Understanding the Barriers to Accessing Perinatal Mental Health Services

Royal Borough of Greenwich

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This report was commissioned by
Bromley, Lewisham & Greenwich Mind
on behalf of NHS England

Executive Summary

In the year after childbirth, 15–20% of women are affected by depression and anxiety. NICE emphasises the importance of early detection and management of mental health problems during pregnancy and in the postnatal period – perinatal mental health care is a real lifeline for many young families.

The Royal Borough of Greenwich is home to a diverse multicultural population with a higher than average birth rate. Greenwich's young families are well served by children's centres, and there is a specialist community perinatal mental health service for mothers with severe mental health difficulties. Perinatal support is also available from MumsAid, a charity that provides psychotherapy alongside other services, and Bromley, Lewisham & Greenwich Mind, which hosts Mindful Mums groups.

But not all women who might benefit from such services access them. This report explores why some women in Greenwich do not or cannot access perinatal mental health services. It is influenced by the COVID-19 pandemic and uses a peer research methodology to place lived experience at the centre of our findings.

Two focus groups and 12 informal interviews yielded rich qualitative data, which was balanced by quantitative data from 53 survey responses. Shockingly, more than a fifth of respondents said they were unable to access the support that they needed, and almost 40% of those who did access support did not continue with it.

Barriers to accessing perinatal mental health support

Childcare and location: Many mothers find arranging childcare difficult or stressful, and some don't want to talk about their mental health in front of their children. Some services are in a tricky location.

Stigma and self-stigma: Shame and a sense of stigma prevent some mothers from being honest about their feelings and seeking help. Those who do talk about their feelings may be met with a lack of understanding or even disapproval from their family and friends.

Fear of social services: Some mothers are afraid that if they disclose how they are feeling, they might be perceived as a bad parent or be referred to social services – fears that are sadly not wholly unfounded.

Financial barriers: Therapy can be prohibitively expensive, and free courses of therapy usually end after six or eight weeks. Housing issues and other aspects of poverty can worsen mothers' mental health and reduce their capacity to engage with services.

Lack of mental health knowledge: Some mothers (and those around them) do not recognise that they are experiencing a mental health issue, such as postnatal depression. Others do not know where to find the right support.

Domestic abuse: Perinatal mental health problems can be exacerbated by domestic abuse. It is unrealistic to expect women to engage with therapy or other services while they are fearing for their own safety.

Lack of time and continuity in primary care: Staffing and funding pressures mean that GPs, health visitors and midwives are often unable to give mothers the time and attention they need to disclose emotional struggles.

Lack of mental health knowledge in primary care: Some GPs, health visitors and midwives have limited awareness of mental health and fail to show compassion or understanding when mothers attempt to open up.

Pressure to breastfeed: Breastfeeding is widely promoted and supported in the UK, but the relationship between infant feeding and maternal wellbeing is significant and complex. For some mothers, a sense of pressure to breastfeed is harmful to their mental wellbeing and their relationship with healthcare workers.

An emphasis on medication: Some GPs prescribe medication for anxiety and low mood before considering other treatment options. Mothers who are reluctant to take this medication may then disengage or stop seeking support.

Referral to non-perinatal talking therapies: Generic talking therapies are generally more of a hindrance than a help with perinatal mental health issues, and can delay or prevent mothers accessing specialist support.

Falling through the gaps: Some mothers do not get the support they need because their referrals have been delayed or missed by healthcare professionals, or they feel daunted by the process of self-referral.

Recommendations

1. Perinatal mental health needs to be prioritised during the pandemic as a matter of urgency.
2. Mothers in Greenwich need greater provision of perinatal-specific talking therapies to support their mental health.
3. Mothers in Greenwich need greater provision of perinatal-specific peer support for their mental health.
4. All relevant local services should evaluate how feasible it is for mothers to attend appointments/groups and make adjustments accordingly.
5. Midwives, maternity support workers, health visitors, and children's centre staff need more perinatal mental health training.
6. GPs need more perinatal mental health training and an up-to-date understanding of local service provision and referral pathways.
7. Targeted outreach is required to ensure accessibility for mothers from diverse ethnic and cultural backgrounds.
8. Young mothers, and others identified as vulnerable, should receive specialist holistic support.
9. A local perinatal mental health awareness campaign should be launched, with three distinct aims: helping families to identify signs of a potential perinatal mental health problem, de-stigmatising, and signposting to appropriate support.
10. Mothers' mental health should be assessed along with their physical health as part of routine maternity care.

