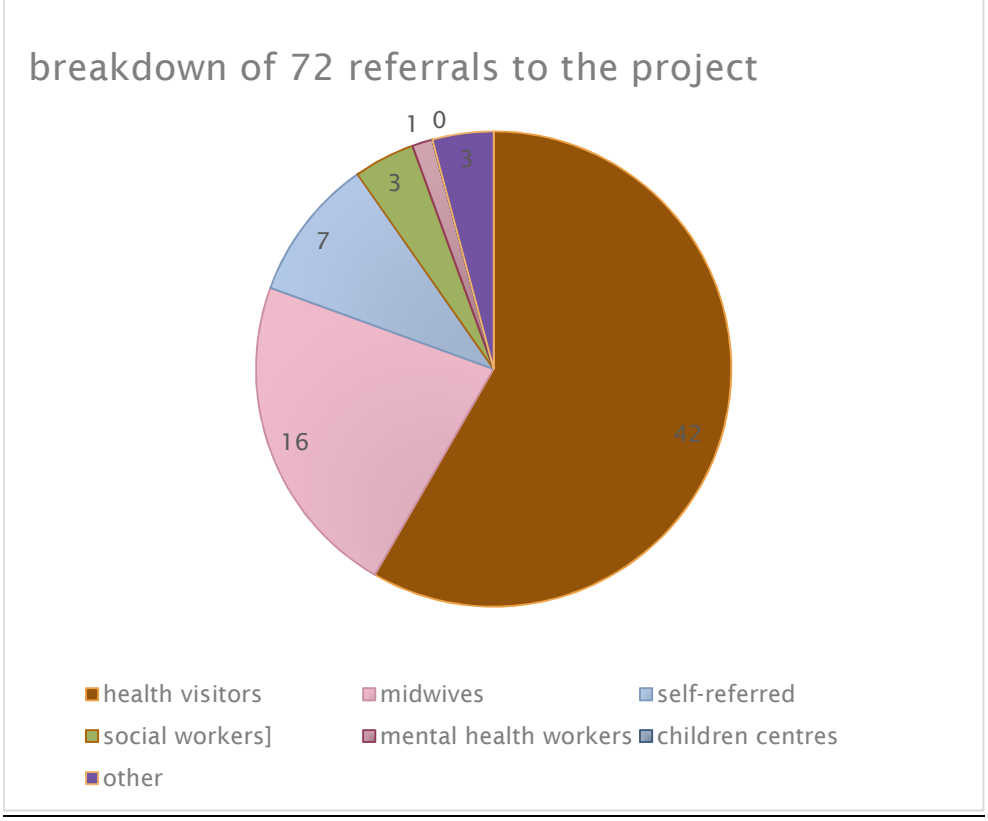
Information about our Mothers in Mind Programme was circulated widely to all health visitors, midwives, children centres and other organisations working with families in the Stroud District of Gloucestershire with a request for referrals. In the main, referrals were made in the ante-natal period by midwives and in the post-natal period by health visitors.

Table of all referrals received in year commencing 1st April 2016

104 referrals received in total (*This was a 10% increase on the previous year*)

72 referrals met our MIM's referral criteria (*from these 72 referrals we went on to accept and support 50 of these families*)

12 further families met the MIM's referral criteria but were based outside of the Stroud locality in the Gloucester locality parishes of Kingsway and Quedgeley *(that the scheme expanded into at the same time as commencing this perinatal project. Referrals only began to be accepted in late December in this area*)



Importantly:

The substantial increase in ante-natal referrals that we received from the Stroud midwifery team. Referrals went up threefold as a direct result of our project. Indeed the project enabled the development of a much stronger link between ante-natal support and Home-Start and this was a key success of the project. Not only did **ante natal referrals go up by 150%** but, also, one of our coordinators, a former midwife herself, became involved in helping run an ante-natal group with the midwives. This result shows that the project encouraged and fostered better joined-up community support coming together to better support local families in the ante-natal period.

We only received one referral from a mental health professional which would indicate the step-down pathway of support from specialist mental health services to community support needs further development.

In Kingsway and Quedgeley where our service started in January 2017[3], we have already received 12 referrals for women affected by perinatal mental health challenges in just over a quarter.

[3] The Clinical Commissioning Group funded Home-Start Stroud District for one year to extend its services into the Gloucester parishes of Kingsway and Quedgeley April 2016 as part of its commitment to providing supervised peer support to families.

Home visiting:

The home visiting element of the project used the Home-Start model of family support; trained volunteers (40 hours of basic training) visiting families in their own homes on a weekly basis for two to three hours offering non-judgemental practical and emotional support to help build families' confidence and ability to cope.

Emotional support focussed on providing a listening ear, reassurance, building confidence and helping to breakdown stigma around seeking specialist support in particular when mental health was affecting their abilities to parent. Practical support offered by the volunteers was very flexible to encompass the individual needs of each family including support with household management and budgeting, advocacy, and accompaniment to appointments, shopping and/or attending a baby or toddler group.

Volunteers work within a structured relationship (we sometimes describe it as a 'negotiated friendship') respecting a family's confidentiality and personal needs. They receive regular supervision and support from trained staff who carry out initial assessments with a family and then quarterly review visits to assess the ongoing needs of the family. We have stringent safeguarding procedures in place. The support is non-time limited in that we stay with a family for as long as is necessary. On average a family is supported for a year. We strongly believe that this is a very valuable aspect of our support as all other services can only offer a set amount of sessions or a time-limited support. Our experience shows us that many of the issues that families face from poor mental health to bringing up children with additional needs are events that can take a long time to overcome or to find the necessary resilience to cope better with what life throws up.

"What makes Home-Start Stroud District so invaluable it that they do not have a limit on the length of time they stay involved with families,….they get to know the families to ensure that the support offered is tailored to suit…" (Referrer)

For the Mothers In Mind project we followed our practice as above but enhanced the support by upskilling our staff and volunteers to better understand the issues around perinatal mental health and giving them some tools to better support the families with these issues *(see section 6 Training Needs)*. We were also able to offer the families additional services during this time including mental health wellbeing courses, mindfulness courses and a six week informal drop-in group. These additional activities are reviewed individually in this evaluation.

"Home-Start volunteers are great at helping families to access community groups…. and this piece of work is invaluable." *Children Centre worker*

"This 'whole family approach' with practical support, is crucial and I think we would be lost without it." *Funder*

Monitoring and evaluation of Home-Start support (MESH):

The support of these families was tracked through our MESH (Monitoring and Evaluation system in Home-Start), charting their progress and outcomes and providing systematic evidence to show the difference our volunteers' support can make to families. Home-Start staff help families to identify their needs and put in place practical and achievable goals. The volunteers support each family to make their changes. This way of working with each of our families is central to our empowering approach and demonstrating to families the changes they are making is a key part of the ongoing support offered.

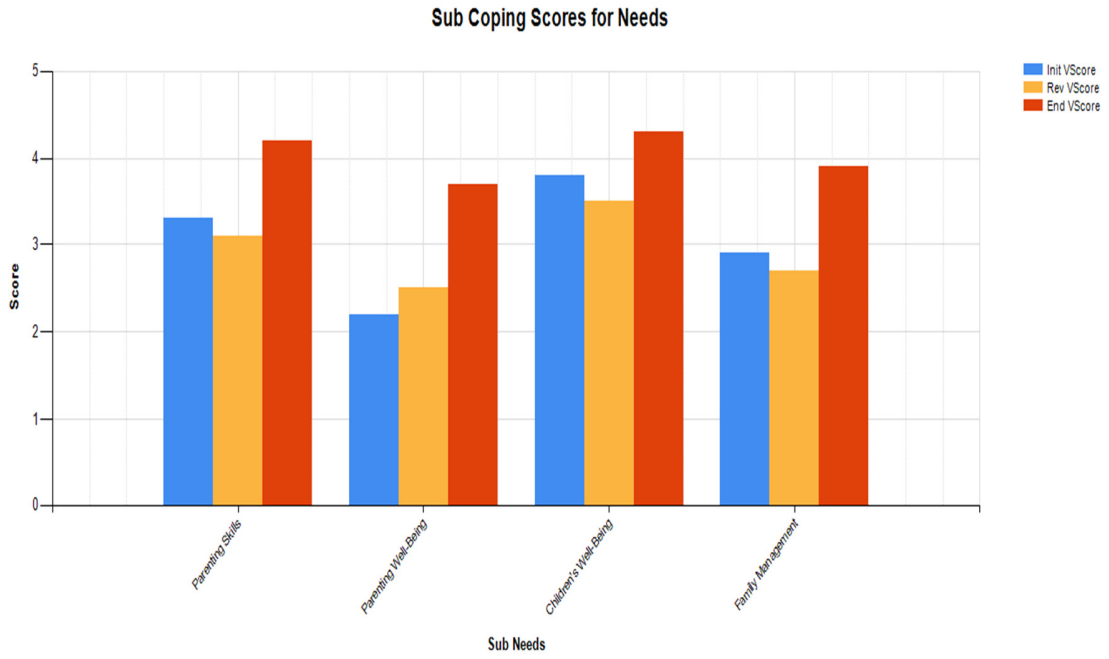
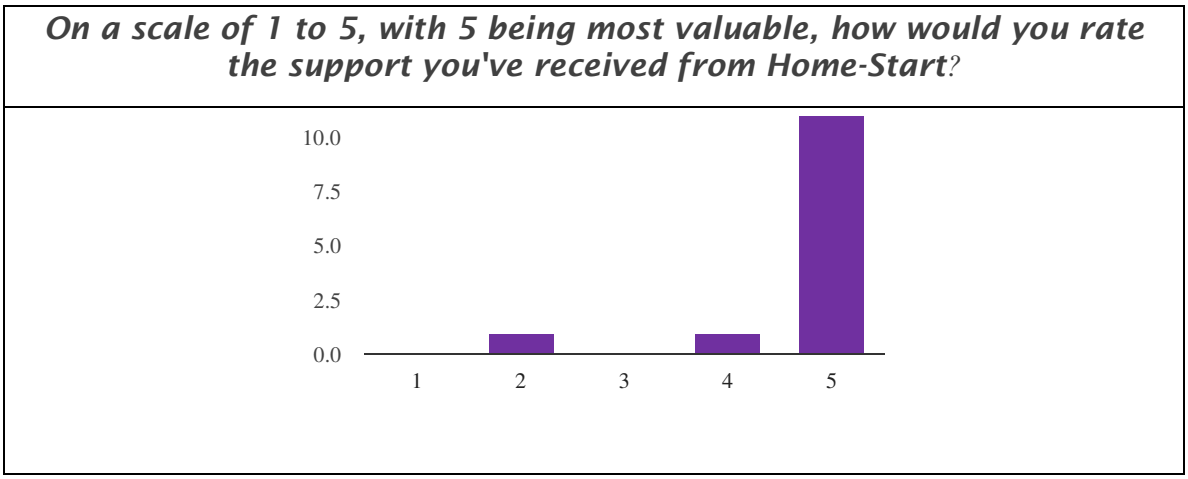


Chart shows initial visit score, review score and scores at end of support for parenting skills, wellbeing, children's wellbeing and family management

Experiences of home visiting support:



"I think having support has been great and has has helped me to stay with a positive attitude, helping with my motivation and encouraging me to become happier and healthier all round."

GAD7 PHQ9: (Spitzer RL, n.d.)

In addition we were asked to use the GAD7 and PHQ9 to screen for anxiety and depression. These same self-scoring systems are used by Lets Talk to measure the impact of their services.

Families referred into the project were asked by our coordinators as part of their initial assessment visit to complete the easy to use self-administered patient questionnaires GAD7 and PHQ9. Families were made aware that this was voluntary, would remain anonymous and separate from their other Home-Start records and was being done as an additional screening for our Mothers in Mind Project. Generally women were happy to do the questionnaires with the visiting coordinator.[4]

The scores for both patient questionnaires were surprising. We had assumed that the average scores in our cohort of referred women would be around the mild to moderate mark but in fact in both the GAD7 and the PHQ9 the average score for both depression and anxiety showed a level just above the scoring for moderate levels of anxiety in PHQ9 and depression in GAD7.

[4] *Where individual scoring levels were above 10 our coordinators emphasised the availability of the LetsTalk service and encouraged families to self-refer into the service or to speak to their GP or health visitor.*

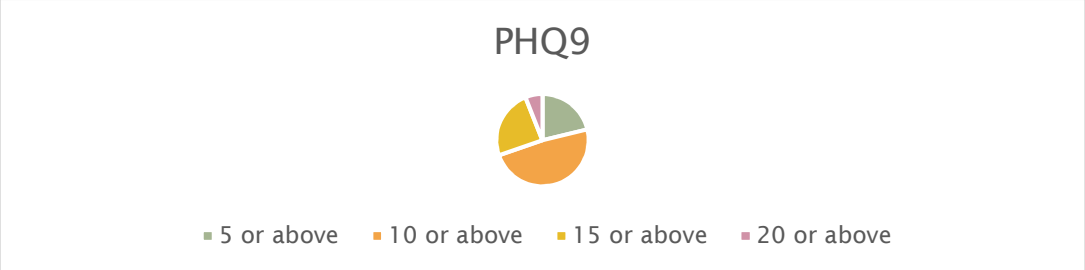
With **PHQ9** which screens for **depression** the average score was **11** *(just in the score range for moderate to severe depression)*

22% of women scored **between mild to moderate depression**

48% of women scored **between moderate and severe depression**

24% of women scored **between moderately severe and severe depression**.

6% of women scored **severe depression.**



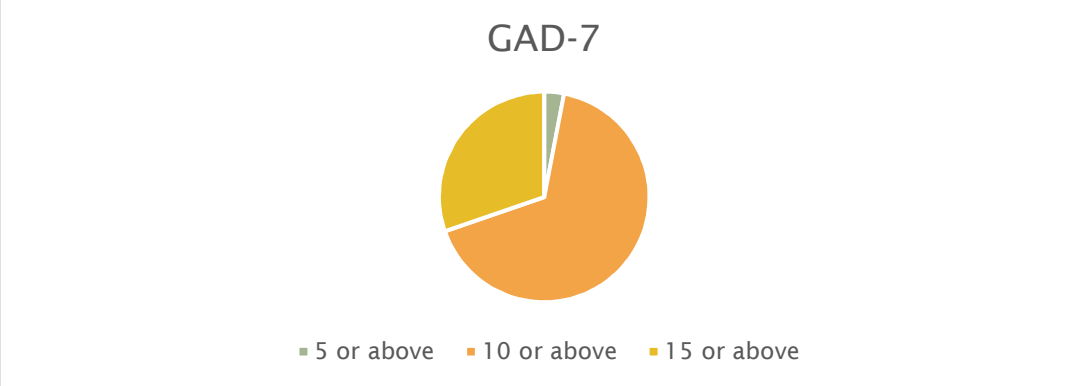
In **GAD7** which screens for **anxiety** the average score was 11

(When screening for individual or any anxiety disorder, a general recommended cutpoint for further evaluation is a score of 10 or greater.)

3% of women scored **between mild and moderate anxiety**

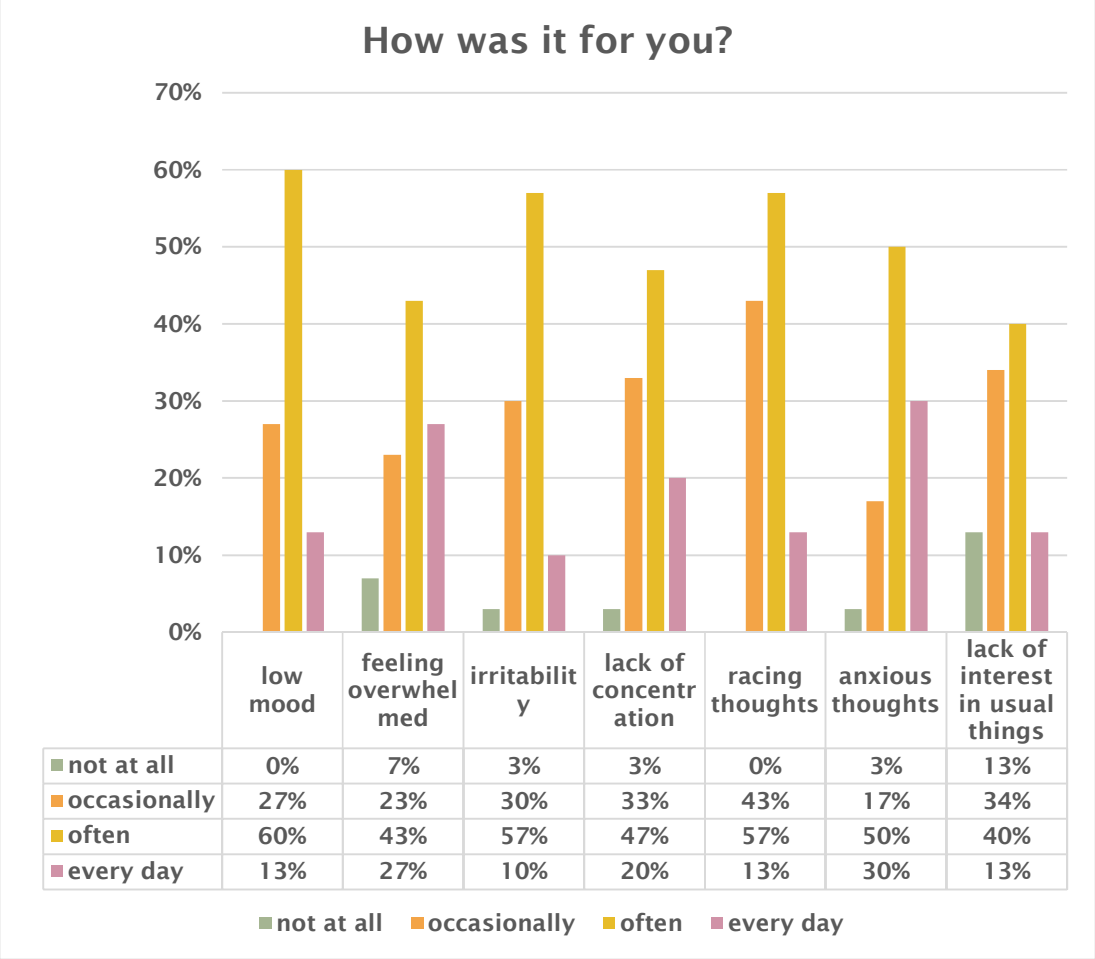
67% of women scored **between moderate and severe anxiety.**

30% of women scored **in a range that indicated severe anxiety**.



We also used the online questionnaire to gain further insight into the levels and type of women's mental health issues affecting the women we were supporting.

We asked women what particular areas of perinatal mental health had/was affecting them:



	low mood	feeling overwhelmed	irritability	lack of concentration	racing thoughts	anxious thoughts	lack of interest in usual things
not at all	0%	7%	3%	3%	0%	3%	13%
occasionally	27%	23%	30%	33%	43%	17%	34%
often	60%	43%	57%	47%	57%	50%	40%
every day	13%	27%	10%	20%	13%	30%	13%

The online questionnaire data showed similar scoring levels for symptoms of anxiety and/or depression

The following are some of the answers our families gave about their initial thoughts about receiving Home-Start support:

Main themes around concern in accepting Home-Start support:

NOT WORTHY	SOMEONE ELSE NEEDS HELP MORE THAN ME	HAVING A STRANGER IN THE HOUSE	HARD TO ACCEPT HELP

"I suppose that the nature of my mental illness made it difficult for me to accept help."

"I was sure there were other families that needed the help more than me. I wasn't used to having help, and find I it hard to accept help."

"Doubting that I was worthy of having support, do I really need to have it?"

"Having a stranger in my house but I was desperate… but she made me feel comfortable, she was warm, friendly and easy to be with."

" My Midwife referred me having told me about Let's Talk but I didn't want to call Let's Talk so she suggested Home-Start… my coordinator was lovely, and made it clear there was no pressure, I could opt out at any time…. When the volunteer started I had no idea what I was meant to do I had always done everything so was awkward letting someone else help me…. It took about 2 or 3 weeks before I began to feel comfortable"

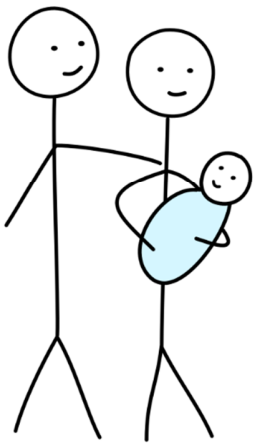
"Part of my anxiety issues were to do with scheduled times for things especially in relation to my daughter's unpredictable napping times. I hated the thought of wasting peoples time and also the feeling of being bound by something. The volunteer was very understanding and we worked it out to the point I look forward to her visits instead of feeling anxious."