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Introduction and Background

Greenwich is a royal borough in southeast Greater London with a diverse multicultural population. At the time of the last census in 2011, there were 254,557 people living in the borough, 52.3% of whom defined themselves as White British, compared with a national average of 80%. The largest minority groups represented were of Black and Asian heritage.[1]

In 2015, the borough had a fertility rate of 72.7 live births per 1,000 aged 15–44, higher than both the London average of 63.9 and the England average of 62.5.[2] As such, new parents represent a significant portion of the population in Greenwich, and one would expect both the number and diversity of young families in the area to be reflected in the provision of support available.

The National Institute of Clinical Excellence (NICE) reports that 15–20% of women are affected by depression and anxiety in the first year after childbirth. NICE stresses the importance of early detection and management of mental health problems during pregnancy and in the postnatal period.[3] As such, perinatal mental health care is an essential component of services for young families.

Greenwich has 23 children's centres, ample provision compared to other parts of the country. Nationally children's centres have seen a 62% cut in funding between 2010 and 2019, and education charity The Sutton Trust estimates more than 1000 centres closed between 2009 and 2019.[4] Funding for children's centres has been better protected in Greenwich than in most other areas. The children's centres host family support workers, 'stay and play' groups, baby massage, baby yoga, and interactive story time and music groups for under-fives, as well as craft workshops, cookery, and nutritional advice for adults. Home-Start Greenwich work in partnership with Royal Greenwich delivering children centre services from seven of these settings, and also run a home visiting volunteer support service.[5] It seems that most, if not all, local children's centres have halted face-to-face contact in the wake of COVID-19, including over the summer. Some but not all these activities are continuing online.

Since February 2019, mothers who are affected by more severe perinatal mental health difficulties can be referred to the specialist community perinatal mental health service for women in Bexley, Bromley and Greenwich. This service offers assessment and treatment for women during pregnancy and up to a year after childbirth, although its remit is limited to those with complex needs and severe mental illness.[6]

Mothers in Greenwich can benefit from services offered by MumsAid, a registered charity providing free counselling from trained counsellors and psychotherapists for women experiencing mental or emotional difficulties in pregnancy or after having a baby. Since 2015, MumsAid have also been delivering the YoungMumsAid service for mothers as young as 14, many of whom have complex needs which can prevent

[1] Office for National Statistics (2011): http://www.ons.gov.uk/ons/rel/census/2011-census/key-statistics-and-quick-statistics-for-wards-and-output-areas-in-england-and-wales/rft---qs211ew-wm.xls.
[2] Greenwich Joint Strategic Needs Assessment (2015): http://www.greenwichjsna.org/app/uploads/2015/08/Demography_JSNA-1.pdf.
[3] National Institute of Clinical Excellence (2018): Antenatal and postnatal mental health: clinical management and service guidance: https://www.nice.org.uk/guidance/cg192.
[4] Action for Children (2019): https://www.actionforchildren.org.uk/news-and-blogs/policy-updates/2019/june/the-result-of-cuts-and-children-s-centre-closures/.
[5] Home-Start Greenwich (2020): About Us: https://homestartgreenwich.org.uk/about-us/.
[6] Oxleas NHS Foundation Trust: Bexley, Bromley & Greenwich Specialist Perinatal Mental Health Service: http://oxleas.nhs.uk/services/service/perinatal-mental-health-servic/.

their accessing support services. In addition, they run an outreach service of peer supporters, a parenting group, and an art therapy group, as well as co-running a weekly group with the NHS perinatal mental health service. Bromley, Lewisham and Greenwich Mind (BLG Mind) host 'Mindful Mums' groups, which have been operational in Greenwich since 2019. The groups are run by trained volunteers, and offer free support to new mothers with an emphasis on peer support and self-care skills.[7]

[7] BLG Mind: Mindful Mums: https://blgmind.org.uk/greenwich/mindful-mums/.

Research Summary

BLG Mind were commissioned by NHS England to lead research into why women in South East London may not wish or be able to access perinatal mental health services (defined as services for pregnant women and women with children up to the age of two years). BLG Mind appointed MumsAid to undertake community engagement within the borough of Greenwich, examining barriers to accessing perinatal mental health services, and to recommend approaches to overcome these.

MumsAid is a specialist perinatal mental health project that has supported approximately 700 mothers in Greenwich since 2012. They were winners of the Maternal Mental Health Alliance's and Big Lottery's national award for Inclusivity and Diversity (2018), 'for showing innovation in meeting the needs of a diverse range of families experiencing perinatal mental health difficulties'.[8] In their evaluation of January 2020, 58% of their clients come from black and minority ethnic communities.