" I don't really need help I'd be taking it away from other people who need it more. … but meeting my volunteer really helped, it was very relaxed."

"Didn't feel my needs justified having support & there were others more needy than me out there. This was overcome by Home-start's co-ordinator's reassurance & helping me realise I was worth the help."

"Worried about the state of my house and how nice my volunteer would be. I've learnt with 4 young kids my house will always be a bit messy! My volunteer is lovely need not have worried!"

You are doing a brilliant job.



(Hurrahforgin)

We asked what it is about Home-Start support that has been most effective:

Main themes around effectiveness:

FLEXIBILITY	NEUTRALITY	NON-JUDGEMENTAL	A LISTENING EAR	PRACTICAL HELP

Some of the responses:

"Simply that there was concern shown towards me and my welfare."

"Getting time to do a few bits that I can't do with kids under my feet and having someone to talk to about anything. This helped my anxiety levels hugely."

"The empathy and understanding of the service."

"The flexibility, patience & understanding of the Home-Start service helped immeasurably."

"Non-judgemental."

Contd/. (Effectiveness of Home-Start support)

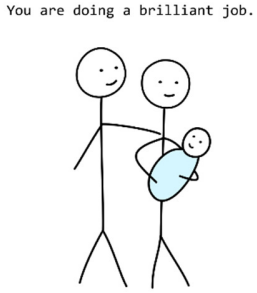
"The volunteer provides structure in visiting on a weekly basis."

"The flexibility of the support and being able to build a good relationship with someone I can trust with my children, who just see her as a friend who visits us."

"The relaxed way it works, not a set structure, flexibility and spontaneous."

"Having someone independent of family and friends, totally neutral, to talk to about things. She encourages me to get out, takes me to places, helps me with motivation and there is flexibility in what we do each visit."

"The flexibility of what the volunteer will do, sometimes we go for a coffee, sometimes she takes my son out for a walk…. What happens each visit depends on what is needed at that time volunteer reacts to what's needed."



Can you think of a specific example of when Home-Start support was particularly valuable?

Main themes around value of support:

- GOING FOR A WALK
- HAVING SOMEONE TO TALK TO
- EXTRA PAIR OF HANDS
- JUST HAVING SOMEONE AROUND
- REASSURANCE

Some comments:

"I definitely feel like my general ability to feel as if I was, or could, cope was increased, which made me a more relaxed Mum and person to be around."

"The co-ordinator of Home Start was brilliant .. so hugely kind, empathetic, on my wave length and supportive..."

"My volunteer came with me to a GP visit which didn't go well and it was good to have her there afterwards to comfort me and give me practical suggestions that really helped."

"Going for a walk and having someone to talk to rather than just a toddler for company."

"I suffer with chronic ill health issues and being able to leave my child with my volunteer whilst I have a shower or a sleep has been incredibly valuable."

"Regular visits providing an understanding ear."

"Having support with hair pulling ,trichotillomania, being able to speak to Coordinator and volunteer about it and get some help."

"Every week makes a difference because she's there for me and the children love playing with her."

"Gave me time to go out & walk & have a moment of mental freedom at a time when I was feeling very low."

What might the impact have been, on you and your family, if you hadn't had support from Home-Start?

"I'd have plodded on, probably withdrawn again and might well have got very low again."

"I would have probably been much more depressed & found it much harder to keep going."

"I think I would have been really run down and struggled to see any light."

"I had to wait for a volunteer and when she started visiting it felt like I was coming out of a dark cloud. Hard to imagine how it would have been without Home-Start"

"I was depressed in the past so it may have happened again and I could have become more anxious."

"I don't know that I'd be here necessarily without them and I mean that honestly, it really was a lifeline for me."

"I'd have continued to be isolated… Don't want to think about it."

"Life would be much trickier."

If you hadn't had support from Home-Start where might you have got help instead?

"Wouldn't have had any…."

"I haven't got a clue. Probably toddler groups, but that takes a lot of courage to initially take that first step and it was my volunteer who helped me with that anyway!"

My GP has been ok but you get 10 minutes with a GP and I know from having been one myself that you can't wave a magic wand…. These things can't be dealt with in 10 minutes can they?"

"Don't know. Let's Talk maybe but I didn't like the idea of help over the telephone."

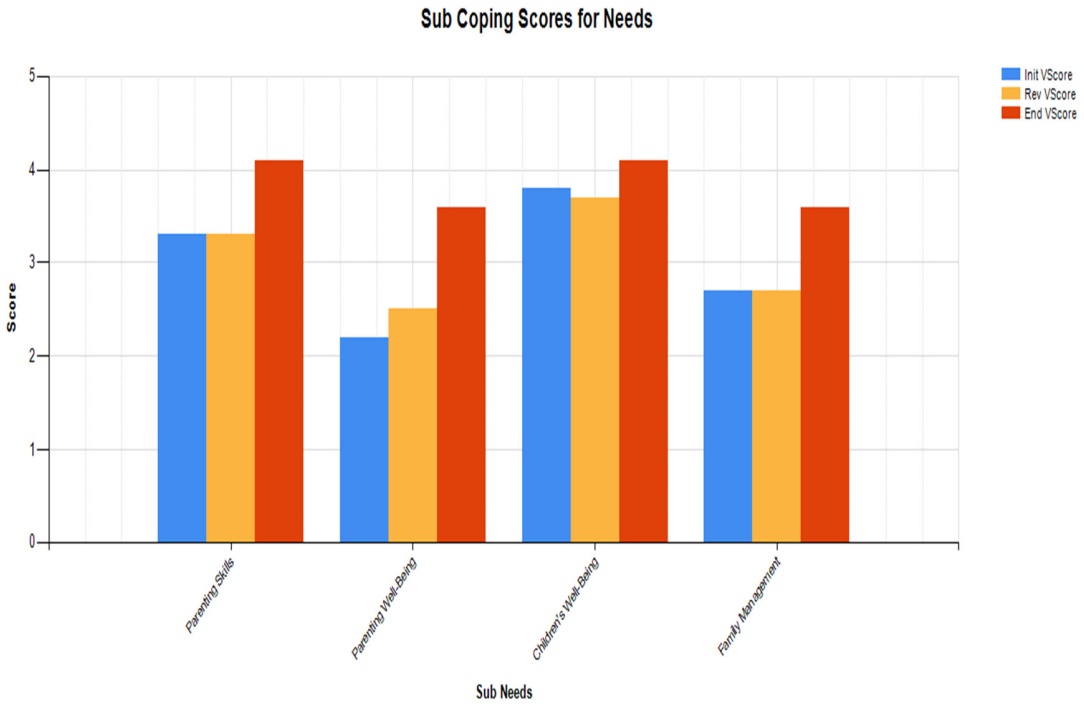
"I doubt I would have had or been offered any other help, so nowhere…"

Two Case studies of women supported by the project

(names have been changed to protect identities)

Celia

MESH scores diagram – journey of change



GAD7	at start of support score: 15	at end 11
PHQ-9 Depression	at start of support score: 21	at end 11

Celia and her daughter were referred to us by their health visitor when her daughter was nearly 12 months old. Although she was concerned about the referral she recognised that she needed support:

"Yes, it was a case of I felt like I wasn't coping and normally I coped… At the time I was in a bad place … I needed to try anything that would try and make it better. I was willing to try because I was so desperate… Chronic mental and physical ill health with a toddler is really difficult…Her growing needs were becoming more obvious … how was I going to manage parenting? How am I going to do this? …I was in a really funny place…"

When asked what worried her the most about a referral to Home-Start she replied:

"Invasion of privacy, having a stranger coming into my home, fear of the unknown really, what you are all about…"

This is a common fear for any family referred to our services and our staff are always mindful of the bravery of a family to accept the offer of support. During the volunteer training course volunteers learn about how it feels to be visited by a stranger and we explore the dynamics of asking for help. Volunteers are trained to work from the premise that they are invited visitors going into a family's home. When asked how Celia's concerns were overcome by Home-Start she replied:

"The coordinator came in first and made me feel very comfortable, I didn't feel like she was invading my space. She was very warm and friendly and homely…. very easy to get along with - her whole perspective, persona made it a lot easier."

"She did initial assessment and came back with Julia *(volunteer)* and Michelle (*a new coordinator who was introduced to Celia with her volunteer by original coordinator due to changes in staffing*). If I remember rightly, I think, one sat on the sofa with me and 2 sat on the floor, so where they positioned themselves it wasn't intimidating to me. They came into my home and 2 went to lower level and one remained high, so wasn't so intimidating… Three people descending I didn't know - was nice how they positioned themselves in my home- made it quite easy."

This comment from Celia is an important one: our staff and volunteers receive a lot of training around communication skills including body language, listening and empathy. This example shows that intuitively the staff and volunteer functioned in a way that made the first visit feel easier for this mother.

When asked about what was the most effective thing about our home visiting and the way we work, Celia replied:

"Very relaxed way of going about things - volunteer comes in … and suggest things I hadn't thought about, sits and play with my daughter, or talk to me. All very relaxed - there's no structure unless you want to put the structure in - sometimes we plan ahead, sometimes we don't - spontaneous…. Different things, different days - - I can arrange my appointments and we fit around each other. We can do what we both need to do separately and incorporate each other into our lives.
It doesn't feel rigid and cold because of the flexibility. Some weeks I have nothing and other weeks I'm busy every day. That flexibility works for us."

Again Celia is describing one of the fundamental strengths of our home-visiting support. It can be as flexible as it needs to be to meet the differing needs of families. For some, an unchanging weekly time slot can bring structure, permanence and solidity to a family's life. The volunteer may be the only structured event of a new mum's week and having a particular day and time to expect their volunteer can be hugely positive. For families like Celia whose week is often shaped by different health appointments for both herself and her daughter, a degree of flexibility has meant that Celia has not

felt stressed about fitting in around her volunteer's needs rather than her own. However, there is an awareness in the relationship between a family and a volunteer that the volunteer gives their time freely and will do their best to accommodate a family in terms of times of visits but not when it impinges on their own life. This is part of building up strong boundaries for volunteers and to make families understand why they are in place.

We asked Celia about specific examples of practical support offered by our service:

"I have difficulty with little things like showering so it was nice to think that I had time to get on with it with... no pressure so I could relax in the shower… In my own little water bubble… She was just like 'go and do that'. On other occasions, she'd let me have a sleep if that's what I needed. Nice but easy things, taking pressure off. Letting me do what was necessary at the time, on that day."

Practical aspects of Home-Start home visiting are an important and valuable part of the support offered to women affected by anxiety and/or low mood. This was cited by many of the women who responded to our questionnaire and to women that we interviewed.

We asked Celia what things would have been like over the last year if she had not had our support;

"I don't want to think about that, if I am honest. I dread to think what would have happened, I was not in a good place. I don't even want to think about it.

We explained to all families that got involved in the project that we were keen to share both good and bad experiences that families had had with different professionals through their perinatal mental health challenges in order to help future awareness in professionals and to improve services.

"My first health visitor started asking me really personal questions that I didn't want to talk about … it felt quite uncomfortable at the time - she kept pushing, and really upset me. I changed health visitors - and that's how I got Home-Start. The first one was probing and pushing and asking lots of difficult questions at that time and I was angry at the time. She could have asked them in a better way, thought a bit more before she asked what she asked - asked in a different way, very insensitive. To me it came across like that - maybe to her it was completely normal - I was vulnerable at the time. It felt attacking… Maybe it wasn't how she intended it but it was the way I interpreted it. It was horrific.

Celia's experience with her 2nd health visitor was very different and far more supportive:

"My current health visitor has been fantastic. Really supportive, house visiting, referred to Home-Start, got help with things I needed in the kitchen, been fantastic, really different and people friendly approach, Very different to the first one. More sensitive. We've bonded quite well.

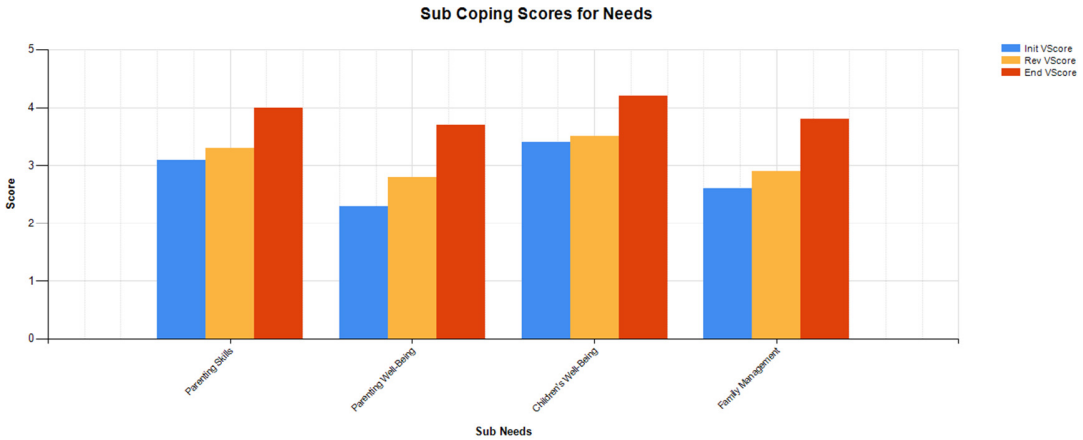
Celia has been an important and committed member of our mum's focus group and the running of our pilot drop-in group sessions that ran in October 2016. She also accepted to be referred into the CBT Wellbeing course by her coordinator which is an example of how by gaining the trust of the family Home-Start are able to make opportune referrals to mores specialist mental health support that families would not normally agree to. We asked her about her experience in general of the Mothers in Mind Project:

"Support from Home-Start has helped me manage and cope better. I am now doing the emotional wellbeing course run by the project and Let's Talk, I have been coming to the Mothers in Mind drop-in Groups… Expanding out!"

"If my coordinator had just given me the Let's Talk number then I wouldn't have picked up the phone - but she put me forward (*for assessment*) and they contacted me - the way it happened enabled it to happen … and because they called me … I wouldn't have called. I wouldn't have picked up a phone, or looked at a website …but people have reached out to me and brought it to my attention. I had no choice as Home-Start referred me to Let's Talk - I didn't have to speak to Jayne (CBT therapist) but then I thought let's just go with it. She was pleasant on the phone so obviously I've gone with it … and there are more options open to me that I didn't know about. I might progress onto others…"

Sasha

Sasha was referred to us by her health visitor with perinatal mental health issues when her daughter was three months old.



This family were not screened for GAD7 and PHQ9

Did you know about Home-Start before?

"I probably thought it was something to do with selling houses or something! I had a very good health visitor, I was very very lucky as she was the one that made the referral to Home-Start and they were an absolute lifesaver… maybe

I'm putting it a bit strong… but maybe not… here it goes: I don't know that I'd be here necessarily without them and I mean that honestly … it really was a lifeline for me.

How it was different from statutory service?

"More than anything it was the regularity of the visits that helped … providing structure in a week and somebody that you could really talk to.

"The support is not set in concrete and it depends how the relationship is going whereas if it was a statutory organisation the rules would be absolutely set in concrete.

"It's just that comfort blanket it provides, one of the reasons aside from mental health problems was that we have no family at all nearby. For me that was a huge thing, to have that feeling of 'oh my goodness what happens if' …. And that I could ask for help from someone I really trusted. Knowing there is a person who knows you and the baby, that for me was very important.

"One of the other things that I thought was very good about Home-Start and I don't know whether it was done intentionally but I was matched with a volunteer who had a fairly similar background to myself and that for me was a wonderful sounding board because she understood about my past career and some of the issues. I don't know whether it was a conscious decision, I have no idea and something I've never asked actually."

Here Sasha turns to a very important aspect of Home-Start's method of support and that is the matching process. It is really important that coordinators make a good match between family and volunteer. Coordinators are trained to make good solid professional judgements on whether a volunteer will work well with a family. If there is a feeling that it won't work between the two then we will turn away the family or refer them onto another source of support wherever possible but we will not place an ill matched volunteer. To work, the 'negotiated friendship' must have its base in some kind of mutual interest, experience or a 'gut feeling' by the coordinator that the family and volunteer will 'get on'. Sasha did indeed 'get on' with her volunteer and this was a base from which the relationship could develop into being such a powerful form of support for Sasha. Many volunteers remark in their feedback and evaluations that they are always surprised how well they are matched with families.

Sasha suffered a breakdown after the birth of her first child. She came from a professional background which had been very stressful for her and led to a form of post-traumatic stress disorder:

"I've always had OCD obsessive tendencies but I began to have terrible OCD. Everyone jokes about OCD, and it's the butt of many a joke, but this has been something that has really really put a shadow on my life. I know everyone jokes about it but it's not funny… I was at my worst shortly after my daughter was born. She was unfortunately one of those babies who decided not to

sleep. I got very very sick and ended up at a psychiatrist and was probably far sicker than they actually assessed. I sort of functioned but only just, I put a brave face on a lot of the time and there was very little they could offer me really. I'm obviously on medication and have been since my daughter was very little but I think if you are seen to function there is little they do."

"If I did not have the support from Home Start where would I be now? I really don't know. I'm not sure I would be here now… It's been difficult I have to say. I think one of the things about becoming a mother is it makes you reflect a lot on your own upbringing and you suddenly realise what you want to give to your child and how you want to be a mother to them and if you haven't had that then it sort of all comes tumbling down a little bit."

Sasha has now ended support with Home-Start. She was also a member of our focus group and helped enormously with the drop-in group and the design of the leaflet.

Costings: How much does it cost to support a family through Home-Start home visiting?

To support a family for one year through monitored home visiting of a trained volunteer costs approximately **£1400 p.a.**

That's £120 per month

Which is £30 per week

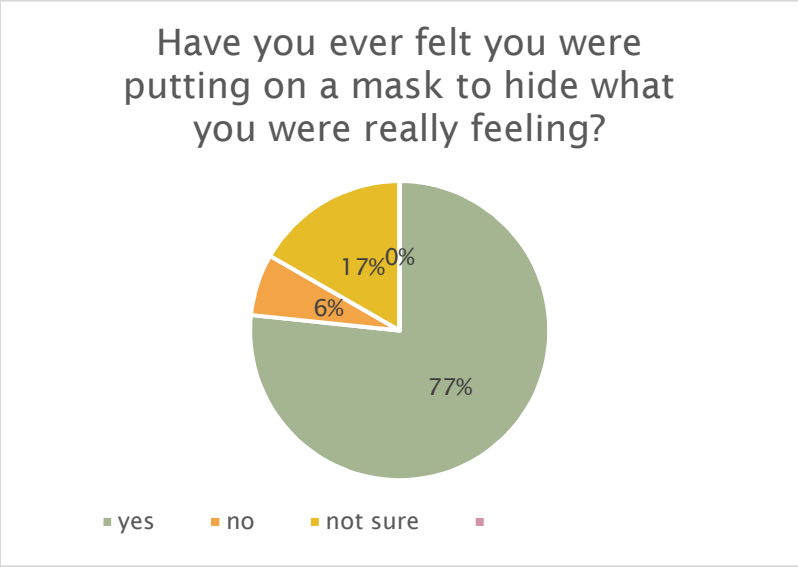
Which is £15 per hour (That's a total cost of £15 per hour face to face support)*

*A full costings sheet can be found in the appendix of this report**

2 Stigma and Attitudes to Mental Health

30 families responded to our online questionnaire which included a section on stigma and attitudes to mental health. 27 of these families were currently being supported by Home-Start and 3 had recently ended support.

Wearing a Mask: 77% of of mums said they had put on a mask to hide their feelings:



"I am mindful of how people put a face on because I completely and utterly acted a part for so long and it was absolutely exhausting."

50% of women agreed with the statement:

'If I admit to having mental health problems I'm worried my baby/child may be taken away'.

"Why I took so long to ask for help was the real fear that I would be deemed unfit to look after my children and labelled 'mad' or 'crazy'."

"I am lucky as I can be very open with my friends and family. I have had anxiety before, and since then I have come to appreciate how important it is to get the support of those around you."

"Anxiety has affected the way I have been able to bond with my son for fear of terrible things happening."

"Depression has made everyday tasks monumental and caused me to doubt all my abilities and decisions. But no one around me would have known it."

SOCIAL STIGMA

53% agreed that mental health issues are seen as a sign of weakness.

70% agreed that most people are often ashamed to talk openly about mental health issues.