MumsAid recruited Laura Wood, a peer researcher whose work is informed by her own lived experience of perinatal mental health difficulties, to deliver informal interviews (telephone conversations) and focus groups with mothers in Greenwich, to analyse the results of an accompanying survey, and to write up this report of the findings. Peer research methodology challenges traditional academic structures of research by placing lived experience at the centre. It seeks to address the ways in which traditional approaches to research can be tokenistic in their engagement of people with experiential expertise, and it fosters authentic and mutual participation for both researcher and those participating in research. Peer research breaks down barriers between researcher and 'participant', shifting roles from 'expert' and 'person being researched' to peers with shared understanding.

These activities took place between March and October 2020, and subsequently have been influenced by the COVID-19 pandemic. Factors such as increased social isolation, reduced access to childcare and support structures, and health anxieties have caused difficulties for everyone, from staff at MumsAid, to the peer researcher, to the mothers participating in this research. Subsequently conversations with these mothers, and the answers they gave, will have been coloured by this situation. MumsAid have been managing decreased capacity and increased demand for their services, while the peer researcher has had a lengthy illness after being infected with COVID-19. The focus groups, which were originally intended to be 'face-to-face', switched to remote delivery, which reduced accessibility as many mothers do not have access to smartphones or the technology to do video calls. For these reasons, two focus groups took place instead of the four that were originally planned.

Participant Demographics

Survey Respondent Demographics

The 53 survey respondents were all aged between 25 and 49 years, with the majority (39.62%) in the 25–34 age bracket, followed closely by the 35–39 age bracket (33.96%). Most respondents were employed, equally split between part-time and full-time (32.08% each). Most were married (60.38%), and the majority were heterosexual (86.27%) while the rest identified as bisexual or pansexual. 56.60% were white British, which is

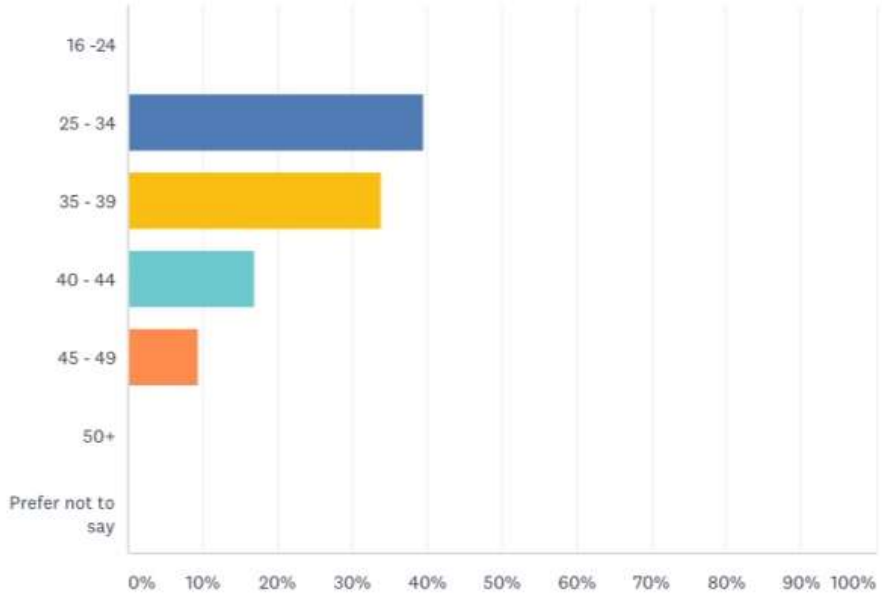
[8] Maternal Mental Health Alliance: Perinatal Mental Health Awards 2018 https://maternalmentalhealthalliance.org/tag/mmhaconf2018/.

roughly representative of the local population, with a wide variety of other ethnicities represented. The majority had no religious affiliation (45.10%), while most others identified with Christian religions (including Catholicism and Protestantism).

Q9

What age group do you belong to?