56% agreed that 'poor mental health is not something that happens to people like me' BUT 83% agreed that having mental health issues is nothing to be be ashamed about.

90% of women agreed that it was very important to address the stigma around talking openly and honestly about mental health.

"Where I come from in America, people are fighting hard to remove the stigma and multiple cases of women who people would never have guessed to have suffered from postpartum depression have killed themselves and their families are speaking out. It is becoming safe to speak out and share as more people open up and speak out and doing this here will save lives and families."

THE LANGUAGE OF STIGMA

We asked women which terms they would prefer to be used when talking about perinatal mental health:

20% suggested perinatal mental health issues

25% suggested perinatal mental health challenges

10% suggested poor perinatal mental health

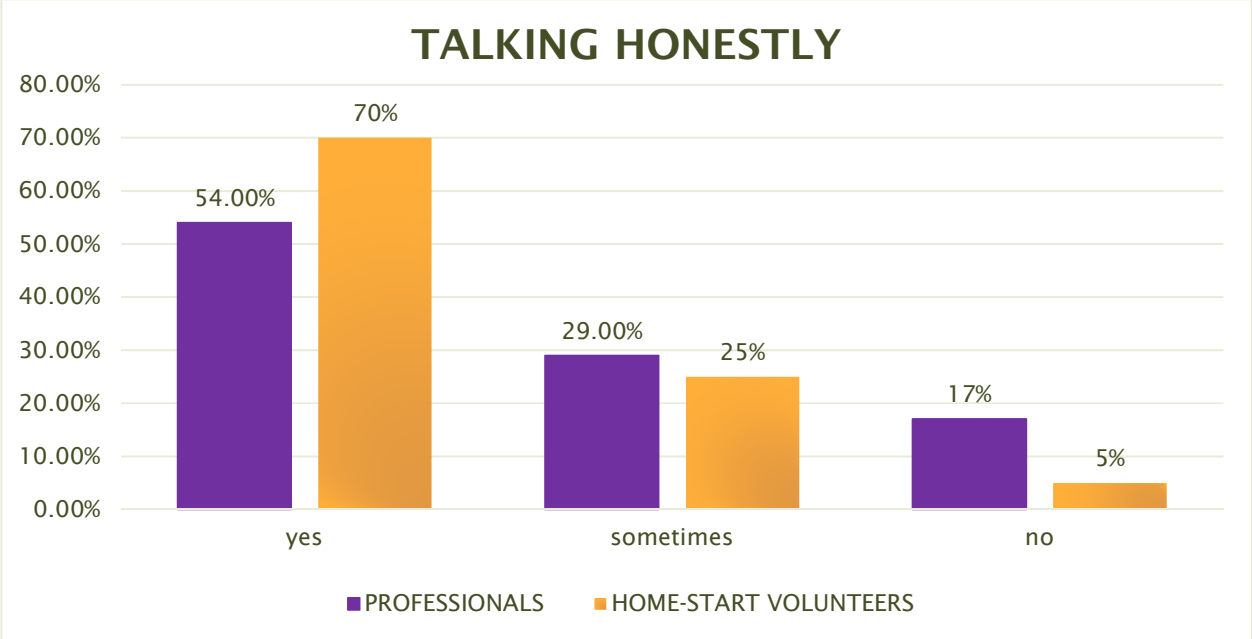
55% had no strong feelings about the terminology

70% agreed that they find it easier to talk about suffering with 'anxiety' or 'depression' rather than to talk about 'mental health'.

" Having 'Perinatal mental health check-ups' would be a positive way for professionals to approach pregnant or post-natal women."

Stigma around talking to professionals

We wanted to explore why it is that women find it difficult to speak to professionals about their mental health in an open and honest way. We asked if they had been able to be talk honestly with a professional (either midwife, health visitor or GP) and with their Home-Start volunteer:

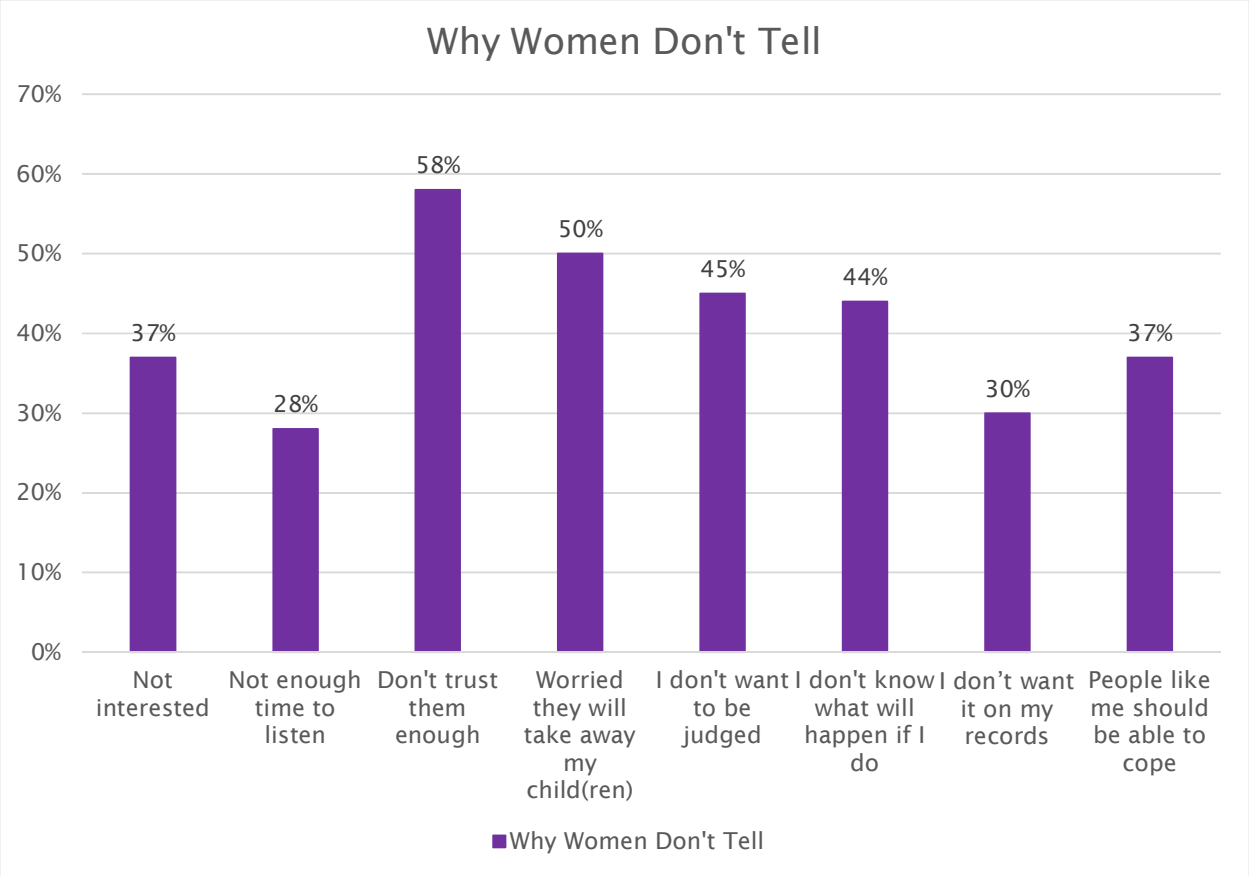


These scores indicate that families are more likely to talk to their volunteers about their mental health than to other professionals. This is not surprising as the enduring non-judgemental and non-statutory nature of our support makes it easier for families to confide in their volunteers. However, importantly, and a key point to the project, is that the volunteer is in a position to support the mother to seek professional help from either her GP, midwife, health visitor or Lets Talk. This is a crucial link to creating a pathway between specialist services and community support and a central component to the efficacy and value of a volunteer home visiting model of support.

If 46% of women have not been able to be completely truthful about the state of their mental health, then professionals must strive to better understand, reflect upon and approach these women in a way that will make it easier for mothers to be honest with them.

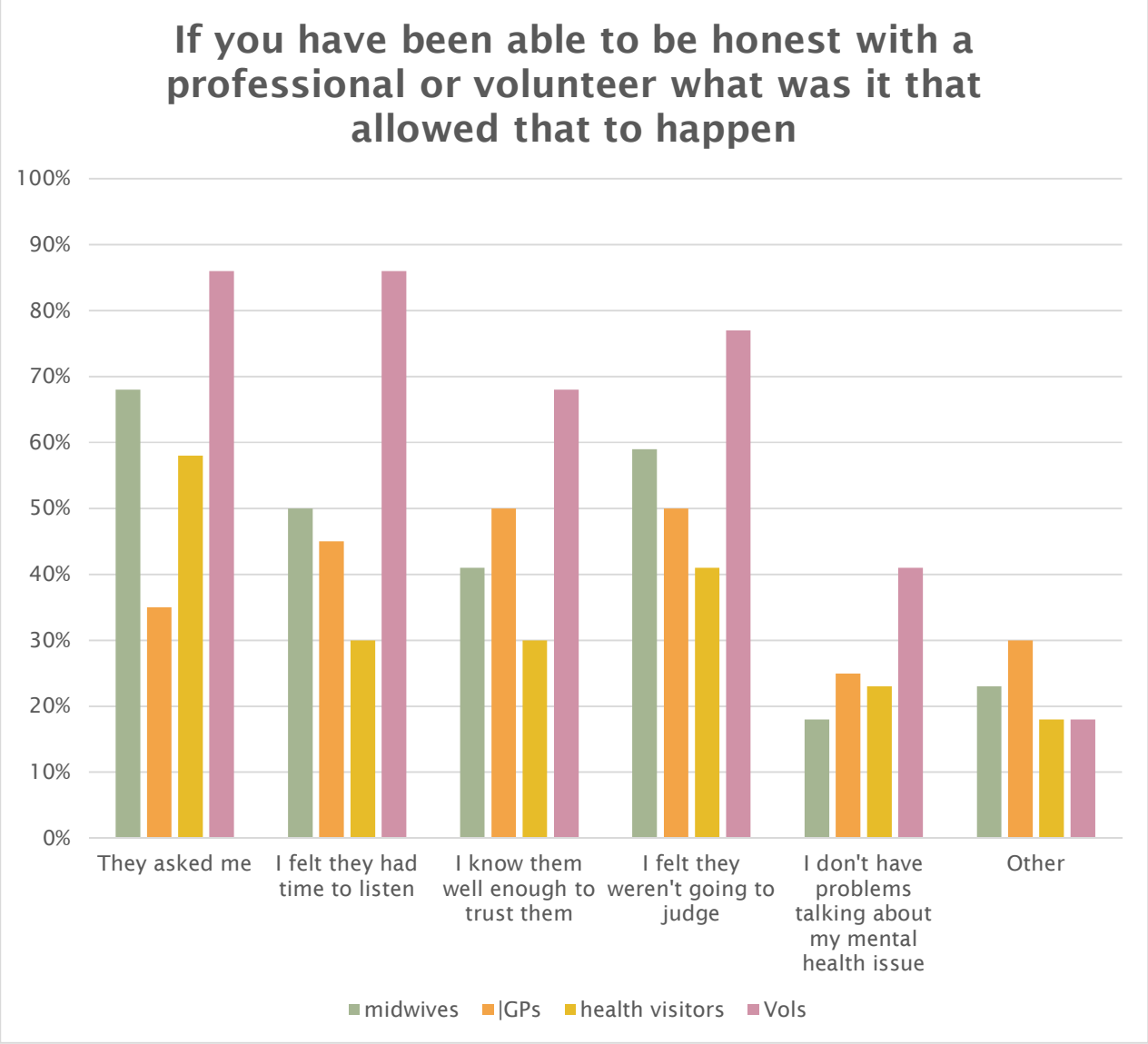
WHY WOMEN DON'T TELL –

We asked the women who had not felt able to talk to a professional (midwife, health visitor or GP) about their mental health what is was that stopped them:

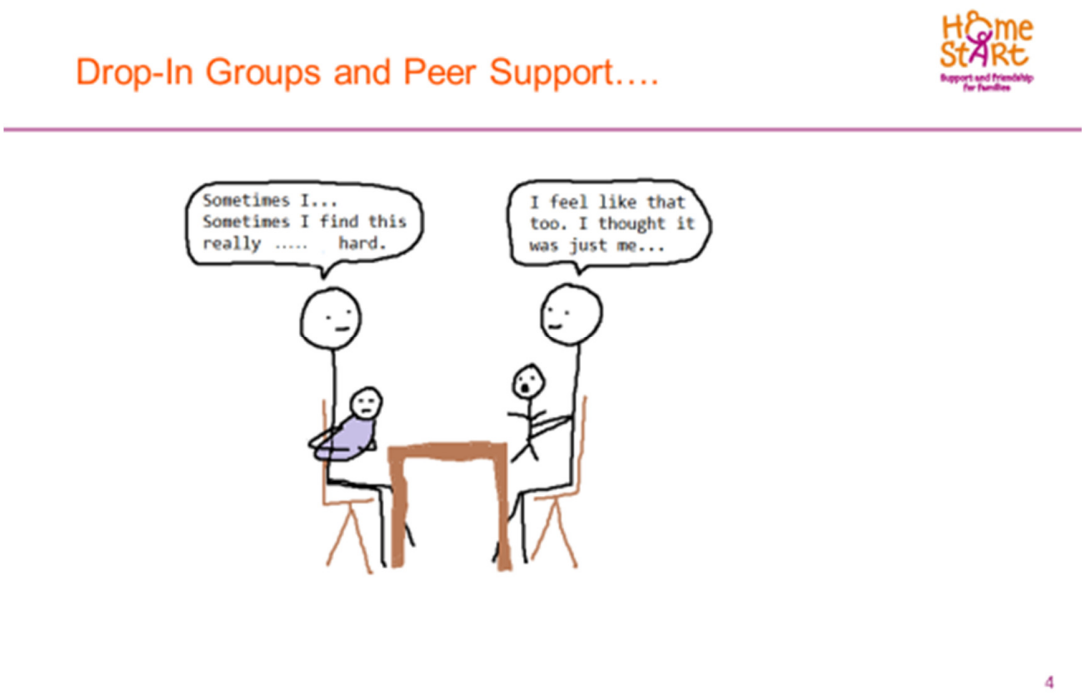


WHY WOMEN DO TELL –

We asked the women who felt they had been able to talk to a professional (midwife, health visitor or GP) or volunteer about their mental health what is was that enabled them:



3 Women's Focus Group, Drop-In Group and developing Peer Support



The focus Group:

The development of the drop-in group began from a Focus group of local mums who had personal experience of perinatal mental health issues.

From April through to September we ran monthly meetings looking at what we wanted to achieve in our Mothers in Mind Project which included the development of a pilot drop-in group and to shape an information leaflet which we wanted to produce to give information and reassurance to new parents in the Stroud District. Meetings were held in our office in an informal manner. Women were able to bring their children if they needed to and the group was supported either by a volunteer or a member of staff.

The focus group was extremely valuable in shaping the project as a whole, the questionnaires, the leaflet, the drop-in group and the exploration of online peer support.

The Drop-in Group:

We encouraged some of our focus group mothers to take on an active role in helping to run the drop-ins. We wanted to create a space to promote peer support in an easy and non-threatening manner through a six week pilot support group. The group took place in a friendly family orientated community Centre (The Arkell, Forest Green, Nailsworth) which Home-Start has used previously for events. Only families being supported by Home-Start were invited to attend. Sessions ran for two hours and families were invited to come at any time during the two hours and to stay for as long as they wanted to.

Informal conversations and group discussions were facilitated by one of our volunteers. Some families were brought along by their volunteers, they then stayed for the session helping and chatting with other families and playing with the older children.

Learning points to develop included a strong recognition by the families themselves that having a volunteer accompanying them to the group helped them cope with the social anxiety they felt attending a group and the fear of being judged by other parents. There was also the practical aspects of getting to a group that were overcome by the support of a volunteer.

The pilot group explored different activities around improving wellbeing including crafts, coloring in and music. There was a general agreement that it could be a good link between community support and specialist mental health services if mental professionals might visit the groups as a guest to informally chat to women who needed some specialist guidance or help in referring into a specialist mental health service. Or, it was also suggested that they might lead some short wellbeing workshops as part of the drop-in groups on an occasional basis.

Future Provision

Following the success of this pilot, the Gloucestershire Clinical Commissioning Group have funded Home-Start Stroud District for one year to run two groups the Stroud locality. They will be Mothers in Mind perinatal mental health drop-in groups run on a similar basis as discussed above. It is hoped that there will be involvement from some of the women that got in involved in our focus group to give peer support and to run a closed Facebook group as additional online support for women who attend the groups.

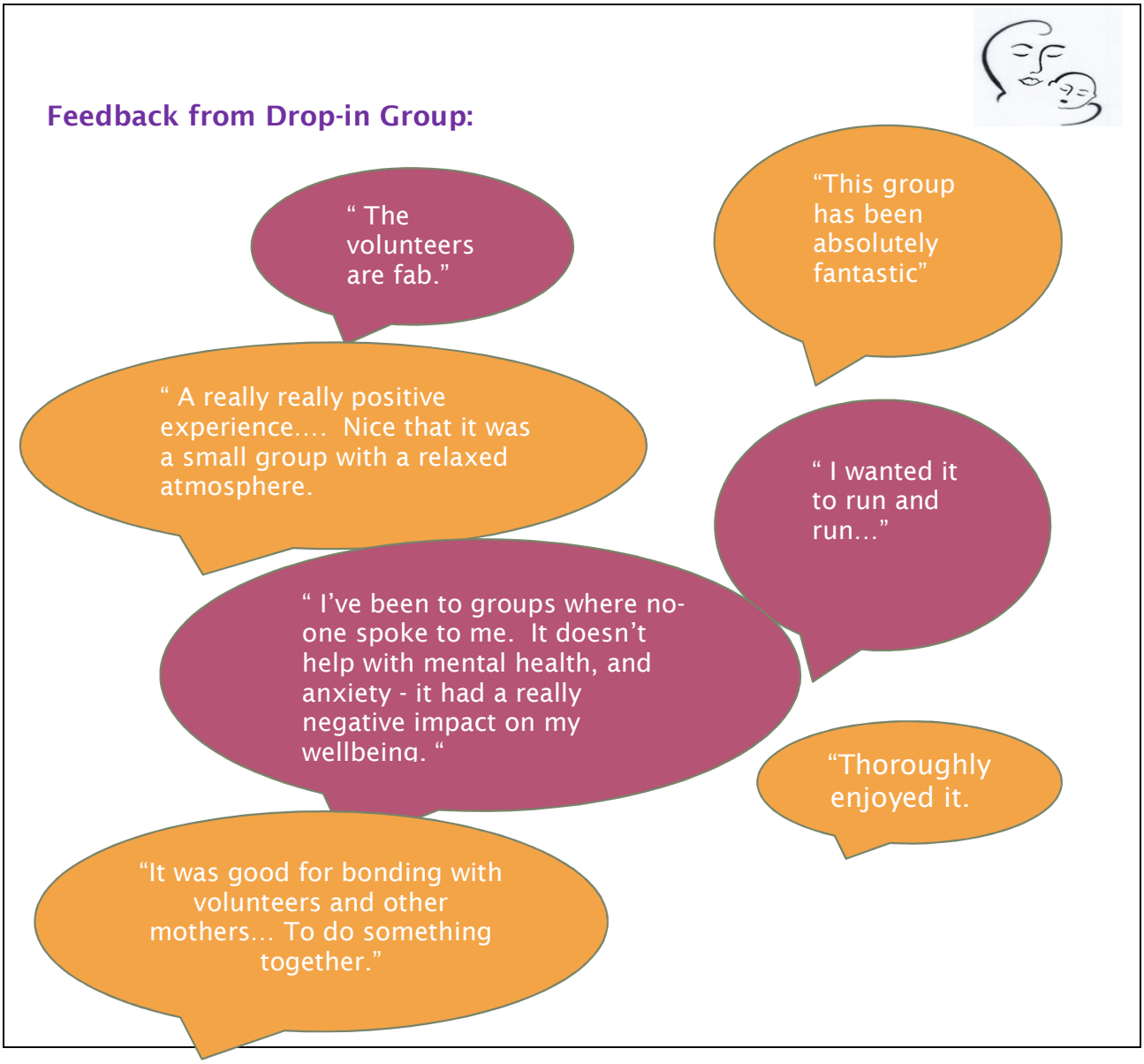
We will be recruiting for a specialist group worker to run these groups in the very near future.

Groups will move around the locality running for six sessions in each place.