Answered: 53 Skipped: 0

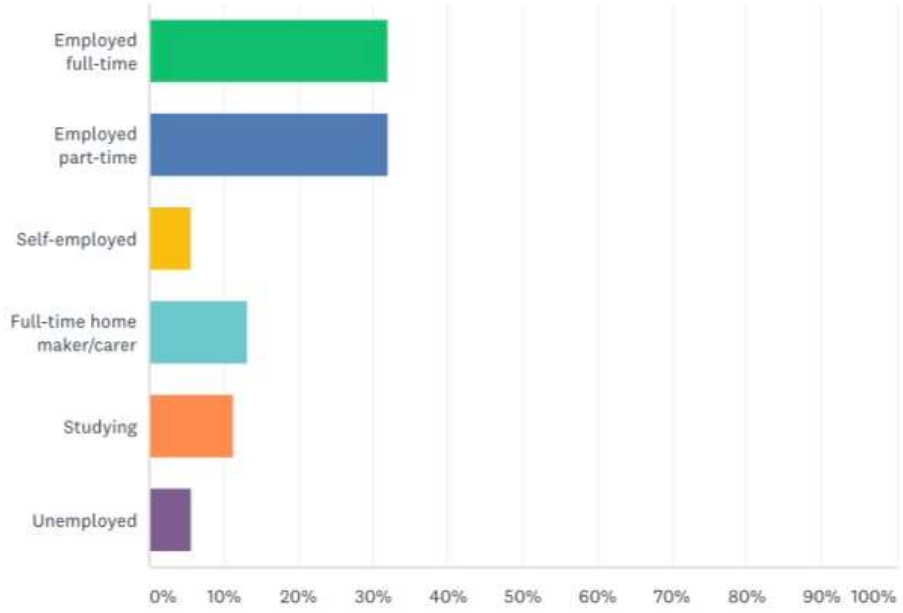


ANSWER CHOICES	RESPONSES	
16 -24	0.00%	0
25 - 34	39.62%	21
35 - 39	33.96%	18
40 - 44	16.98%	9
45 - 49	9.43%	5
50+	0.00%	0
Prefer not to say	0.00%	0
TOTAL		**53**

Q10

Are you

Answered: 53 Skipped: 0

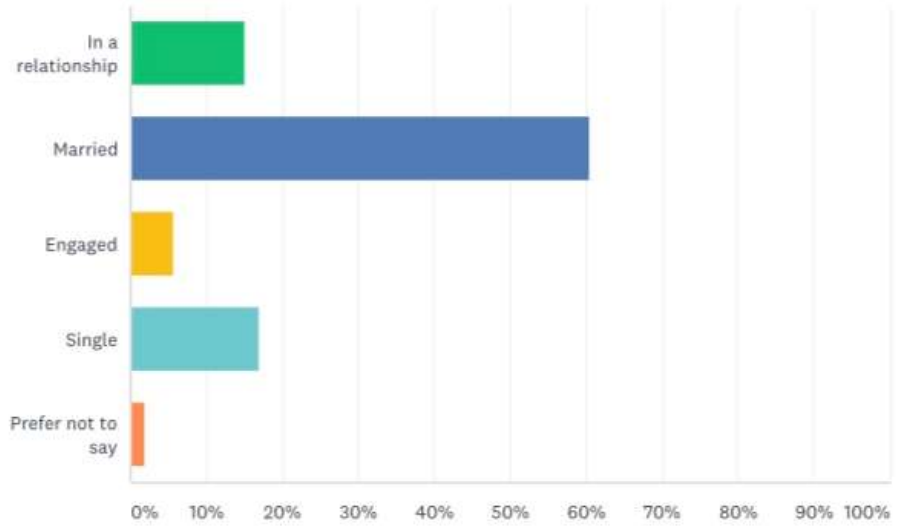


ANSWER CHOICES	RESPONSES	
Employed full-time	32.08%	17
Employed part-time	32.08%	17
Self-employed	5.66%	3
Full-time home maker/carer	13.21%	7
Studying	11.32%	6
Unemployed	5.66%	3
TOTAL		53

Q11

What's your current relationship status?

Answered: 53 Skipped: 0

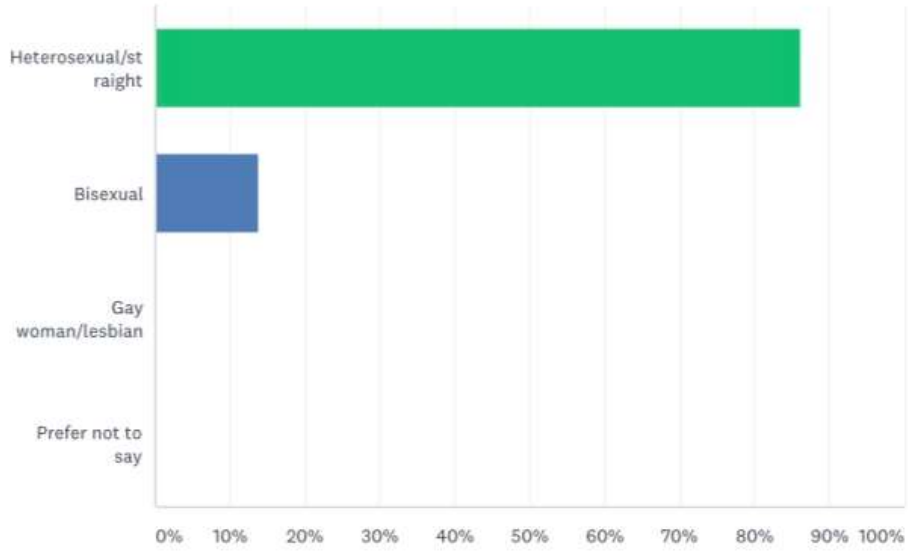


ANSWER CHOICES	RESPONSES	
In a relationship	15.09%	8
Married	60.38%	32
Engaged	5.66%	3
Single	16.98%	9
Prefer not to say	1.89%	1
TOTAL		53