Costings

Costings to run six sessions (one term) of a drop-in group in a community venue:

Room rental/group facilitator/volunteer expenses/refreshments/Management and supervision/administration = approximately £1200 per term, over one year £3600



Developing Peer Support:

Online Peer Support

Early on in our MIMS Focus Group there was a clear consensus that online peer support was something they had all found helpful at some point during their own experiences of perinatal mental health challenges.

Online peer support is like face-to-face peer support except that women contact others through computers, or other electronic devices, and can interact virtually.

There is the obvious factor that they do not have to leave their home in order to get support, which has practical advantages for pregnant women and new mothers ("rather like a Home-Start volunteer visiting you at home" said one mum). It also has practical advantages for families facing rural isolation and poor transport options. Online peer support for parents can have similar benefits to face-to-face support (Moore, 2016) and is available through forums (also known as message boards or online support groups), online chat rooms, personal messaging, email and various social media sites, such as Facebook and Twitter. These online communities allow people with similar health concerns to connect with each other. They can be quite general, for example 'antenatal and postnatal mental illness', or more specific, for example 'birth trauma'.

Women can read forum posts and start and/or contribute to existing conversations, or threads. Visitors sometimes have to sign up to become a member, but this rarely involves more than creating a password, supplying an email account (normally not visible to others) and agreeing to the forum terms and conditions. Twitter supports online communities such as one run by Rosey, a survivor of perinatal mental illness. Women can access each other's posts, or 'tweets' by creating a Twitter account and either including the tag #PNDChat in their posts or by replying to others' posts. Contributors vary from current sufferers to recovered women, and healthcare professionals often participate.

Some forums offer support day and night and are easy to access through a wide range of technology, such as computers, mobile phones and tablets. Some women find it valuable to have access exactly when they need to, for example, while out, or in the middle of the night when other forms of peer support may not be available. This is particularly important if there are no available resources in the local community or if they are waiting for professional help.

> 'Often women are left waiting for formal support/therapy such as counselling etc. so having access to online peer support can really help bridge that gap and offer hope for recovery.'
>
> **Rosey @PNDandMe**

Again the majority of the focus group said that they had felt supported even if they had not actively posted online; they had benefited from just knowing others were there should they wish to ask for support and that there were others going through similar things. One of the most commonly cited advantages was that they could

access information and support from others without being identified. Anonymity was valued as a way to overcome mental health stigma in order to seek peer support.

With this valuable feedback and with some online research done by the group we included some online sources of support in our Mothers In Mind leaflet.

Future Peer Support

One of the core members of our focus group expressed an interest to help us run a closed Facebook group as part of our ongoing Mothers in Mind work. This is something we hope to develop with her, under the supervision of one of our members of staff, to run alongside our Mothers in Mind Drop-In groups that will commence in summer 2017 having been commissioned by the Clinical Commissioning Group.

4 Mindfulness

Mindfulness for Parents Course Review for Home-Start Parents

This course did not finish until 29/03/2017 – Therefore a full evaluation will follow from the Oxford Mindfulness Centre who match-funded Our Mothers In Mind funding from The Coventry Building Society and the Summerfield Trust – This interim report is written by the facilitators Donna Morris and Claire-Louise Symonds

Introduction:

Due to the needs of the parents wanting to attend the course (anxiety and depression) we tailored a Mindfulness Based Course to specifically meet those needs. We therefore used material from Mindfulness Based Cognitive Therapy and Mindfulness for Parents courses. (J. M. Twenge, n.d.)

As a result there was a good flow to the sessions and course as a whole but there were some sessions that felt quite full for the time allocated.

The Aim:

MPCP will support vulnerable parents to manage their own mental health and connect with the joy of parenting. [5]

The Objectives:

1. **Perinatal with identified mental ill health –with crèche**

Using MBCT and Mindful Parenting practices to support parents to break destructive intergenerational parenting cycles.

To better understand the role of mindfulness for parents and its effect on:

- Perinatal stress
- Parental mental health
- Parent child attachment and attunement

The Outcomes:

- Manage anxiety, depression and stress more effectively
- Improve their emotional regulation and resilience
- Improve family communication and relationships

Facilitator Reflections

What is going well?

- We ran a taster session for Homestart volunteers to inform them of the course and appropriate referrals.
- Homestart volunteers initially recruited 15 participants. 10 of whom started the course.
- We produced course booklets, DVDs and weekly emailed notes and practices to ensure full accessibility of home practice resources.
- We have collated pre course measures relating to our aims and intend to capture this post course, along with follow up interviews
- We decided to add a morning of practice in place of the retreat day, to help embed the practices as these participants would not otherwise be able to access this due to childcare issues.
- We are running with a group of seven parents on week 7.
- We have had to be very creative and flexible with our practice delivery in order to be able to support anxious participants to be able to access mindful embodiment and therefore be able to move towards difficulty.
- Participants have described feeling safe and supported within the group and trusting of facilitators. This has enabled them to take risks to manage their anxiety, depression and stress in a new, unique way.
- Participants have described adapting and using these practices with their children and partners with great affect, therefore improving parent child attachment and attunement as well as improved family communication and relationships.
- We are now collaborating effectively with Exeter University to externally evaluate the course findings.
- The Bristol branch of Homestart are now interested in bringing mindfulness to their volunteers and parents as a result of this work in Stroud. There is real interest in this work but current financial constraints are a real barrier.

What are the challenges?

- We started with 10 parents and have had three parents dropping out due to children's illness.
- There was no taster session run for the participants themselves and this may have had an impact on attendance rates.
- MPCP did not have access to communicate with the course participants prior to the running of the course. So pre course questions or concerns not able to be ironed out through that process.
- Weekly attendance has been affected by children's illness so we have had a floating population for first few weeks of the course.
- The complex individual needs of the participants demanded individualised responses, which required further adaptations.

How have we managed them?

- We have had to do weekly 1:1 catch up sessions via phone and email to ensure participants were all kept up to date and able to continue with the course.

- We devised individualise responses in the group, through the evaluation process and 1:1 support.

Plans for next steps

- Practice session to take place 30/3/17

What we learned thus far

- Question the time of year for running these courses in relation to children and illness.
- The importance of a taster session for participants rather than being recruited by volunteers
- The importance of pre course meetings to get to know the participants in advance of the start of the course.

Participants' progress regarding own goals:

0 = no progress, 10 = maximum progress

Parent 1:
Parent's Goal: +5
Child's Goal: +5

Parent 2
Parent's Goal: +7
Child's Goal: +7

Parent 3
Parent's Goal: +5
Child's Goal: +6

(full progress goals from all participants still being gathered)

Participants' Comments:

"Higher awareness of my children and what they are saying and doing and using Rift and Repair has been very powerful and changed the dynamic with my younger child in a very positive way."

"The 3 Step Practice has been really helpful in work as it helped me to refocus and think clearly when feeling overwhelmed by my workload"

"Brilliant course with amazing facilitators. It will absolutely increase your parenting skills and your quality of life."

"I used mindful walking with my children by sneaking round the house together like we are going on a bear hunt and also used "I hear with my little ear" – both used to calm situations with myself and my children. Rift and Repair was useful"

"Really has been a wonderful and useful experience. It has given me the opportunity to explore my own feelings in a way that I never thought was possible."

"Thank you I am so grateful for your teachings over the last 8 wks. I've experienced lots of therapy before and that included mindfulness. However, I was never able to find something that worked for me. Now, thanks to the both of you, I am able to find ways to help calm myself, and my mind."

I know this will be my life-saver. There have been times since starting the course whereby I would normally have been compelled to self-harm. Sometimes now I am able to let these emotions be and breathe my way to a better state of mind. I'm sure you think I am exaggerating but for 37yrs I've buried so much and found coping mechanisms that have saved my life, but have been severely detrimental. I honestly feel that I will be able to have a more positive future. Stressful times will come and bad things will happen but I know if I continue to practice I can work through them."

"I have changed how I see situations and I can take a step back to think about things. Thank you for the phone contact and messages this helped me to still feel able to attend even though I had missed some sessions"

"I wanted to say thank you for this course. It is what has helped me the most in the past few months. I know that I was not able to attend many sessions because of the sickness of my children but I can't tell you how much it has helped. It has seriously been fantastic. It has helped lift me out of the winter blues and has also enabled me to find a way to tackle some of the recent problems I have been having."

"It has given me the mind space I need to solve a lot of things."

Key learning points from Home-Start Stroud District's perspective:

As with the CBT wellbeing workshops, we were aware of the practical difficulties that made it challenging or impossible for families to attend any or some of the sessions. This was exacerbated by the seasonal addition of an inordinate amount of illness with even the most determined families finding it a real struggle to attend sessions because of poorly infants or themselves succumbing to illness. For a rural locality it is very difficult to position a relatively costly course in a geographical location that is going to be accessible to all the families that we support or feel would benefit from a particular course.

Crèche costs are high and are a drain on resources when families do not or are unable to attend sessions.

We were impressed by the positive feedback received from those mothers that were able to participate in the course. It seems to have had a very profound effect on the participants.

For future provision of using Mindfulness within our model of community support we would look at bringing in some elements of training into our weekly drop-in groups that will not incur the cost of crèche facilities but could informally provide some introduction and practice in Mindfulness. This is something that we will be trialling in our drop-in groups in the autumn.

Similarly we would like to continue to provide Mindfulness training to our volunteers in the future.

Costings

£790.00 for all room hire plus crèche workers in January (GL11)
£900.00 for crèche workers in Feb & March (GL11)
£28.00 for last meal (GL11)
£67.00 for drinks (GL11)
£200 materials
£2550 for Admin Planning evaluation facilitation and supervision (MPCP)
£300 workshop facilitation for volunteers and staff
£100 room hire and refreshments
£200 travel expenses and staff time

£5135 Total

Mindfulness training course for volunteers:

A two hour mindfulness workshop was run by the Mindful parenting and Community Project, Bristol (MPCP) prior to recruitment for the parents 10 week mindfulness course.

The workshop explored what our habitual patterns of reactivity are like and how mindfulness based practices can help us learn how to regulate our emotions, including the stress reaction. Evidence clearly shows that when under stress parenting skills collapse. The workshop looked to enable the volunteers to:

1. Have a working definition of mindfulness and some of its benefits
2. Experience mindfulness directly through a number of practices
3. Use the practices learned in managing stress and anxiety
4. Discuss mindfulness more knowledgeably with Home-Start families in order to give them relevant information and support to attend the upcoming mindfulness course.

22 volunteers and 3 members of staff attended the training.

We sent out an electronic questionnaire to volunteers to seek their feedback on the course and received 20 replies.

Scores are from 0-5 where 5 is the most positive score and 0 the lowest

Has this training helped you personally?
Not at All: 1 0 0%
2 0 0%
3 7 35%
4 9 45%
Greatly: 5 4 20%

Would you recommend this training to other volunteers?
Not at All: 1 0 0%
2 0 0%
3 7 35%
4 9 45%
Greatly: 5 4 20%

Do you feel this training will help you in your role of supporting women with perinatal mental health challenges?
Not at All: 1 0 0%
2 0 0.0%
3 5 20%
4 5 20%
Greatly: 5 10 66%

How do you feel it will help in your role in supporting families?

'Encourage my family mum to practice mindfulness'

'To help family be more present with their situation and support them in that…"

'Being more present, listening, kind, non-judgemental'

'Great to practice the breathing when stressed'

'Suspending judgement and really being in the moment, especially with effective listening'

'To hopefully help families to understand the importance of thinking/getting outside their immediate problems'

'An understanding of how the family are feeling if stressed'

Great techniques and useful to be more aware of the many impacts of stress'

Costings

2 hour mindfulness training for volunteers facilitated by MPCP

Facilitation	£300	
Room hire	£45	
Refreshments	£15	
Staff time	£100	
Volunteer expenses	£100	(mileage)
Printing and admin	£100	
Total:	£670	**(training per person = £27)**

5 CBT Emotional Wellbeing Courses

This section is written by Jayne Harris, [2]Gether NHS Foundation Trust

Aim

- Review of work undertaken in the project to meet the requirements for Part 6 of the CQUIN

- Home-Start and [2]gether NHS Foundation Trust to develop mental health wellbeing groups for women (ante and postnatal)

- To set up a pathway with [2]gether NHS Foundation Trust into and out of Mental Health Intermediate Care Team (MHICT) / Let's Talk Service to improve the links and access to advice for volunteers and professionals working with women in the perinatal period

Wellbeing groups

One aim of the pilot was that the groups would be run in line with the Improving Access to Psychological Therapies (IAPT) Cognitive Behaviour Therapy (CBT) treatment model so that in future it could potentially be replicated across the county within the IAPT treatment programme. It was part of the role of an accredited IAPT CBT Therapist appointed to deliver the Changing Minds in Perinatal Mental Health training, to co-facilitate the group and be a direct link with HomeStart.

Participants

The women attending the group were to be women who are currently engaged with Home- Start who were experiencing mild or moderate anxiety or depression and not already receiving treatment from IAPT. The benefits of treating women with mental health difficulties during the perinatal period are well documented (Hogg, S., 2014, Bauer et al, 2016). The evidence relates to women who are pregnant or within the year after giving birth and this is reflected in the National Institute for Health and Care Excellence (NICE) guidelines CG192 for Antenatal and Post-Natal Mental Health (2014).

IAPT prioritises perinatal women, aiming to start treatment within a month as per NICE Guideline (2014). For the purposes of this project it was decided to include women who were pregnant or had a baby under 2 years old. Home-Start estimated that there were at least 20 women who would access the treatment groups. It was decided to offer 2 treatment groups, one in Dursley and one in Stroud. Each course would last 6 weeks, 1.5 hours a week plus 30 minutes for settling babies into the crèche and coffee / social contact time.

Home-Start provided a crèche for each session to help women to access the group sessions.

The groups were to be jointly facilitated by the Home-Start Manager and CBT Therapist appointed for the project. The CBT Therapist attended the Home-Start co-ordinators meeting to discuss women who they thought may benefit from attending the group.

They were given a referral form (Appendix 1) which was adapted from the standard IAPT referral form.

The first group was planned for Friday mornings 10:15 to 12:15 in November and December 2016 at Cashes Green Children's Centre, Stroud with the crèche in the room next door. The second group was booked to take place at GL11 Community Hub in Dursley 10.15-12.15 on Friday mornings from 13th January 2017.

Referrals

Five referrals were received from Home-Start for the first CBT Treatment group. Each woman was contacted to arrange an assessment. In line with the usual IAPT assessment for CBT treatment, 45 minute telephone appointments were offered unless the woman was not able or willing to do the assessment by telephone. All agreed to undertake telephone assessments.

There was an enquiry asking if women who were receiving support from the Cashes Green Children's centre could also attend. However the group was only open to women engaged with Home-Start as these were the parameters of the project at that time.

Women were invited to a taster session and to self-refer for assessment for the second course.

Outcome of referrals

All five women who were referred by Home-Start for the first CBT treatment group were offered assessment appointments. Three women completed assessments. One woman did not attend her assessment appointment on two occasions and so was discharged in line with MHICT Did Not Attend (DNA) policy. One woman did not complete the assessment because she said at the start of the appointment that she did not feel anxious or depressed and wanted to attend the course so that she could write a blog about it. We agreed that this was not appropriate.

Of the three women who were assessed, two said that they did not feel anxious or depressed and this was supported by their scores on the Patient Health Questionnaire (PHQ9) and General Anxiety Disorder (GAD7) questionnaires which suggested they did not have symptoms of anxiety or depression. Both said that they wanted to attend the Home-Start CBT treatment group as they like having groups to go to with their babies and they thought it might be interesting.

One woman who was assessed said that she had experienced long term depression, anxiety and chronic fatigue syndrome. She had received several CBT treatments in the past. Her PHQ 9 and GAD 7 scores suggested she was suffering symptoms of severe anxiety and depression. Her baby was 23 months old. She was offered the usual range or IAPT interventions, including individual CBT. She chose to join the Home-Start treatment group.

One woman did not attend for 2 assessment appointments which had been arranged and so was discharged, stepping down to Home-Start support.

Changes for the Second Course

Due to the low numbers available for the first CBT treatment course the Home-Start Manager requested that a taster session was provided for the second course and that referrals were opened up to Health Visitors and Children Centre staff for women who were pregnant or had a baby under 2 years and who were experiencing mild/moderate anxiety or depression.

Following the taster sessions women could sign up for an assessment if they wished with a view to attending the course. It was also decided that this course would be an Emotional Wellbeing course as this was felt it may be more appealing to women. Home-

Start arranged and paid for a crèche for the taster session and each of the course sessions. At the Dursley course seven women booked a place at the taster session and three women attended the taster session.

The taster session took place on 13th January 2017 at GL11 Community Centre in Dursley. Of the seven women signed up to attend the taster session, one cancelled on the day as she had an antenatal appointment and her Home-Start Coordinator sent a written referral. Three women attended and signed up for telephone assessment.

Following the taster session the women who had signed up but had not attended were contacted by the person who had referred them to find out if they wanted to be referred for assessment for this course. One woman did want to be referred and had an assessment appointment and took up the offer of 1:1 treatment with IAPT. In addition five women were referred after the taster session and they were also offered an assessment.

In total thirteen women had assessment appointments booked with a view to attending either the Stroud or Dursley course.

Outcome of assessments	
Place allocated on Stroud course	3
Place allocated on Dursley course	2
1:1 treatment with IAPT	2
Declined assessment	2
Signposted to eating disorder service	1
Declined service after assessment	1
Discharged having DNA 2 appointments	2

Only one woman who was assessed for either group met the usual criteria for priority perinatal mental health treatment. The remainder were either not perinatal or were not showing symptoms of anxiety or depression.

Attendance

Where transport was an issue Home-Start offered to take the woman and her child to the group by car.

At the Stroud course one woman attended each session and one missed one session when she was ill. One woman told Home-Start the day before it was due to start that she did not want to attend the group and then later decided that she would. She attended twice.

At the Dursley course both women attended 4 out of 5 sessions after the taster session.

Course Content

The Home-Start Manager decided not to attend any of the sessions as the number of women due to attend the course was small so it was facilitated by the CBT Therapist alone.

The first Course was based on the Lets Talk Low Mood course and the second course was based on the IAPT Emotional Wellbeing Course. The content was adapted during the sessions to suit the needs of the participants. Some of the content was equivalent to Step 3 IAPT intervention as it covered challenging "rules and assumptions for living" and the participants worked on their own examples for Behavioural Activation and Thought Challenging with the facilitator and each other.

Outcomes after the course

Four women completed the courses missing no more than 1 session

One woman dropped out after attending 2 sessions

Stepped up Face to Face CBT	2
Discharged – above caseness-declined further treatment	1
Discharged - below caseness	1
Discharged - dropped out – below caseness	1

Feedback

During the course all the women said that they were finding the course helpful and enjoyed the sessions.

The PHQ 9 and GAD 7 scores for two of the women were already in the non caseness rage when they stared the course, suggesting mild or no symptoms. The PHQ9 score of one woman showed reduction from severe to moderate symptoms of depression. The scores of the other two women did not show a significant change. A short CBT group would not generally be expected to be sufficient treatment to achieve recovery from severe anxiety or depression. It can provide a foundation for future individual work and is seen as part of a stepped approach towards treating a person's mental health difficulties in IAPT.

PHQ 9 and GAD 7 questionnaires are used by IAPT as a measure of the frequency of symptoms of anxiety and depression. They do not measure intensity of symptoms. They indicate a score and are completed every week to monitor changes. It is normally the case that scores change from week to week based on levels of anxiety and depression as well as reaction to events and stresses in a person's life.