Q12

Do you consider yourself to be:

Answered: 51 Skipped: 2

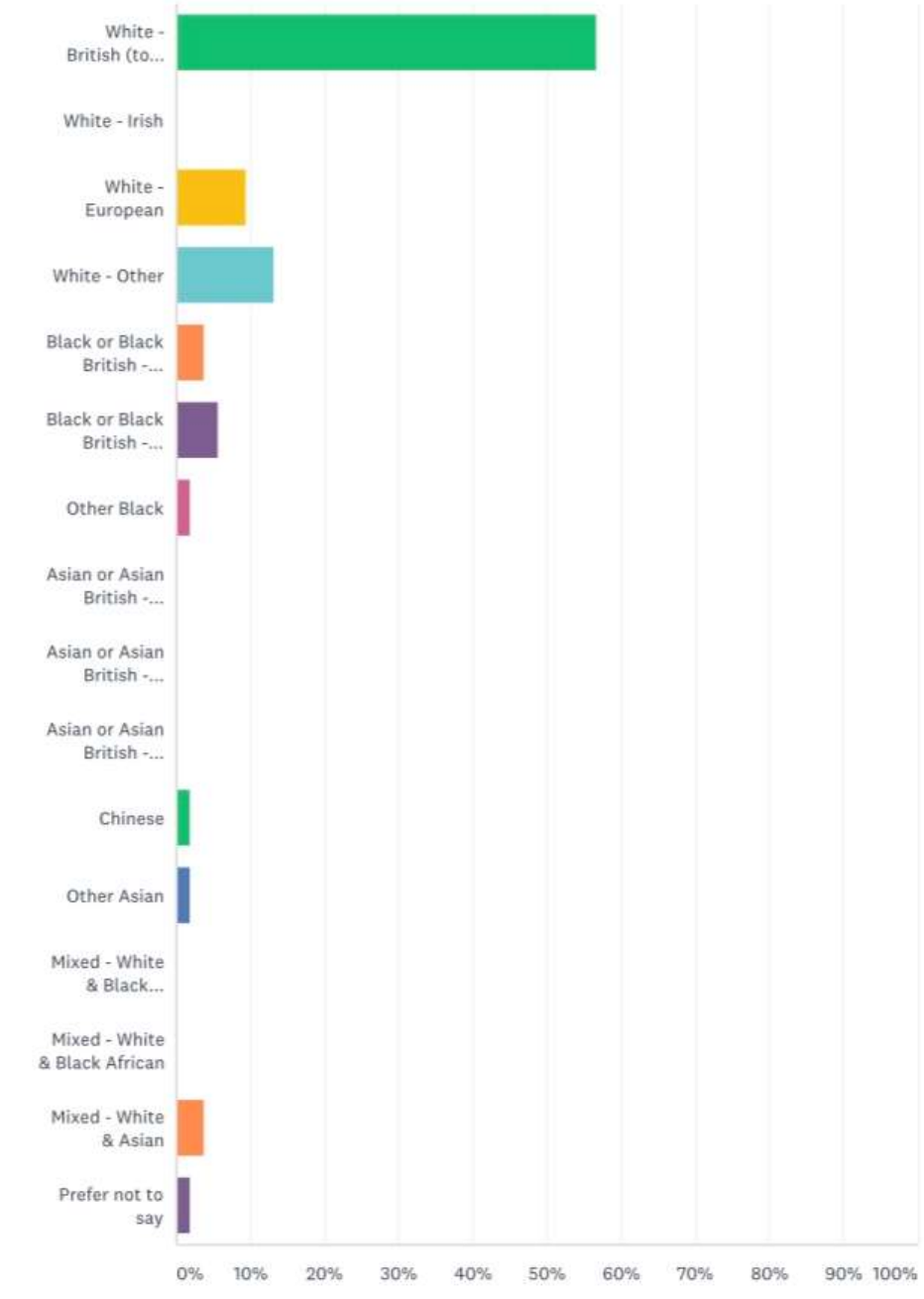


ANSWER CHOICES	RESPONSES	
Heterosexual/straight	86.27%	44
Bisexual	13.73%	7
Gay woman/lesbian	0.00%	0
Prefer not to say	0.00%	0
TOTAL		51

Q13

Please indicate which ethnic group you consider yourself to be from?

Answered: 53 Skipped: 0

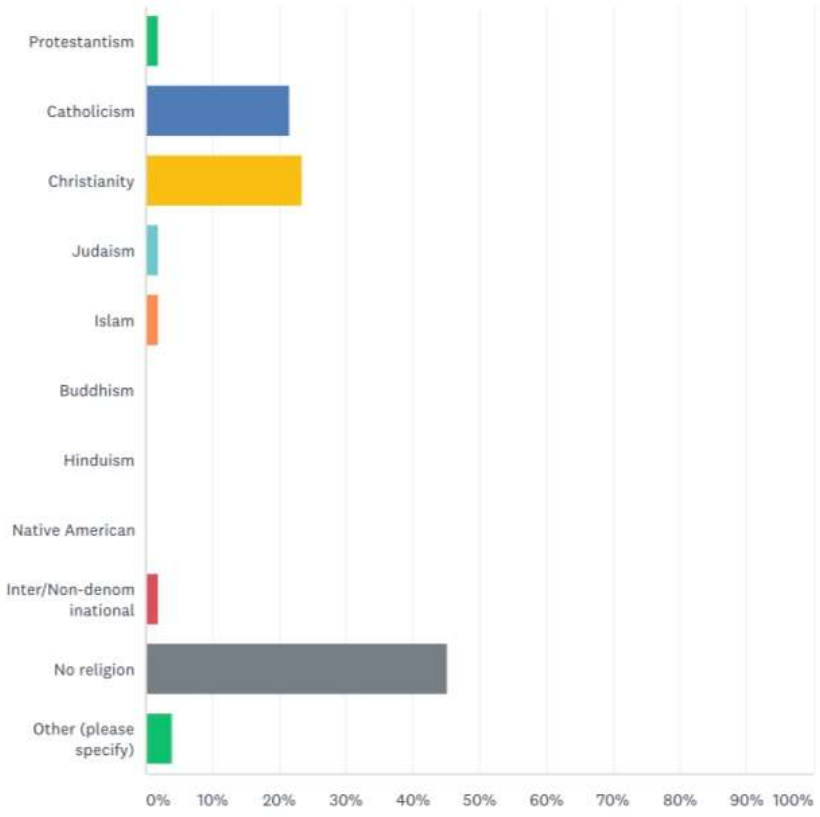


ANSWER CHOICES	RESPONSES	
White - British (to include Northern Ireland, Scotland and Wales)	56.60%	30
White - Irish	0.00%	0
White - European	9.43%	5
White - Other	13.21%	7
Black or Black British - Caribbean	3.77%	2
Black or Black British - African	5.66%	3
Other Black	1.89%	1
Asian or Asian British - Indian	0.00%	0
Asian or Asian British - Pakistani	0.00%	0
Asian or Asian British - Bangladeshi	0.00%	0
Chinese	1.89%	1
Other Asian	1.89%	1
Mixed - White & Black Caribbean	0.00%	0
Mixed - White & Black African	0.00%	0
Mixed - White & Asian	3.77%	2
Prefer not to say	1.89%	1
TOTAL		**53**

Q14

Do you identify with any of the following religions? (Please select all that apply.)