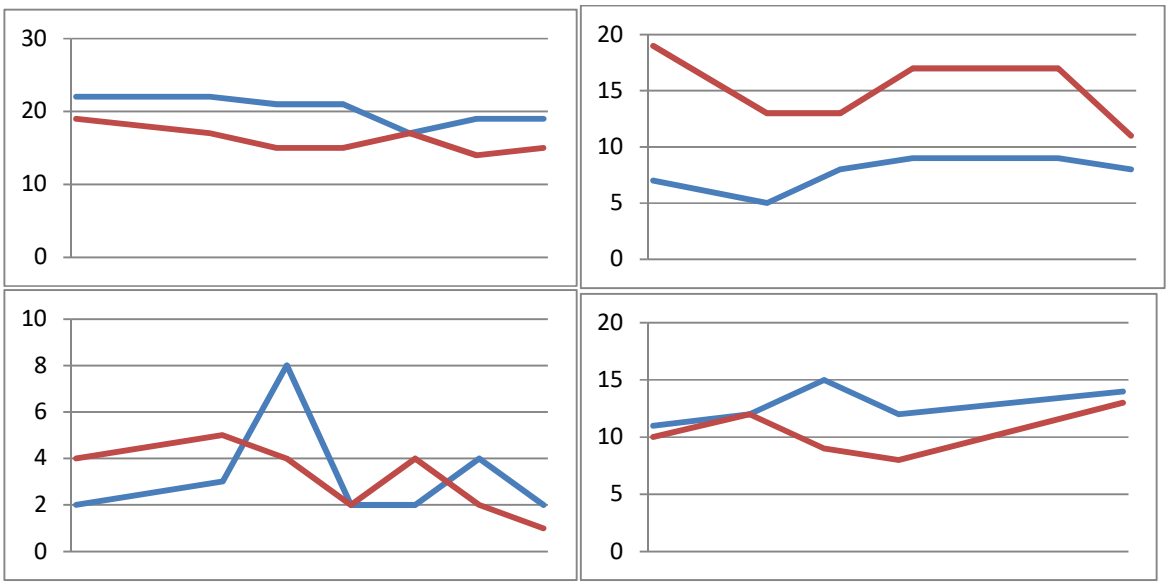
They are interpreted as follows.

Score	**GAD7 Anxiety (maximum score 21)**	**PHQ9 Depression**
0-4	no symptoms	no symptoms
5-8	mild symptoms	Mild symptoms
9-14	moderate symptoms	Moderate symptoms
15-21	severe symptoms	Moderate to severe symptoms
22-27	N/A	Severe symptoms

The graphs below show the PHQ9 and GAD7 Scores of the four women who completed the courses. They show that three women started the course with symptoms ranging

from moderate to severe anxiety and/or depression. One of the women showed significant reduction in her symptoms of anxiety. One showed a small reduction in her symptoms. One woman was in the range which suggests no significant symptoms for most of the course.

GAD 7 (anxiety symptoms) **PHQ 9 (Depression symptoms)**



Evaluation

All four women who finished the courses completed the standard IAPT course evaluatioin forms with the following results.

How effective was the course in helping you understand and manage your problems?	Very effective	2
	Mostly effective	2
	Some of it was effective	-
	None of it was effective	-
How helpful were the exercises in helping you learn?	Very helpful	2
	Mostly helpful	1
	Some of it was helpful	1
	Not very helpful	-
How satisfied were you with the facilitators?	Very satisfied	4
	Mostly satisfied	-
	Neutral/not sure	-
	disatisfied	-
How satisfied were you with the venue	Very satisfied	3
	Mostly satisfied	1
	Neutral/not sure	-
	dissatisfied	-

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Would you recommend the course to family and friends?	Definaltey	2
	Most likely	2
	maybe	-
	no	-

Themes of other comments made on the evaluation form were:

- It was helpful to meet other mums who were also struggling with their mood and know it is not just me
- It was good to learn about thoughts and how to challenge them rather than just believe them
- It is good to have an understanding of how adrenaline affects us
- It was good to have a crèche

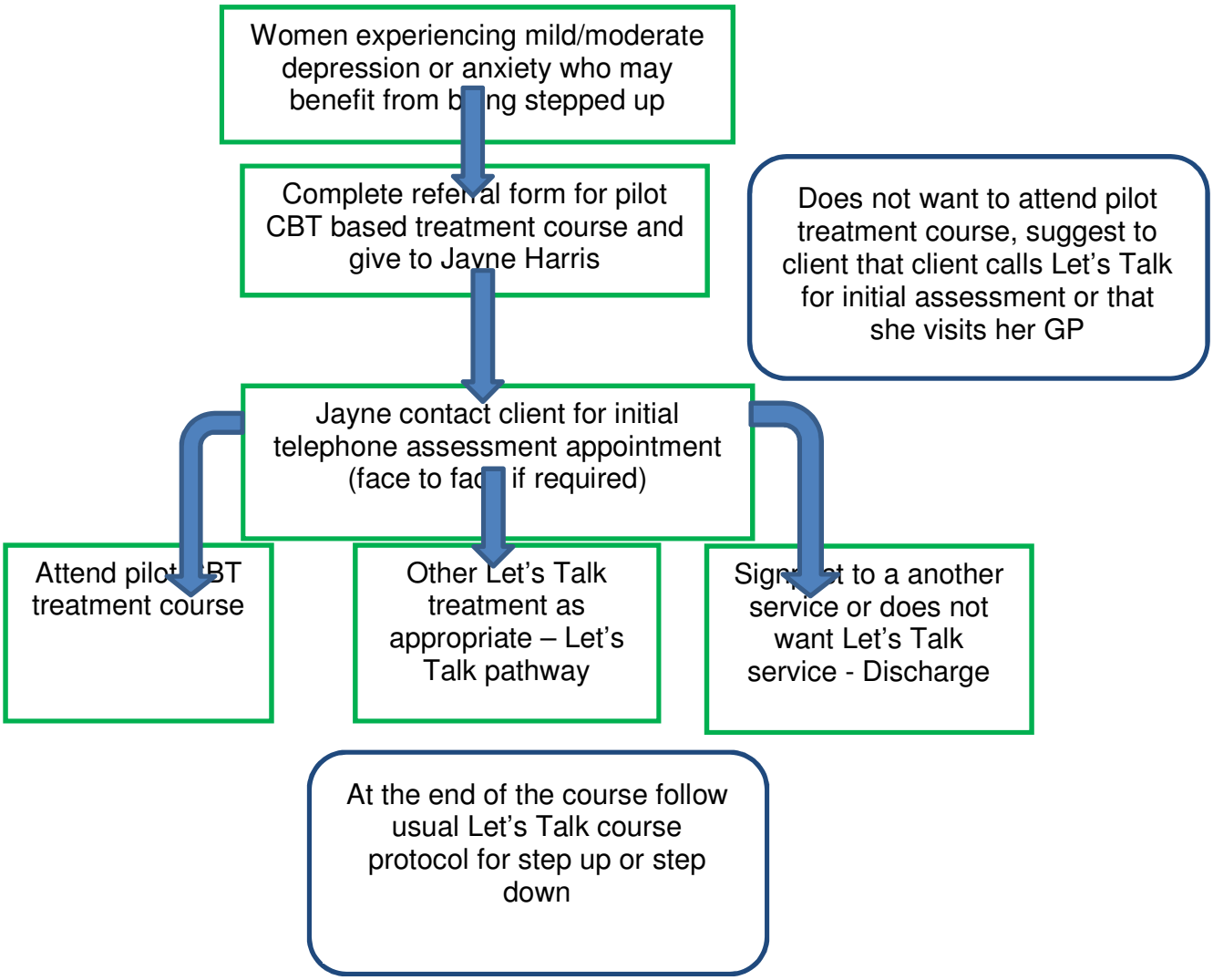
Further evaluation

Home-Start will be collecting further information to contribute to the evaluation of this group which will be through volunteers, online survey, and the MESH assessment tool. Home-Start will also be collecting information to gain an understanding supporter/partner views on programme and difference it has made and the social impact of programme on participants.

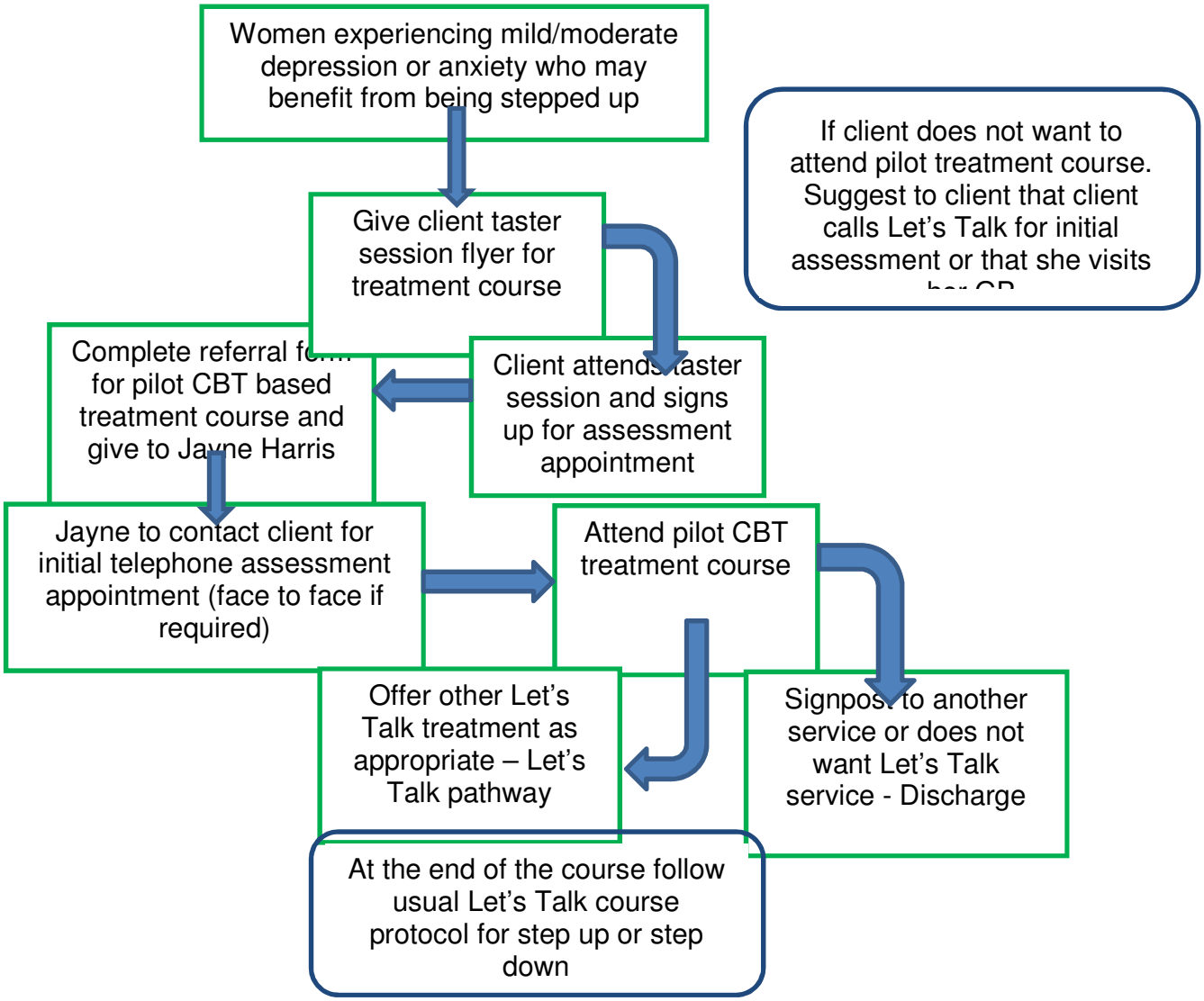
Pathway and links with HomeStart

The pathway in and out of the Home-Start project and the treatment group was established and had been agreed as meeting the requirements of Part 6 of the CQUIN as described in the quarter 2 and Quarter 3 reports. This is demonstrated in the two pathway diagrams below.

Pathway between Home-Start and MHICT for women working with Home-Start during pilot project who are not currently working with ²gether.



Pathway between Home-Start and MHICT for women working with Home-Start during pilot project who are not currently working with ²gether. Amended for second CBT treatment course This second course has been opened up to clients of Children's Centres and Health Visitors. They have been given information about the course and they will invite women to attend the taster session. That pathway is not part of the ²gether CQUIN



There was an aim to improve the links and access to advice for staff and volunteers working in Home-Start. Some of the staff and volunteers attended the Changing Minds in Perinatal Mental Health which is also part of the CQUIN. Some of those staff took the opportunity during the Changing Minds workshops to clarify what could help individual women they were seeing. As self-referral is the most common pathway into the IAPT service, advice usually centred on describing to volunteers what IAPT may be able to offer women.

In addition, it was hoped that joint working between Home-Start and the MHICT would be improved through frequent contact between the CBT Therapist and Home-Start staff. It had been anticipated that the CBT Therapist would spend some time based at

the Home-Start office, and that the Home-Start Manager would co-facilitate the CBT treatment groups.

Unfortunately the Home-Start office could not accommodate the Therapist and the HomeStart Manager decided not to co-facilitate the treatment groups as the numbers of women attending was small. The plan for the CBT Therapist to attend the Home-Start drop in groups was cancelled because the Home-Start facilitator wanted to use that session to gain feedback from the participants about their experience of giving birth.

Resources

A HI Therapist was appointed to deliver the Changing Minds in Perinatal Mental Health workshops and to co facilitate the CBT Treatment groups. Within [2]gether NHS Foundation Trust the cost of a Whole Time equivalent Band 7 HI Therapist for 7 months is £28,252 at the 2016-2017 pay rates.

There were further costs relating to the venue, crèche, materials and Home-Start administration as described in the table below. The Hill Valley and Vale Children's Centres did not charge for the use of Cashes Green Children's Centre

Item	**Cost**
Crèche	£650
Venue hire Dursley	£240
Materials	£ 10
Home-Start administration	£400
Total	**£1300**

Summary

Feedback received at the end of the courses and informally during the sessions shows that the course was well received by those women who did attend. The first course appears to have been marginally more helpful to the participants than the second course. This may be because the Emotional Wellbeing Course, which was offered for the second course, may not have been the best fit for the women who attended. However both women were keen to attend because a crèche was offered.

Only one woman who was assessed for either group met the usual criteria for priority perinatal mental health treatment. The remainder were either not perinatal or were not showing symptoms of anxiety or depression.

Prior to the CQUIN project, IAPT ran a rolling programme of Emotional Wellbeing Courses with Children's Centres in Stroud and Dursley district for families with children under 5, and the Children's Centres provided a crèche. These courses were co facilitated by IAPT clinicians and Children's Centre Family Support Workers. The Stroud and Dursley Children's Centre Emotional Wellbeing programme was stopped by IAPT when the Home-Start project started. Any future plans for community projects aiming to support women during the perinatal period could benefit from promoting a coordinated approach between providers of community support from the wide range of agencies and charities supporting women at this time.

IAPT follows the NICE guidelines for treatment of women who access treatment with IAPT during the perinatal period of pregnancy and their baby's first year. Women are prioritised and treatment usually starts within a month. Thresholds for face to face treatment are lower than the general population. Efforts are made to accommodate

the woman's childcare arrangements to help them access appropriate treatment. IAPT does not provide any childcare facilities at its courses or for individual treatment.

Uptake of the Home-Start CBT Treatment courses was low although Home-Start had approached other women about the course. It is not known how many of these women had symptoms of mild to moderate anxiety or depression. IAPT currently aims to provide access and treatment for 15% of a local population who are experiencing symptoms of mild to moderate anxiety or depression. There are many reasons why people do not access CBT treatment groups when they are for depressed or anxious.

Women from Home-Start who did not want to attend the group gave common reasons for not committing to a course of group therapy as follows:

- wrong time in their life
- reluctance to attend groups
- inconvenient time of group
- previous CBT
- too many other things in their life at present
- prefer to try other a different psychological approach

Some women who are working with Home-Start were already accessing individual treatment with IAPT. It is generally accepted that people do not benefit from receiving two psychological treatments at the same time.

It would appear that the number of women in the Stroud District who are experiencing mild / moderate anxiety or depression during pregnancy or up to 2 years after giving birth, who want psychological help but are not accessing that help is low.

Recommendations

There are 6500 births annually in Gloucestershire (2015-2016) with the highest number of births in Gloucester City (2041 births). Taking into account the NICE guidelines for offering treatment within a month a new course would need to start every month.

In Gloucester City using the highest estimates and targets of 20% of perinatal women experiencing mental health difficulties and a future target rate for access to IAPT of 25% this would mean a maximum of approximately 8/9 women per month in Gloucester City who need treatment for mental health difficulties. Some of these women would require secondary mental health services while others would require 1:1 treatment, and some women may not be willing or able to attend or be suitable for an IAPT group. It would therefore not be viable for IAPT to offer specific perinatal treatment groups as part of their group treatment programme.

Improving the Pathway

The pathway into IAPT from Community and Voluntary Services is via self-referral. Home-Start workers are in an ideal position to support self-referral only if they have a good understanding of what IAPT may be able to offer and the assessment process. It has been known for Home-Start volunteers to organise their weekly visit to look after children to enable women to attend IAPT appointments which may be on the phone or face to face. Home-Start has also helped with transport to appointments.

It would be helpful if 2gether NHS Foundation Trust services were aware of all the community and voluntary support which is available for women who may be engaged with 2gether NHS Foundation Trust for treatment. The new Specialist Perinatal Mental Health Service may help by educating secondary care colleagues.

Furthermore, if there was a nominated person in the MHICT, they could maintain contact with those community and voluntary sector organisations and could also act as a point of contact for staff in MHICT staff who want to refer women for extra community support. This role does not currently exist as it cannot be accommodated using existing MHICT resources.

Any future plans for community projects aiming to support women during the perinatal period could benefit from promoting a coordinated approach between providers of community support from the wide range of agencies and charities supporting women at this time. This could form part of a role of a Perinatal Primary Mental Health Liaison worker as described in the recommendations for Part 5 of the [2]gether NHS Foundation Trust Quarter 4 CQUIN report. (Bauer, 2016) (Hogg, 2014)

Key learning points from Home-Start Stroud District's perspective:

As with the Mindfulness course, we were very aware of the practical constraints that make it difficult for families to attend any or some of the sessions.

For a rural locality it is difficult to position a relatively costly course in a geographical location that is going to be accessible to all the families that we support or feel would benefit from a particular course. Crèche costs are high and a drain on stretched resources if families (often through no fault of their own) do not attend.

Similarly because of the very low take-up of places on both courses, the Home-Start scheme manager made the decision that it would be a poor use of staff time to co-facilitate groups that had a total of five participants.

The referral process was time-consuming from Home-Start's perspective. We had approximately 23 families interested in the first CBT course but the reality was that for many, and for one reason or another[6], they could not or did not wish to attend.

We agree with Jayne Harris that IAPT should not offer perinatal treatment groups within the community and we will not be recommending them as an element of our recommendations for locality support. Our recommendations look at other ways to better support pathways in and out of MHICT/Lets Talk Service.

Ways to provide future wellbeing workshops at an affordable cost could be through our **perinatal mental health Drop-in groups** which will not run the cost of crèche facilities but could informally provide some introduction and practice in CBT particularly if there is occasional representation from an MHICT worker (within the role of perinatal primary mental health liaison worker as described in the recommendations for part 5 CQUIN Report). Volunteers will offer their families transport and support to attend the sessions in order to maximise take-up of these support sessions. With volunteers attending there will be the possibility of volunteers forming an informal crèche within the group for a period of time in each session.

Also, if from the drop-in groups a sufficient cohort of women was identified we might think about putting on a specific workshop (such as using CBT to improve wellbeing) for them with the necessary funding.

[6] See interim report written by Home-Start Stroud District when analysing low rate of take-up from 23 families (appendices)

6. Training Professionals and Volunteers

1 Changing Minds in Perinatal Mental Health

Part 5 of the Perinatal Mental Health CQUIN 2016 - 2017 was to develop and pilot a Cognitive Behaviour Therapy (CBT) training programme for 30 Health Visitors in Gloucestershire. This was to enable Health Visitors to effectively support women who are experiencing early signs of anxiety and depression in the perinatal period via an evidenced based framework. It was intended for the course to enable Health Visitors to have a positive conversation during interactions with women with a focus on the Listening Visits that Health Visitors undertake when women are suffering with mental health issues. It was intended for the CBT training programme to be supported by regular staff supervision.

Part 5 of the CQUIN overlaps with one of the original objectives of the Mothers in Mind Project which was to train professionals and volunteers to better support women affected by perinatal mental health issues. The Changing Minds training programme therefore overlapped and was opened up to include Home-Start staff and volunteers.

The full final report and evaluation of the pilot including its effectiveness and recommendations for taking the programme forward and options for roll out to the whole Health Visiting workforce is part of the CQUIN 5 report. Some of its conclusions recommendations are agreed and replicated in the recommendations of this Mothers in Mind Project evaluation.

2 Training held for volunteers as part of Mothers in Mind Project

In February 2017 the Royal College of Obstetricians and Gynaecologists published their report Maternal Mental Health – Women's Voices (Gynaecologists, 2017) recommended that 'all healthcare professionals working to support women during and after pregnancy should be better trained in the range of perinatal mental health conditions to recognise and respond to potential signs of perinatal mental health problems – from the mild to the severe'. We fully agreed with this statement and are particularly clear that home visiting volunteers should be included in this statement because it is these volunteers who will be spending, by far, the most time with some of these women over an extended period of time. Therefore training and ongoing regular supervision are crucial to making the most of this face-to-face support time.

Introduction to training volunteers in Home-Start

All of our volunteers receive forty hours of training in order to prepare themselves to support families through home visiting. The training is accredited through CERTA and volunteers can choose whether or not to work towards accreditation. The course covers many areas of family support including listening skills, safeguarding, confidentiality, sources of support in the community, the role of the health visitor, attachment and infant mental health, domestic abuse, play and positive parenting techniques. There is a two and half hour session specifically assigned to understanding and better supporting perinatal mental health. Speakers including health visitors, infant mental health workers and domestic abuse workers give workshops as part of the course.

After completing the course of preparation and commencing support of families, volunteers are offered an ongoing programme of training and development. There is usually a training event held every two months and a chance to meet socially once a month.

The Mothers in Mind Project meant that we geared most of our training events over the year to cover areas pertinent to perinatal mental health.

The following specialist training sessions were held for volunteers and staff over the course of the year-long Project Introduction to the Mothers in Mind Project:

Perinatal mental health and A Solution Focused Approach (Nailsworth Sub Rooms 12th May 2016)

HomeStart Stroud District AGM and Project Launch with a presentation from Sally Hogg (FGR, Forest Green, 12th July 2016)

Mindfulness for Parents Workshop (Arkell Centre, 12th October 2016)

Drop In's for Home-Start Families (Arkell Centre, Tuesdays, November 2016)

CBT Workshop for Volunteers (Mortimer Rooms, 9th February 2017)

Changing Minds Course (Hawkwood College and St Lukes Therapy Centre, 5 weeks)

We asked volunteers how the specialist training helped their understanding of perinatal mental health issues and how it helped in supporting their Home-Start family:

"I wish I had attended the CBT session earlier in the program in order to support the mother to attend her CBT. I may have been more persuasive had I had more information."

Greater awareness of how widespread poor mental health is among mothers.

"The courses have greatly increased my understanding of perinatal mental health issues and have made me very interested in pursuing further study in this area."

Not being 'frightened of asking ' about mental health.

More confident in choosing the right vocabulary when asking about how they feel and how they manage day to day living with their problems.

It helped confirm that perinatal health issues can affect any mother regardless of class religion or status.

To understand just how common mental health issues are in mums.

To understand the difference between anxiety and depression.
To generally be more aware of the issues and what help there is available.

It has helped to open up discussion about mental health issues with the mum I support,
and for us both to be more open.

The drop in sessions were particularly useful especially with the conversations gently coming around to mental health issues, as they began to get to know each other, and the mums realising they were not alone in what they were dealing with.

It has made me much more aware of what signs to look out for, how best to deal with anxiety and depression, and where to signposts.

Most of all, how to maintain a healthy mind on a day to day basis and understanding that thoughts can change your attitude to life.

I gained a much better picture of what Anxiety can feel like and how CBT works. Recognising early signs of perinatal health issues, being able to identify symptoms of anxiety/ depression and understanding practical methods of improving mental wellbeing.

Key Learning points around training for volunteers

The Changing Minds workshops were well received by both staff and volunteers. All participants from Home-Start Stroud District found that the course increased their knowledge and understanding of perinatal mental health issues and developed their skills in supporting mothers.

However, the sessions were only able to accommodate training for a very small proportion of our volunteers (less than 10%). If the Changing Minds workshops are to be continued ,as recommended in CQUIN 5, there is a question as to how many home visiting volunteers the courses would be able to accommodate. In order to fulfil our objective to upskill all our volunteers in perinatal mental health, we may need to be looking at alternative ways to provide training that will have the potential to train between 50% and 75% of our volunteers (approximately 30 to 50 people). We might also consider further developing a Home-Start UK accredited course specifically aimed at voluntary and community support organisations involved in supporting women affected by perinatal mental health.

Other future training will look at ways to support volunteers in being more open and active in asking about mental health. We will also be focussing on breaking down different elements of poor maternal mental health and ways to better support anxiety and depression.

Volunteers will also have the opportunity to come along to the perinatal mental health drop-in groups which will be a source of ongoing learning and experience in understanding of issues affecting women living with perinatal mental health challenges.

7. Women's Voices: Experience of Services

An important objective of the Mothers in Mind Project was to record and reflect the views and experiences of women affected by perinatal mental health issues. There was so much goodwill and bravery in wanting to share their experiences in order to break down barriers and stigma, improve services, increase professional understanding and, ultimately, to improve the experiences for future families.

We sought the opinions and experiences of women through a variety of means:

a. An online questionnaire was sent out to 70 families and we received 30 replies.
b. We interviewed five women and sought their permission to transcribe the interviews.
c. We held a number of focus groups with a core group of 5 women. Again we recorded and transcribed many of the group discussions.
d. We held informal small group2 discussions at our pilot drop-in group sessions when we looked at particular issues around parenting and poor mental health.
e. We did initial assessments with all mothers that were referred into the project and who wished to have support, followed by quarterly reviews and a final review when support ended during the 12 months of the project.

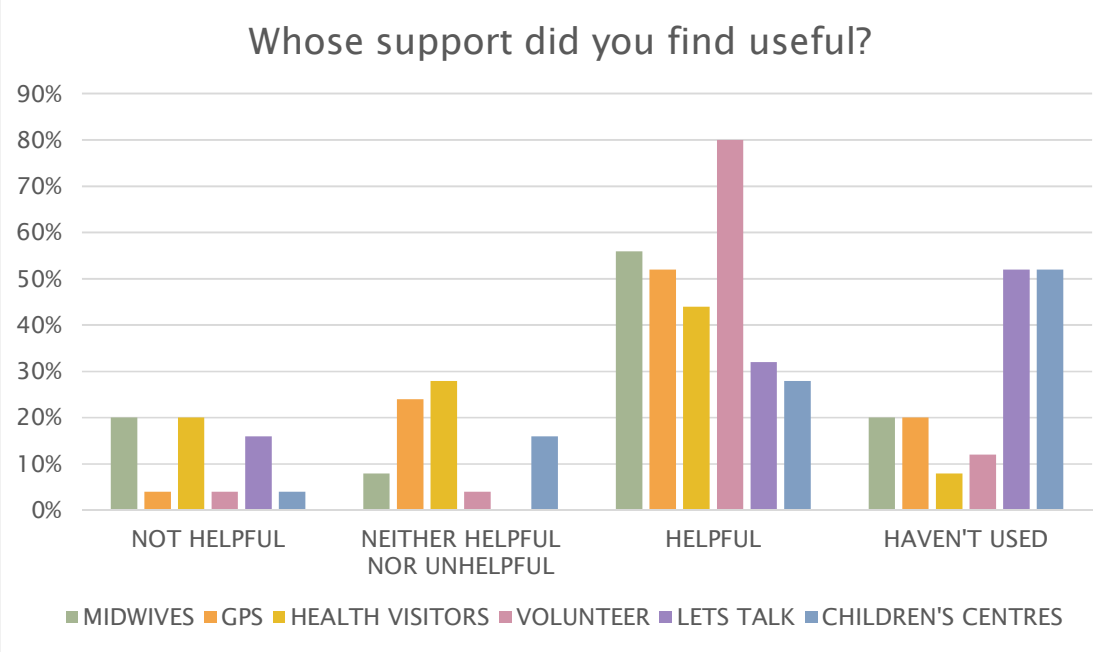
Experiences of Services:

What treatment have you received?

"Apart from Home-Start I wasn't offered any other type of support."

"I was very very keen not to take medication as I did not want to lose the highs of life."

"Offered anti-depressants & wish I'd taken them."



Experiences of Let's Talk Services:

As the project sought to improve pathways between specialist mental health services and community support such as Home-Start, we dedicated a section of our questionnaire to gathering data around families views of the support they had received from Lets Talk, Gloucestershire's IAPT service, part of the [2]Gether NHS Foundation Trust.

Feedback was mixed and gave a range of different viewpoints as to its efficacy. Many women didn't get as far as picking up the phone to make a self-referral. A lot of the more negative feedback seemed to stem from the very prescriptive elements of the service.

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I didn't find let's talk helped at all. I actually felt it added stress rather than taking it away.

I remember feeling that no one knew how to fix the way I was feeling so instead people sent out a book that was filled with useless ideas just to say they were doing something … while ignoring the fact I was feeling very very black and an unfit mother.

The telephone appointments were hopeless. I had never met the person on the other end and I felt they were working through a spreadsheet where they were ticking things off….

I just wanted to talk to someone about how I was feeling and the person to understand and say 'it's great, you are doing fine, these things will pass I promise', and instead I was never allowed to talk about my real issues but had to answer their questions.

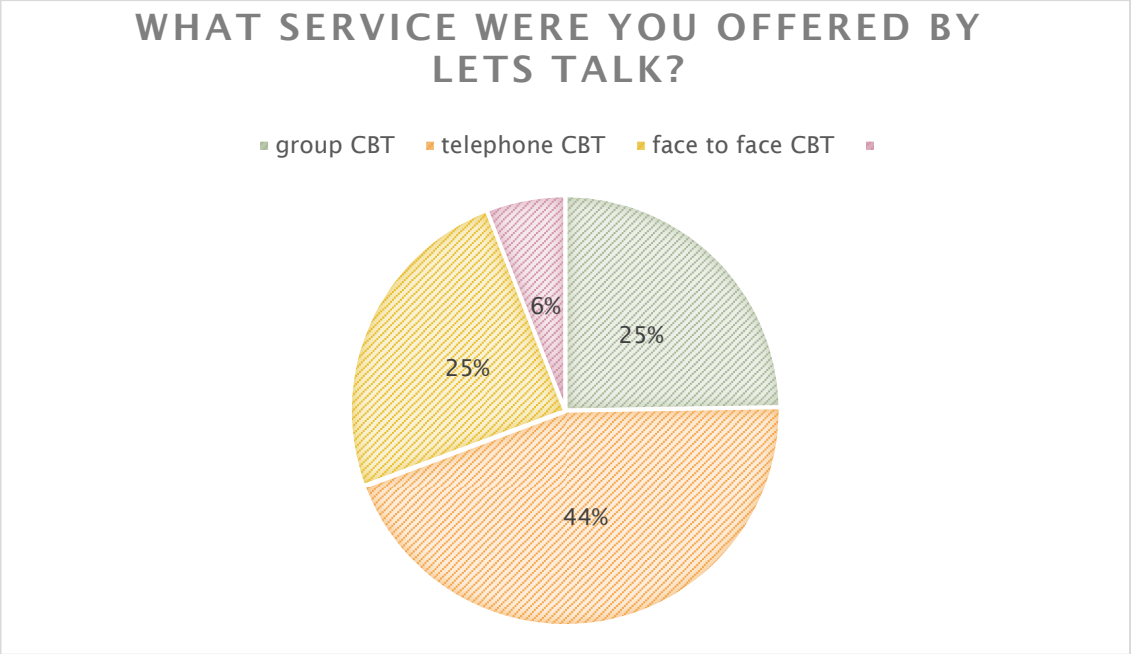
"I became more stressed by the service because the appointments were set up in advance and I had to try to guess what time my baby was asleep so I could do it during that time.

I felt robbed of sleeping time but I didn't want to break the appointment in case they thought I didn't want to fix myself and would send someone round to take away my child.

The workbooks helped me identify my worries and set aside a time for worrying, so that I was able to stop my cycle of anxiety

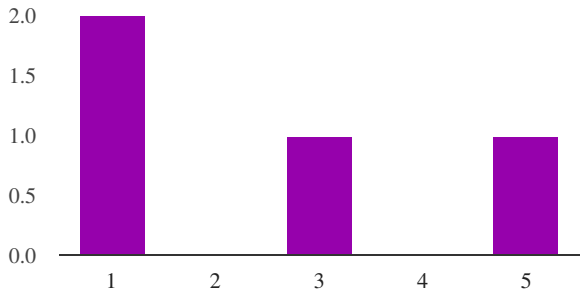
I found them especially helpful at addressing my issues with sleep.

Of the mothers that referred into Lets Talk, we asked what services they had received:



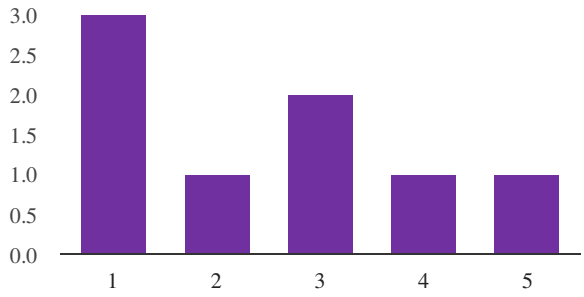
Mums were asked to score on a scale of 1 to 5 ***(where 1 is the least helpful and 5 is the most helpful)*** **their experiences of the different Lets Talk services:**

<u>If you attended a Group Programme how useful did you find it?</u>



"Helpful to know other people feel the same as you and found a kind of kinship with fellow sufferers."

If you used the Lets Talk Telephone Support how useful did you find it?

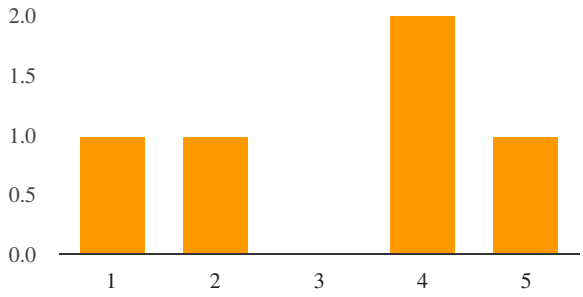


"It was helpful when I was directed to the material relevant to my own needs, and to have any queries cleared up."

"Because I was heavily pregnant and couldn't attend a group I was given priority for telephone support."

"Came off antidepressants when I learnt I was pregnant and being pregnant I was allowed some telephone counselling which included CBT."

If you received face to face CBT treatment, how useful did you find it?



"Found it difficult to concentrate and implement things learnt due to racing mind."

8. Dads/Partners

The Mothers in Mind project recognises that pregnancy and the first year of life are also a very important time to support dads and dads-to-be and that pregnancy is not just an important time for mums. It's a life transition for dads too, a time of huge psychological and social change. Many fathers will suffer poor mental health during the perinatal period.

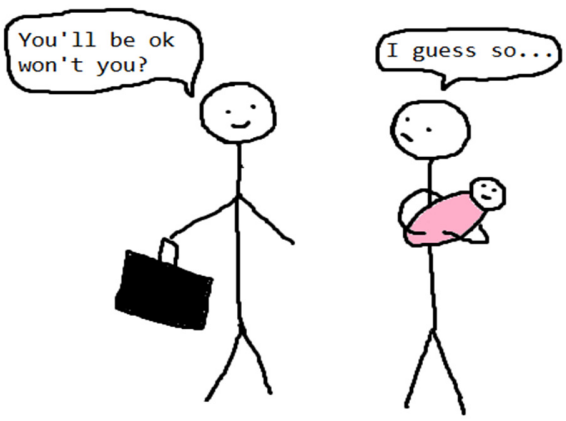
We particularly wanted to explore developing support for dads and partners of women affected by perinatal mental health challenges because we were aware that the reality is that there is very little out there.

We were also very aware that partners will usually be the first people to notice if something is changing in their partner and that they should be better informed about the prevalence of poor mental health in the perinatal period and know who they could seek advice from.

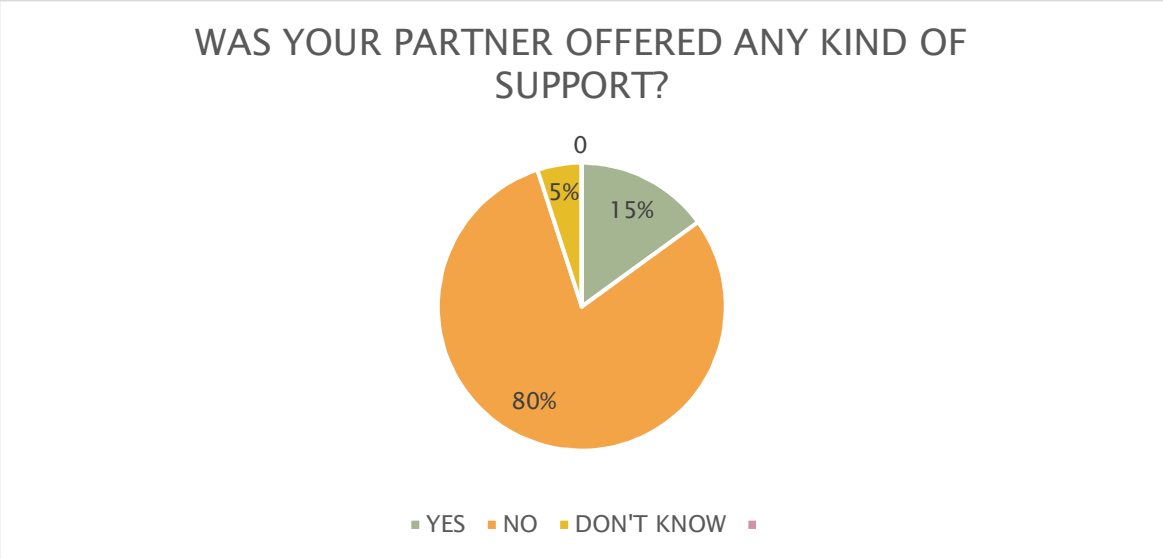
We managed two things; one was to collect feedback from women about the support offered to their partners.

The second was to include an information page for dads in our project leaflet which was distributed across the locality. It contained information about national websites and links for telephone and/or online support.

We know there is still a lot of work to be done to provide inclusive family services for dads. They should be included from the very start (NSPCC) (Hogg, 2014).



We asked women if their partners had received any support to help them cope with their own perinatal mental health issues:



80% of respondents said their partners had not been offered any kind of support

Comments:

"I think, when you raise this issue with the question, that this is a really neglected area. The partners need support, not lecturing"

"For a while he went to Listening Post and I think that things were talked about in those sessions that considerably helped him to see how things were for me. He certainly started to support me a great deal more during and after he had finished the Listening Post sessions."

"He was looking for work, the health visitors kept trying to get him to look after the kids for me so I could have a break. I don't think they realised how fragile his mental health was at that time. He was made to feel guilty for not being able to cope when he was doing his best to get a job and had no spare energy outside that role. He had no idea how I was feeling and was overwhelmed by his own situation."
."

"My challenges have not been too extreme, my partner is amazing."

"Homestart offered support."

"My husband is very easy to open up to, and he helped me open up to the midwife."

"When I was staying at Stroud, the midwives helped my husband by encouraging to eat and look after himself so that he could in turn look after me."

"He had access to crisis team number and offered sessions with my care coordinator. Given self-help numbers and leaflets etc."

"My partner had his own mental health challenges … no one helped him bar the HomeStart Co-ordinator."

We asked mothers how important it is that there is information available specifically aimed at partners?

"It's a no-brainer. partners may well have their own issues (feeling left out from the mother baby bond is one amongst many, overwhelmed with having to be responsible for yet another mouth...) that could be clouding their perception of the mother's low mental health."

"The whole stigma of mental health can affect the relationship between the partners as much as the mum and the community. And father's mental health will adversely affect the situation too."

"Things are so different now as his mental health is infinitely better and under control, his self-esteem was very low due to the work he was doing… Now he is in a supported role he is, in a fair few things, extremely supportive to me."

"A Partner has to be strong for all - this is a lot of pressure!"

"Often find that whilst partners want to support they often don't know how as their experience is very different."

"Partners need to feel supported and be able to understand what is happening to the woman. Sometimes due to nature of illness the man may have to take on far more than usual and may need additional support."

Governance:

Governance

Home-Start Stroud District

Home-Start Stroud District is an independent voluntary organisation which works towards the increased confidence and independence of the family by:

- offering support, friendship and practical assistance
- visiting families in their own homes, where the dignity and identity of each individual can be respected and protected
- reassuring parents that difficulties in bringing up children are not unusual and encouraging enjoyment in family life
- developing a relationship with the family in which time can be shared and understanding can be developed; the approach is flexible to take account of different needs
- encouraging the parents' strengths and emotional well-being for the ultimate benefit of their own children
- encouraging families to widen their network of relationships and to use effectively the support and services available within the community.

Quality Assurance
The quality of our practice has been assessed under the Home-Start Quality Assurance System. This is a robust, bespoke system originally developed in collaboration with Charities Evaluation Service (designers of PQASSO). It is based on a programme of self-assessment against Home-Start's nationwide quality standards.