Answered: 51 Skipped: 2

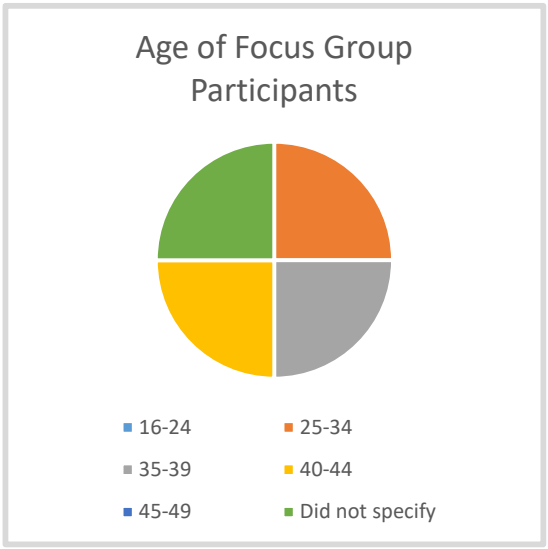


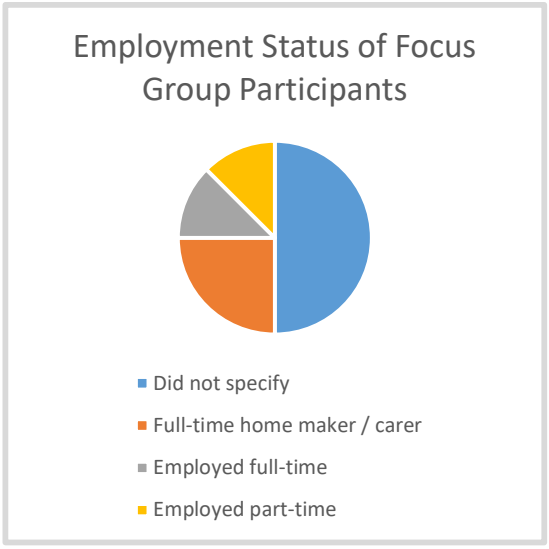
ANSWER CHOICES		RESPONSES	
Protestantism		1.96%	1
Catholicism		21.57%	11
Christianity		23.53%	12
Judaism		1.96%	1
Islam		1.96%	1
Buddhism		0.00%	0
Hinduism		0.00%	0
Native American		0.00%	0
Inter/Non-denominational		1.96%	1
No religion		45.10%	23
Other (please specify)	Responses	3.92%	2
Total Respondents: 51			

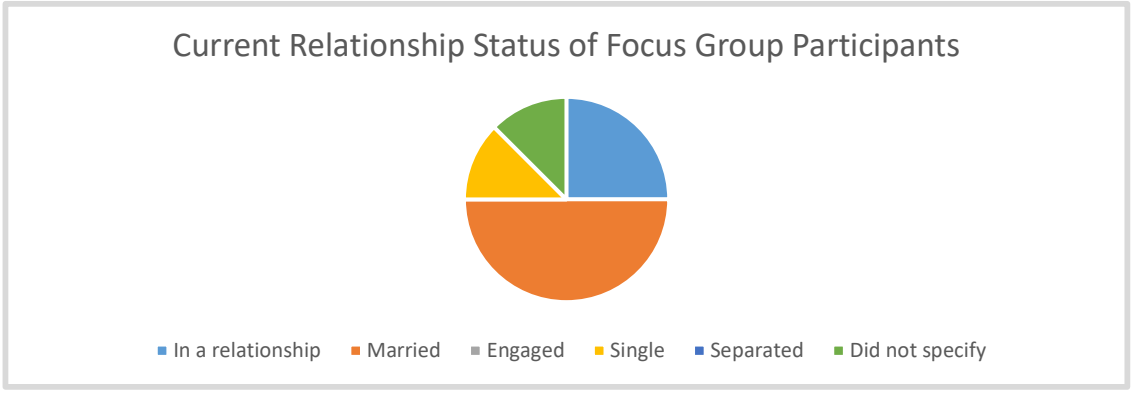
Focus Group Demographics

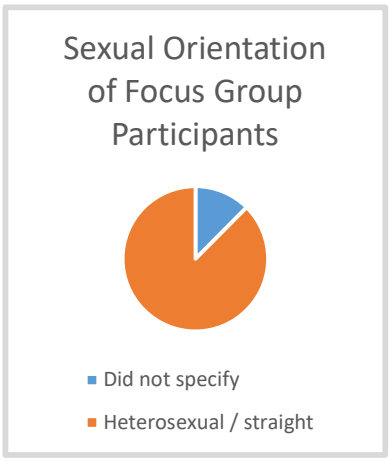
A greater proportion of the focus group participants opted to leave some of the demographics questions blank or to tick the 'Prefer not to say' box than survey respondents who were asked the same questions. This may be because participants were approached by local children's centres and offered the opportunity to take part orally, and they were supported in accessing the technology. Therefore they were not required to be proficient in reading or writing English. This may explain why they answered some of the demographics questions and not others. This approach to recruitment was designed to diversify participation, to reach different demographics to those who filled in the online survey. The challenging and unpredictable life circumstances that many of these women are currently facing is reflected in a high 'drop out' rate. Subsequently there were far fewer focus group participants than survey respondents: eight in total, compared to 53.

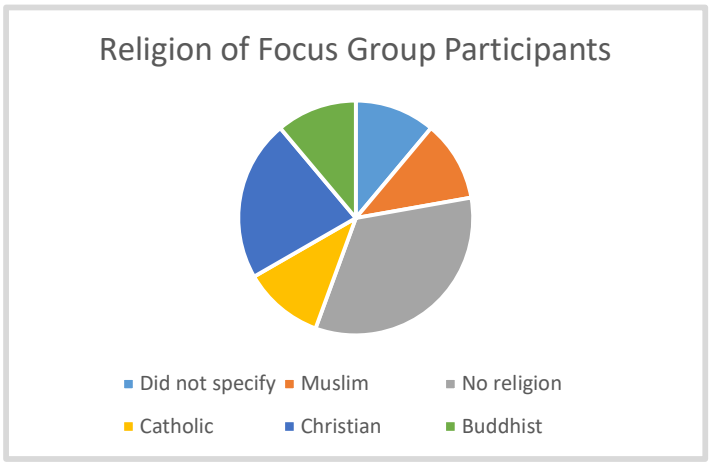
The 75% of focus group participants who disclosed their ages were between 25 and 44 years old, with an equal spread across the age groups. Of the 50% who specified their employment status, most were full-time carers or homemakers (50%, or 25% of the total). 88% disclosed their relationship status and most of these were married. 88% of participants identified as heterosexual while all the others declined to answer. 50% identified as White British, while the others who answered this question were equally split between Black/Black British and Asian. This, again, is roughly representative of the local population. 37.5% had no religious affiliation, but a variety of faith backgrounds were represented.