The ongoing development of our services has been reviewed, as well as the continuous improvement of practice areas relating to governance, management and safeguarding & service delivery. The standards also incorporate principles of IS0 9001 & Investors in People requirements. Reviews are undertaken by Home-Start UK's quality assurance specialists who are accredited ISO auditors. In addition Home-Start UK holds ISO 9001 accreditation and the Investors in People Award.

Values
In all external and internal dealings Home-Start schemes and Home-Start work within and demonstrate the essential ethos of:

- choice
- partnership
- openness
- encouragement
- flexibility
- responsiveness
- ….. and enjoyment!

Approach
All relationships are based on good communication, respect and trust.

The special Home-Start ethos and approach have been valued by schemes, families and volunteers alike over the years. Their consistent application throughout the organisation has ensured all involved in Home-Start can be assured of and benefit from the quality and standards enshrined in the ethos and approach.

The voluntary ethic permeates the whole organisation:

- each community chooses to develop a Home-Start scheme
- volunteers choose to work for Home-Start
- families choose to have Home-Start support.

To Home-Start every family is special and we respond to each family's needs through a combination of home-visiting support, group work and social events.

Home-Start Schemes are rooted in the communities they serve – managed locally but supported by the national organisation which offers direction, training, information and guidance to schemes to ensure consistent and quality support for parents and children wherever they are.

Home-Start has a proven, lasting, positive impact on the development of children and on the health and welfare of the family.

Implementation group

The Commissioning Team, Home-Start and the [2]Gether NHS Foundation Trust formed an implementation group, chaired by Nathan Gregory ([2]Gether NHS Foundation Trust) that first met and formed in May 2016 to scope a draft project implementation plan and considered the following areas:

- Model of Service Delivery
- Referral Process
- Data Collection and Analysis
- Stakeholders Views and Experiences
- Communication
- Training
- Governance
- Evaluation Report

The group met every six to eight weeks to review key milestones and progress of the project as a whole. The last meeting was held in March 2017.

Gloucestershire Perinatal and infant mental health network

The Mothers in Mind project remained an agenda item in this group which met regularly over the course of the 12 months that the project run.

The group is made up of committed clinicians and commissioners that see this as an area worthy of improvement and also understand the impact on women and families. Including a psychiatrist, a mental health nurse from the recovery team and members of the IAPT team as well as people from maternity services, children's centres, paediatrics, the voluntary and community sector, health visitors and a lead GP.

This evaluation report is due to presented to the group when it next meets in May 2017.

Locality professionals group

It was envisaged when developing the project that a group of local professionals involved in supporting women and families would meet on a regular basis to develop the agenda and direction of the project. A first meeting was held which was very helpful and planted a seed of awareness and enthusiasm for the project. However, subsequently it was felt that a regular meeting was too much for many of the participants and that the implementation group chaired by Nathan Gregory (see above) and the already established locality family support networks and county perinatal group were sufficient. Staff networked and gave presentations and training sessions to a diverse range of professionals and community organisations within the locality creating a large network of professional understanding and awareness.

A final presentation of the evaluation of the project and its recommendations will be help in July and all relevant professionals and organisations will be invited to attend.

Methodology and Data Analysis

Charting the progress and outcomes for families supported by Home-Start

Home-Start is committed to providing evidence to show the difference our volunteers' support can make for families. The impact of our service and the outcomes for families is demonstrated by our systematic data collection and reporting system.

The system charts the journey of change that parents and children make while supported by Home-Start. Home-Start staff help families to identify their needs and put in place practical and emotional solutions. Our volunteers support each family to make their changes. This way of working with each of our families is central to our approach and demonstrating to families the changes they are making is a key part of the ongoing support offered.

Further methods of evaluation that were used in the project included:

- Family questionnaires – online (see appendix)
- volunteer questionnaires - online
- GAD7 PHQ9 screening tools
- MESH – families journey of change
- Face to face 1-2-1 interviews
- Focus groups discussions
- Group discussions within drop-in group
- Volunteer feedback sheets from trainings attended
- Emotional wellbeing groups feedback sheets
- Coordinator review interviews

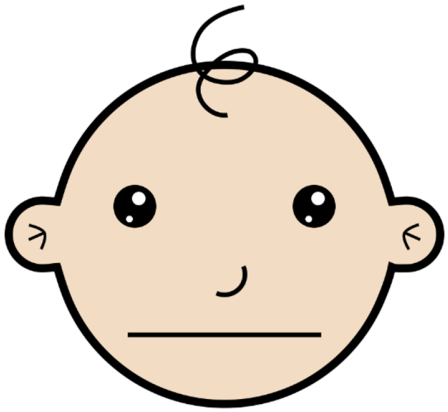
Issues and challenges

The following issues and challenges are noted:

1. Time - The project generated a large amount of extra work for the scheme that was not fully funded. There should have been funding sought for the staff hours that were directly spent on the project and its evaluation, in the same way that the psychological therapist post (full time over seven months) was funded through the perinatal CQUIN.

2. Changes in statutory family support provision over the course of this 12 month project meant that Children Centres were being re-developed and their services put out to tender. Therefore it was not possible to fully include the Children Centres into the project and their future role in perinatal community support. This might be a reason why referrals into the project were so low from this agency.

3. Language and organisational barriers – As a third sector organisation working in partnership with the [2]Gether NHS Foundation Trust and the Clinical Commissioning group we sometimes found it difficult to understand some of the language, acronyms and jargon used by the organisations in meetings, minutes and other paperwork.



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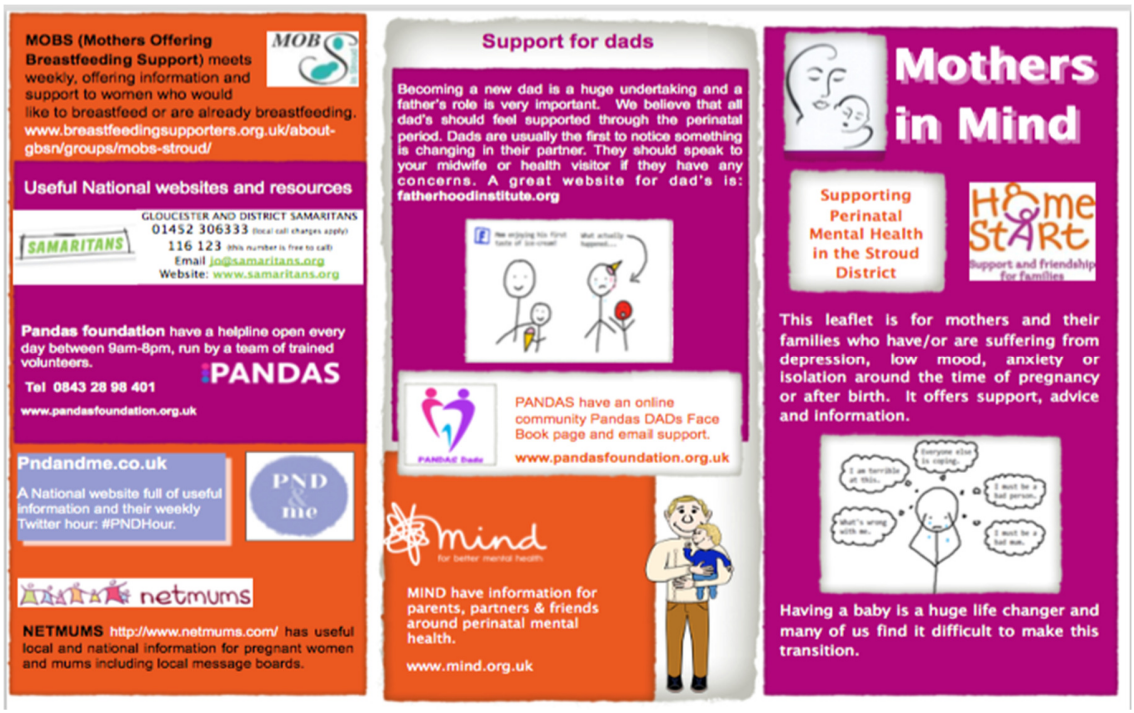
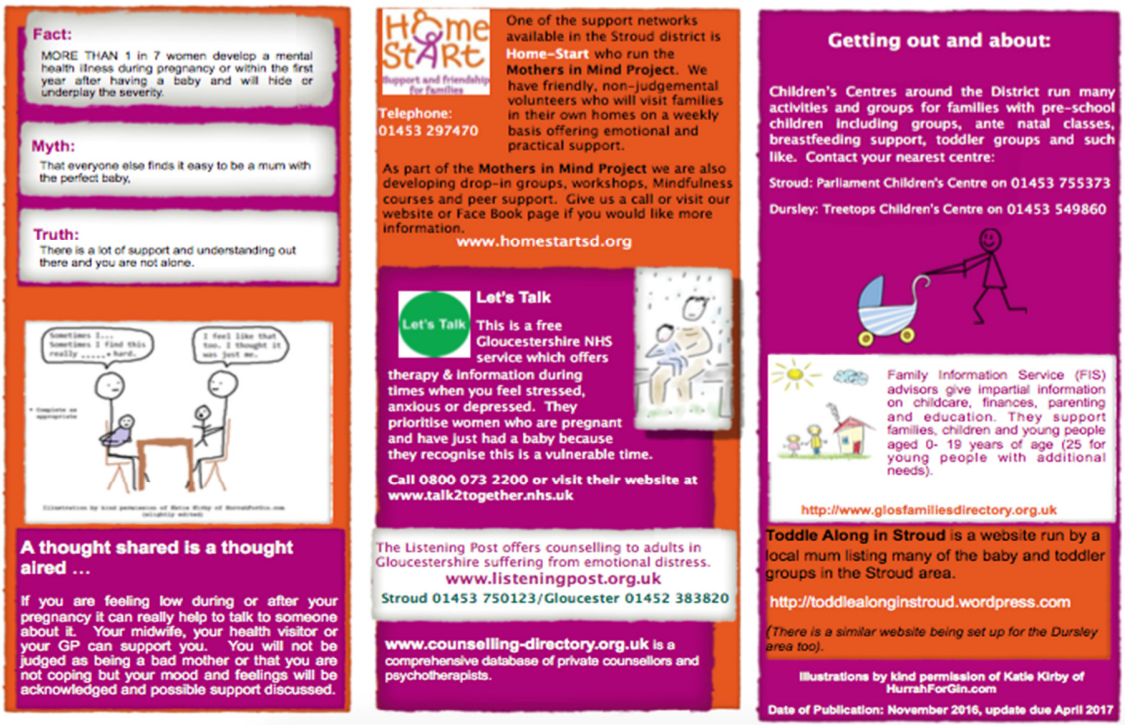
Glossary of Terms

Term	Meaning
CBT	Cognitive Behaviour Therapy. A Psychological Therapy which promotes change by addressing the link between thoughts, behaviour and mood
CQUIN	Commissioning for Quality and Innovation. A system whereby a proportion of healthcare providers' income is conditional on demonstrating improvements in quality and innovation in specified areas of patient care
GAD 7	General Anxiety Disorder questionnaire used to assess symptoms of anxiety
IAPT	Improving Access to Psychological Therapies. A national programme to increase the availability of 'talking therapies' primarily for people who have mild to moderate mental health difficulties
MHICT	Mental health intermediate Care Team. The Primary Mental Health service provided by 2gether NHS Trust. In Gloucestershire this includes the IAPT service
NICE	National Institute for Health and Care Excellence. Provides national guidance and advice to improve health and social care.
MESH	Monitoring and Evaluation system in Home-Start
PHQ 9	Patient Health Questionnaire used to assess symptoms of depression

Appendices

1. Leaflet developed for Project – Front and back





2. CBT wellbeing course interim report (cited on page 59 of report)

Perinatal Community Project

Mothers in Mind

Stroud

Home Start
Support and friendship for families

7th Nov 2016

INTERIM REPORT FROM HOME-START STROUD DISTRICT MOTHERS IN MIND PROJECT

RE REFERRAL PROCESS FOR CBT WORKSHOP –

prepared for Community support and MHICT meeting 8th November

The first set of CBT educational workshops facilitated by Jayne Harris, have now started, as part of the Mothers In Mind Stroud District Project, and there have been only 3 families who have agreed to do the course, with only 2 attending the first session held on 4th of November.

With a further course set to run in Dursley from January 13th I felt it was important that we evaluate and respond to the low uptake of the group in order to maximise the uptake of places on the next course.

Method of referral:

For the current group our referral clientele has been set at: women supported by Home-Start who met our perinatal Mothers in Mind Project criteria and who were not currently engaged in any psychological intervention with Lets Talk and were geographically within a 10 mile proximity (or that we could within reason transport to the course) were verbally told about the course and offered a telephone assessment with Jayne Harris (2Gether Trust) who would then make a final assessment about whether the course was the best possible treatment plan to offer the mother at that time.

Coordinators feedback from this initial process:

- It would have been really helpful to have some written information about the workshop to better inform families about the workshops. Possibly take-up for telephone assessment might have been higher.

Result of Referral Process:

From this pool of potential families we had the following responses:

family	reason given
1055	Attending
1056	Practical reasons juggling children make it impossible for mum to attend
1069	Has just finished her last Lets talk sessions – also times clash with playschool pick up
1061	Attending
1062	Has had Lets Talk in the past. Does not wish to do any more CBT.
1065	Does not want to commit to 6 weeks. Would also prefer to do Mindfulness course. Has had Lets Talk in the past.
1080	hands full with new baby (too tired)
1090	Baby due in two weeks – possibly January course
1098	Telephone assessment completed and place not offered
1085	Initially agreed to be Referred to Jayne for telephone assessment but did not respond to Jayne. Follow-up confirmed that she does not wish to do at the moment.
1096	Attending (but did not attend first session)
948	Would prefer to do Mindfulness course in January
890	Has had negative experience of Lets Talk and telephone CBT in the past and does not wish to re-engage with the service.
1075	No. but would like to do Mindfulness or have psychodynamic counselling
1064	Time clashes with children's activities. Would prefer Mindfulness approach.
1089	Practical issues make it too daunting. Does not like groups.

1046	Away when referral process happening.
939	Not wanting to commit to 6 weeks. Practical issues. Does not like groups.
1011	Has had Lets Talk in the Past. Does not wish to do anymore CBT
751	Too much going at present does not want to commit to course.
1058	Too stressful to do. Both for practical and emotional reasons. Has had Lets Talk in past.
933	Does not feel it is for her.
1068	Too much going on. Baby due v soon. Finishing Freedom programme

Number of families approached to attend course = 23 take-up 3

A brief summary of reasons given for low uptake:

Wrong time
Practical considerations
Geographical and transport issues
Perceived as being too stressful and fear of groups
Previous experience of CBT or Lets Talk
Too many other things going on

Conclusions, considerations and possible actions:

The next CBT workshop will run in Dursley from 13th of January. From our current families supported in the South of District we have approximately 12 families who meet the Mothers In Mind Criteria with another 5/7 from the North who have said they might be interested in travelling to Dursley. However, It is highly unlikely that all of these will want to do the course and looking at the results above we might only be looking at a handful committing to a telephone assessment.

We have the potential to fill 12 places for this course. In order to do this, I would propose that we open up the course to health visitors, midwives and children centre workers to make referrals to the workshop.

How this is done needs to be discussed. We have a few options:

Under the Mothers In Mind Project we can send out a letter and referral form from Jayne Harris that outlines the course, its place in the project, and requests referrals using the form that was used for the first course.

Or, as above, except letter and referral form come from Home-Start with clear instructions that referrals will be forwarded onto Jayne Harris and that the referral is for a CBT workshop and

not Home-Start support. In this way, Home-Start can collect data of families to add to our data system (stored in an anonymous way MESH) for our Mothers In Mind evaluation.

Time frame:

Ideally, if we are going to open this up we need to contact and/or send out information to referrers as soon as possible. Or, if we are not going to open it up outside of Home-Start's family I would request that we have written information and/or a poster to disseminate as soon as possible.

Alex Corgier

Further note to evaluation report 1/4/2017: The 2nd course was also poorly attended. The taster session did not prove very helpful in attracting more women to the group. Neither did opening up the group to outside of Home-Start as neither health visitors nor children centres referred many women to the group.

We were also holding a Mindfulness group for mothers during the same term and this was chosen above the CBT wellbeing group by 10 women from the same cohort of potential attendees. This would mean that some of the women that might have attended the CBT course attended the Mindfulness and would be a part of the reason for the very low uptake of the course.

3. Home-Start referral form

Home-Start Stroud District

Please note that all referrals must be made with the consent of the family and the family must have at least one child under the age of five years. *This form will be held in confidence but may be shown to the family if requested.*

Office use only: Date referral received by Home-Start: _____

Name of Main Carer: _____ D.o.B: ……

Main Carer's Ethnicity: _____ Disabled? YES / NO

Name of Partner: _____

Partner's Ethnicity: _____ Disabled? Yes / No

Address: _____ _____

_____ **Post Code:** _____

Tel No.:_____ **Mobile No.**:_____

Email: _____

Please provide details about any other adults living in the household: _____

Name of child up to 18 years (At least one child must be under the age of five years). **List Eldest child first**	Male Or Female ? M/F	D.o.B	Main carer considers Child disabled**?** Yes / No	Child Protection Plan? Yes*/No	CAF / TAC Assessment? Yes*/No	Child in need Yes*/No	Ethnicity
C1.							
C2.							
C3.							
C4.							
Pregnant? Approx due date -							

Referred by:

Name: _____ Role: _____

Agency: _____

Address: _____ **Postcode:** _____

Tel.: _____ Mobile: _____

Family needs

So that we can offer the family the most appropriate support, and match the most suitable volunteer please complete the following table. Families will not be prioritised on the basis of how many categories are ticked. This information, together with information provided by the family, will be used to monitor how our support meets the family's needs.

I hope that Home-Start will help meet needs the family has in the following areas:	✓	*If you have ticked, please tell us why this is a need.*
Managing children's behaviour		
Being involved in the children's development/learning		
Coping with physical health		
Coping with mental health		
Coping with feeling isolated		
Parent's self-esteem		
Coping with child's physical health		
Coping with child's mental health		
Managing the household budget		
The day-to-day running of the home		
Stress caused by conflict in the family		
Coping with extra work caused by multiple birth/children under 5		
Use of services*		
Other (please describe)		

Referral Form Continued:

Please place name (s) in the box of any individual in the family affected by:

Mental Health issues	Health issues	Special Educational Needs	Domestic abuse	Substance abuse	Post natal depression	Lone parent	Teenage parent <19yrs	Other

Additional Family Information:

Family Doctor: _____
Tel.:_____

Health Visitor: _____
Tel.:_____

*Social Worker: _____ Tel. _____

*CAF Lead Professional: _____ Tel.: _____

Other Agencies involved:
_____

Other Agencies referred to:
_____

Please tell us about any **Health and Safety issues** that we need to consider when placing a volunteer with this family.

Have you visited the family home? Yes / No

Also, please add any **background information** that you think we would find useful.

(Continue overleaf if necessary)

Referrer's signature: _____ Date: _____

Thank you for taking the time to provide this information which will help us to process the referral. We will try to respond to you within two weeks after receiving the referral to report progress. If you have any concerns about the referral process or the support for the family please contact the Senior Coordinator or ask for the Chairperson of the Charity.

4 Pilot Community Support and Mental Health Intermediate Care Team Pathway Report (30/06/16)

Pilot Community Support and Mental Health Intermediate Care Team Pathway Report

Author: Nathan Gregory, Gloucestershire Localities Performance & Development Lead**Contributors:** Alex Corgier Home-Start Scheme Manager, Helen Ford Senior Commissioning Manager Children, Young People and Maternity Commissioning Team, Alison Sedgwick Taylor Let's Talk Consultant Psychological Lead and Vicky Townsend Children, Young People and Maternity Commissioning Team **Date:** 30th June 2016

1. Context

1.1. The Gloucestershire Clinical Commissioning Group has set 2gether NHS Foundation Trust a local CQUIN relating to Perinatal Mental Health Service Delivery. The 2016/2017 CQUIN builds upon the previous work undertaken in the 2015/2016 CQUIN.

1.2. The 2016/17 CQUIN description indicator contains 6 parts. The Part 6 description indicator is to develop and pilot a pathway in conjunction with community services (Home-Start) and mental health services (Mental Health Intermediate Care Team). An implementation plan is required which will be developed in conjunction with Commissioners with a final report produced containing recommendations for future service delivery.

2. Introduction

2.1. Home-Start coordinated a first professional's meeting on the 27th April 2016. This was attended by Home-Start staff and volunteers, the Children, Young People & Maternity Commissioning Team, Stroud District Council, 2gether NHS Foundation Trust and Infant Mental Health Team, the Peter Lang Trust, Health Visitors, Public Health Nurse, a Midwifery Manager and a Manager from the Family Services Children's Centre.

2.2. The Commissioning Team introduced the project as being part of the Gloucestershire Clinical Commissioning Group developments in improving perinatal mental health in Gloucestershire and to improve care through co-ordinated services across the county.

2.3. Home-Start provided an overview of the project from a Home-Start perspective including:

- Home-Start home visiting – volunteers receive specialist training for this project (20 families supported).

- Additional training for all professionals working with women with mental health issues during the perinatal period.
- Developing groups in partnership.
- Developing Peer support.
- User group (four mothers identified and first meeting set).
- Professional group to develop the project and ensure effective joined up working (this group).
- Destigmatising mental health.
- Providing a report with recommendations for future services/model in the county.

2.4 It was agreed to establish a "Core Team" and for a further professionals meeting to be organised in the autumn of 2016.

3. Implementation Plan and Pathway

3.1. The Commissioning Team, Home-Start and 2gether NHS Foundation Trust met in May 2016 to scope a draft project implementation plan and considered the following areas:

- Model of Service Delivery
- Referral Process
- Data Collection and Analysis
- Stakeholders Views and Experiences
- Communication
- Training
- Governance
- Evaluation Report

3.2 The Aims of the project were discussed and initially agreed as:

- Set up a pathway for referrals between the Mental Health ICT and Community Service (Home-Start).
- Set up a user group/consultation group of local women affected by poor maternal mental health in order to seek their views on the development of the Home-Start Pilot Project.
- Set up a professionals group to develop and drive the project.
- 20 families to be supported by a Home-Start home visiting volunteer for up to 12 months. Volunteers will receive specialist training for this project.
- Explore/develop and run training for professionals working with perinatal women.
- Explore and set up drop in/support groups for women with poor perinatal mental health (potentially Home-Start and the Children's Centre).
- Home-Start to work with 2gether NHS Foundation Trust to develop maternal mental health wellbeing workshops for women (ante and post-natal).

- De-stigmatising campaign.
- Provide a report on the project (circa) January 2017 with options and recommendations for going forward.

3.3 Please see appendix 1 for the draft Implementation Plan and appendix 2 for the draft pathway.

3.4 It is planned to establish a Leadership Team which will meet every 8 weeks to monitor progress against the project implementation plan. The date of the next meeting is the 4th August 2016.

3.5 The Implementation Team will report to the Commissioners Perinatal Bi-Monthly meeting and the next meeting is planned for the 26th July 2016.

3.6 The project will be launched at the Home-Start AGM planned for the 12th July 2016.

4. Model of Service Delivery

4.1 The vision is to develop a community based model and pathway with Home-Start and the Mental Health Intermediate Care Team (MH ICT) in the Stroud locality. The basis for the pathway will be ease of access for referrals between the Home-Start and the MH ICT so that women can be stepped up or down according to their needs.

4.2 A MH ICT High Intensity Therapist (once appointed) will also deliver two condition specific evidence based treatment groups to 10-12 women over 6-8 weeks co-produced with Home-Start staff using community based venues in Dursley and Stroud.

4.3 It is planned to discuss the project at the Gloucestershire Mums and Babies in Mind meeting on the 23rd June 2016. There is also a meeting on the 27th June 2016 with Commissioners, Home-Start, 2gether NHS Foundation Trust and Acacia who have developed a similar community based model in Birmingham.

5. Referral Process

5.1 Referrals for the Project will be accepted through the usual Home-Start referral process but families will be specifically allocated to the project where it is identified that there is a pregnant mother or a mother with a child up to the age of two with poor mental health.

5.2 Home-Start has funding to support 20 families during the project and have been delivering a service since March 2016.

6. Data Collection and Analysis

6.1. Home-Start uses a systematic data collection, monitoring, evaluation and reporting system called Mesh. This charts the journey of change that parents and children make while supported by Home-Start. It is planned to use Service User feedback about the support received through interviews and a staff evaluation.

6.2. Home-Start has begun the process of gathering information and to date the themes raised by participants are:

- Peer support
- Social media that is accessible from home
- Quicker access to Let's Talk (the 2gether NHS Foundation Trust Improving Access to Psychological Therapies Service)
- Face to Face contact more valued than telephone contact
- Mindfulness
- Drop in group

6.3 For the two conditions specific treatment groups the PHQ 9 and GAD 7 will be used with participants. The GAD 7 is a self-administered questionnaire and is used as a screening tool and severity measure for generalized anxiety disorder. The PHQ 9 is a multipurpose instrument for diagnosing, screening, monitoring and measuring the severity of depression. It screens for the presence and duration of suicidal ideation. The tool is completed by the person and scored by the clinician. It can reflect worsening or improvement of depression in response to treatment.

7. Stakeholders Views and Experiences

7.1. As part of the project it is planned to gather the views and experiences of referrers using a Home-Start Feedback Questionnaire.

8. Communication

8.1. The implementation plan will consider the use of leaflets, posters and social media. It is anticipated that a Psychology Graduate, subject to confirmation, could lead on scoping out a home accessible social media forum and consider the quality governance arrangements.

9. Training

9.1. The MH ICT High Intensity Therapist (once appointed) will deliver Cognitive Behavioural Therapy (CBT) training and supervision to a cohort of Home-Start Coordinators and volunteers.

10. Governance

10.1 Home-Start Co-ordinators (who are paid members of staff) and volunteers have DBS checks in place. Co-ordinators can look after children with their parents' permission in order for women to attend groups.

11. Evaluation Report

11.1. The Home-Start Scheme Manager will be the Lead Author (with contribution from the Leadership Team). To meet the project aims CQUIN requirement the report will require activity on the numbers of referrals and numbers of women stepping up and down in the community model. The report will also be required to make recommendations for future service delivery.

12. Milestones

12.1. The project will operate over a 12 month duration with a final report prepared by March 2017.

6 google Home-Start online family questionnaire

Mothers in Mind

Home Start Stroud District - Perinatal Mental Health Community Project

* Required

We need your help

Home-Start Stroud District has received funding for a project, Mothers in Mind, which aims to improve the support offered to women experiencing perinatal mental health issues, including post-natal depression. (Perinatal refers to a time frame, and is defined as the period from conception to two years after birth.)

This questionnaire is for Mum's who are currently supported, or have in the past been supported, by Home-Start.

THE QUESTIONNAIRE SHOULD TAKE APPROXIMATELY 15 MINUTES TO COMPLETE AND CANNOT BE SAVED MIDWAY SO NEEDS TO BE DONE IN ONE GO!

You can complete the questionnaire anonymously but if you do give your name we can assure you that all individual responses will remain confidential within Home-Start Stroud District. We will be sharing the overall results in a report but no individuals will be identifiable without their permission.

Many, many thanks for taking the time to do this, we really do appreciate your help in making a difference to the future experiences of mothers.

Finally, if you find that completing this questionnaire brings up any questions or concerns then please don't hesitate to contact your Home-Start Co-ordinator, or the Home-Start Office on 01453 297470, for support.

Section 1 - You and Home-Start

1. Are you currently being supported by Home-Start Stroud District? *
   Mark only one oval.

   - ◯ Yes, we are.
   - ◯ No, but we have been in the past.

2. How long have you been supported (or were supported for, if it has now ended) by Home Start? *
   Mark only one oval.

Less than 3 monhts

Between 3 and 6 months

Between one and two years

More than 2 years

Don't know

3 What was the original reason for you being supported by Home Start?Mark only one oval. Doesn'tAgree ApplyNeither Agree nor DisagreeAgree Neither Agree norDisagree Disagree

Disagree

Other:

Don't know

Section 2 - Attitudes to Mental Health

This pilot project is specifically about support with Perinatal Mental Health challenges so we are really interested to hear about your opinions and experience whether or not you have suffered yourself.

Thinking about general attitudes to Mental Health

4. Please read these statements and tick the appropriate box to show whether or not you agree with what's said. * Mark only one oval per row.

	Agree	Neither Agree nor Disagree	Disagree
Many people think that mental health issues are a sign of weakness.			
People often feel uncomfortable when others talk about their mental health			
Many people think that poor mental health is not something that happens to people like them			
Generally people don't understand that we need to look after our mental health as much as we look after our physical health.			
People are often ashamed to talk openly about their mental health issues.			

Thinking about your attitude to your own mental health

5. Please read these statements and tick the appropriate box to show whether or not you agree.
* Mark only one oval per row.

	Doesn't Apply	Agree	Neither Agree nor Disagree	Disagree
I am able to be open with family and friends that I have (or have had) mental health issues	◯	◯	◯	◯
I find it easier to talk about suffering with 'depression' or 'anxiety' than to mention 'mental health'.	◯	◯	◯	◯
If I admit to having mental health problems I'm worried my baby/child may be taken away	◯	◯	◯	◯
I often hide how I am really feeling inside.	◯	◯	◯	◯
People will judge me if I mention I have poor mental health.	◯	◯	◯	◯

6. Which of the following would you prefer to use, or be used by others, when talking about perinatal mental health? * Mark only one oval.

- ◯ Perinatal mental health issues
- ◯ Poor perinatal mental health
- ◯ Perinatal mental health problems
- ◯ Perinatal mental health challenges
- ◯ Don't Know
- ◯ ..... Other:

7. Comments (Optional)

.....

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8. On a scale of 1 -10 how important do you think it is that the stigma around talking openly about mental health issues is addressed? * Mark only one oval.

	1	2	3	4	5	6	7	8	9	10	
Not Important	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	Very Important

9. Comments (Optional)

Section 3 - How's it been for you?

We'd like to know how you have been feeling in the 'perinatal' period - the time from becoming pregnant up until two years after the birth.

10 Since becoming pregnant, and within 2 years of giving birth, would you say you have youNot at All Occasionally Often Every day suffered from any of the following? * Mark only one oval per row.

	Not at All	Occasionally	Often	Every day
Low Mood and/or Tearfulness				
Feeling overwhelmed				
Being irritable/arguing more often				
Lack of concentration				
Problems sleeping or extreme energy				
Changes in appetite				
Racing thoughts				
Feeling more anxious				
Lack of interest in usual things				

11. If you have suffered with any of the above, how difficult have these made it for you to take care of things at home or get along with other people? * Mark only one oval.

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult

12. Have you ever felt like you have been putting on a mask in front of friends and family, pretending that all was okay but underneath you were falling apart? Mark only one oval.

- Yes
- No
- Not sure/Maybe

13. Comments (Optional)

14. If you feel that you have had challenges with your mental health during the perinatal period we'd like to find out a little more about your experience by asking some multiple choice questions in the next section. Are you happy to continue? *
Mark only one oval.

- Yes, I'm happy to help Skip to question 20.
- No, I don't feel able to right now Skip to question 15.
- No, this doesn't apply to me Stop filling out this form.

Advice and SupportYes, always Yes, sometimes No Don't know
If yo~~u feel you need some advice or support because of issues brought up by th~~ese questions pleased don't hesitate to contact your Home Start Co-ordinator or the Home-Start Office on 01453 297470.

15. We understand that you don't want to complete any more questions right now but wonder if you would be willing to have a chat with a member of the Home-Start team about your experiences? * Mark only one oval.

- Yes, I would be interested (Please complete the contact details below)
- No, I wouldn't be interested
- Possibly, I may be interested (Please complete the contact details below)

16. Comments (optional)

17. Your Name

18. Your Email Address

19. Your Telephone Number

Stop filling out this form.

Section 4 - Your Experience of Support

20. Have you felt able to be totally honest with your Midwife, GP, Health Visitor or Home Start volunteer about how you are really feeling in terms of the symptoms mentioned in 'Section 3 How's it been for you'? *

Mark only one oval per row.

	Yes, always	Yes, sometimes	No	Don't know
Midwife				
GP				
Health Visitor				
Home Start Volunteer				

21 If you HAVE been able to be honest with your Midwife what was it that allowed that to happen? (tick as many as apply) Check all that apply.

- [ ] They asked me a direct question about how I was feeling
- [ ] I felt they had time to listen
- [ ] I know them well enough to trust them and feel safe
- [ ] I felt they weren't going to judge me
- [ ] I don't have any problem talking about my mental health issues
- [ ] ..... Other:

22. If you HAVE NOT felt able to be honest with your Midwife what was it that stopped you? (tick as many as apply)

Check all that apply.

- [ ] I didn't feel they were interested
- [ ] They didn't have time to listen
- [ ] I don't trust them enough
- [ ] I'm worried my child(ren) could be taken away if I admit I'm struggling
- [ ] I don't want to be judged as not coping
- [ ] I'm worried because I don't know what will happen if I do
- [ ] I don't want mental health issues to be in my notes or my child's red book
- [ ] People like me should be able to cope
- [ ] It'll pass and I'll get better on my own
- [ ] ..... Other:

23. If you HAVE been able to be honest with your GP what was it that allowed that to happen? (tick as many as apply)

Check all that apply.

They asked me a direct question about how I was feeling

I felt they had time to listen

I know them well enough to trust them and feel safe

I felt they weren't going to judge me

I don't have any problem talking about my mental health issues

Other:

.

24 If you HAVE NOT felt able to be honest with your GP what was it that stopped you? (tick as many as apply)
Check all that apply.

- [ ] I didn't feel they were interested
- [ ] They didn't have time to listen
- [ ] I don't trust them enough
- [ ] I'm worried that my child(ren) could be taken away if I admit I'm struggling
- [ ] I don't want to be judged as not coping
- [ ] I'm worried because I don't know what will happen if I do
- [ ] I don't want mental health issues to be in my notes or my child's red book
- [ ] People like me should be able to cope
- [ ] It'll pass and I'll get better on my own
- [ ] Other: .....

25. If you HAVE been able to be honest with your Health Visitor what was it that allowed that to happen? (tick as many as apply) Check all that apply.

- [ ] They asked me a direct question about how I was feeling
- [ ] I felt they had time to listen
- [ ] I know them well enough to trust them and feel safe
- [ ] I felt they weren't going to judge me
- [ ] I don't have any problem talking about my mental health issues
- [ ] ..... Other:

26. If you HAVE NOT felt able to be honest with your Health Visitor what was it that stopped you? (tick as many as apply) Check all that apply.

- [ ] I didn't feel they were interested
- [ ] They didn't have time to listen
- [ ] I don't trust them enough
- [ ] I'm worried that my child(ren) could be taken away if I admit I'm struggling
- [ ] I don't want to be judged as not coping
- [ ] I'm worried because I don't know what will happen if I do
- [ ] I don't want mental health issues to be in my notes or my child's red book
- [ ] People like me should be able to cope
- [ ] It'll pass and I'll get better on my own
- [ ] Other:

27 If you HAVE been able to be honest with your Home-Start Volunteer what was it that allowed that to happen? (tick as many as apply) Check all that apply.

.

- [ ] They asked me a direct question about how I was feeling
- [ ] I felt they had time to listen
- [ ] I know them well enough to trust them and feel safe
- [ ] I felt they weren't going to judge me
- [ ] I don't have any problem talking about my mental health issues
- [ ] Other: .....

28. If you HAVE NOT felt able to be honest with your Home Start Volunteer what was it that stopped you? (tick as many as apply) Check all that apply.

- [ ] I didn't feel they were interested
- [ ] They didn't have time to listen
- [ ] I don't trust them enough
- [ ] I'm worried that my child(ren) could be taken away if I admit I'm struggling
- [ ] I don't want to be judged as not coping
- [ ] I'm worried because I don't know what will happen if I do
- [ ] I don't want mental health issues to be in my notes or my child's red book
- [ ] People like me should be able to cope
- [ ] It'll pass and I'll get better on my own
- [ ] Other: .....

29. What treatment have you received? * Check all that apply.

- [ ] Medication - eg antidepressants
- [ ] Cognitive Behavioural Therapy (CBT)
- [ ] Counselling/Psychotherapy
- [ ] None
- [ ] Other:

30. Comments (optional)

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31 How would you rate the support you have received in terms of helping with your mental andHaven't used Not helpful Neither helpful or unhelpful Helpful emotional well-being? * Mark only one oval per row.

.

	Haven't used	Not helpful	Neither helpful or unhelpful	Helpful
Midwife				
GP				
Health Visitor				
Home Start				
Let's Talk				
Children's Centre				
Family and friends				
National Childbirth Trust				
Parent and Toddler Group				

32. Comments (optional)

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33. Have you been offered or had experience of Let's Talk services? *
Mark only one oval.

- Yes Skip to question 34.
- No Skip to question 53.
- Don't know Skip to question 53.

Section 5 - Your Experience of Let's Talk Services

As a part of the Mothers in Mind project we are working with Let's Talk and the 2gether Trust (part of the NHS) to improve services for mothers around perinatal mental health challenges. We'd really like to know about your experience of the service.

34. Generally people are given a phone number to call. How did you find making the initial contact with Let's Talk? * Mark only one oval.

- I was given an appointment and didn't have to make a call
- I just called them, no problem
- I had to build myself up to doing it
- It was hard to find the right time to make the call
- I found lots of reasons to put it off but did call in the end
- Too difficult, I didn't call but someone else did it for me
- Too difficult, I didn't call and didn't use the service After the last question in this section, skip to question 53.

.

35 Comments (optional)

Section 5 - Your Experience of Let's Talk Services

36. Which Let's Talk Service(s) were you offered? * Mark only one oval per row.

	Yes	No	Don't Know
Self Help Materials			
A group programme			
Guided Self-Help Materials with Telephone Support Face to face CBT (cognitive behavioural therapy)			

37. Comments (optional)

38. If you used the Self Help materials offered how useful did you find them? Mark only one oval.

	1	2	3	4	5	
Not useful						Very useful

39. Comments (optional)

.

40 If you attended a Group Programme how useful did you find it?
Mark only one oval.

	1	2	3	4	5	
Not useful	◯	◯	◯	◯	◯	Very useful

41. Comments (optional)

42. If you used the Guided Self Help materials with Telephone Support how useful did you find it?
Mark only one oval.

	1	2	3	4	5	
Not useful	◯	◯	◯	◯	◯	Very useful

43. Comments (optional)

44. If you received face to face CBT treatment, how useful did you find it? Mark only one oval.

	1	2	3	4	5	
Not Useful	◯	◯	◯	◯	◯	Very Useful

45. Comments (optional)

.

46 How long did you have to wait for your first appointment?
Mark only one oval.

- Less than 2 weeks
- Between 2 and 4 weeks
- Between 4 weeks and 2 months
- Between 2 and 4 months
- More than 4 months

47. Comments (optional)

48. Do you think that account was taken of your pregnancy or baby, and the particular challenges that brings? * Mark only one oval.

- Yes
- No
- Don't know

49. Comments (optional)

50. Would you be willing to answer some more detailed questions about your experience with Let's Talk? * Mark only one oval.

.

- [ ] Yes
- [ ] No
- [ ] Maybe

51 Comments (optional)

52. If yes, or maybe, please provide your email address below and we will be in touch.

53. Do you have partner who lives with you? * Mark only one oval.

- Yes Skip to question 54.
- No Skip to question 60.

Section 6 - Support for your partner

54. Has your partner received any support to help them cope with your mental health challenges? *

Mark only one oval.

- Yes
- No
- Don't know

55. Comments (optional)

56. If yes, where did it come from? (Tick as many as apply) Check all that apply.

- [ ] Midwife
- [ ] GP
- [ ] Health Visitor
- [ ] Home-Start Volunteer
- [ ] Friends and/or family
- [ ] Social media/websites
- [ ] Other:

57 Comments (optional)

58. How important do you think it is that there is information available specifically aimed at supporting the partners of women suffering with perinatal mental health challenges? *
Mark only one oval.

	1	2	3	4	5	6	7	8	9	10	
Not necessary	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	Extremely Important

59. Comments (optional)

Next Steps

Thank you for taking the time to answer our questions, we really do appreciate your input.

If you have (or have had) perinatal mental health issues your individual experience can be really valuable in helping our understanding of what is working well, and what needs improvement. So, if you would be willing, we'd like to find out more about how it's been for you. This would be arranged at a time to suit you, and could be face to face or on the phone.

60. Would you be willing to have a chat with a member of the Home-Start team to help us collect more detailed information about the experiences of mothers in the Stroud District affected by mental health challenges? * Mark only one oval.

- Yes
- No
- Maybe

61. Comments (optional)

62 Your Name

63. Your Email Address

64. Your Telephone Number

Perinatal Community Project
Mothers in Mind
Stroud

END.