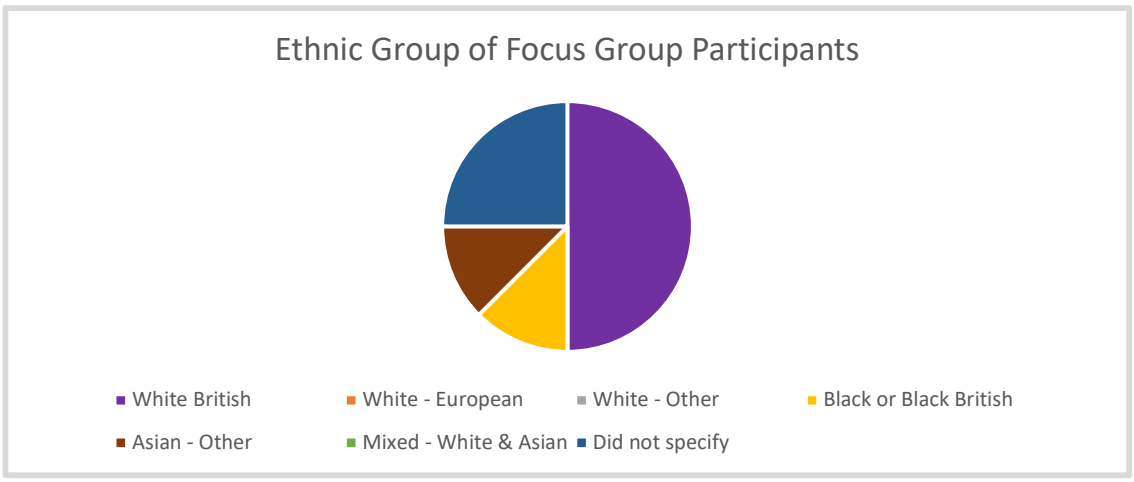










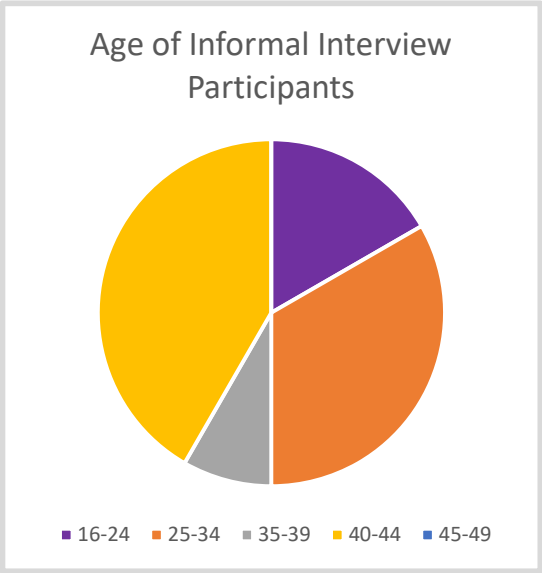


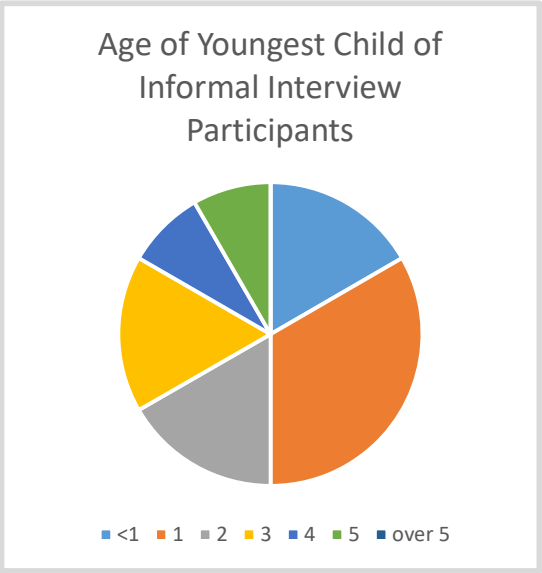
Demographics of Participants in Informal Interviews

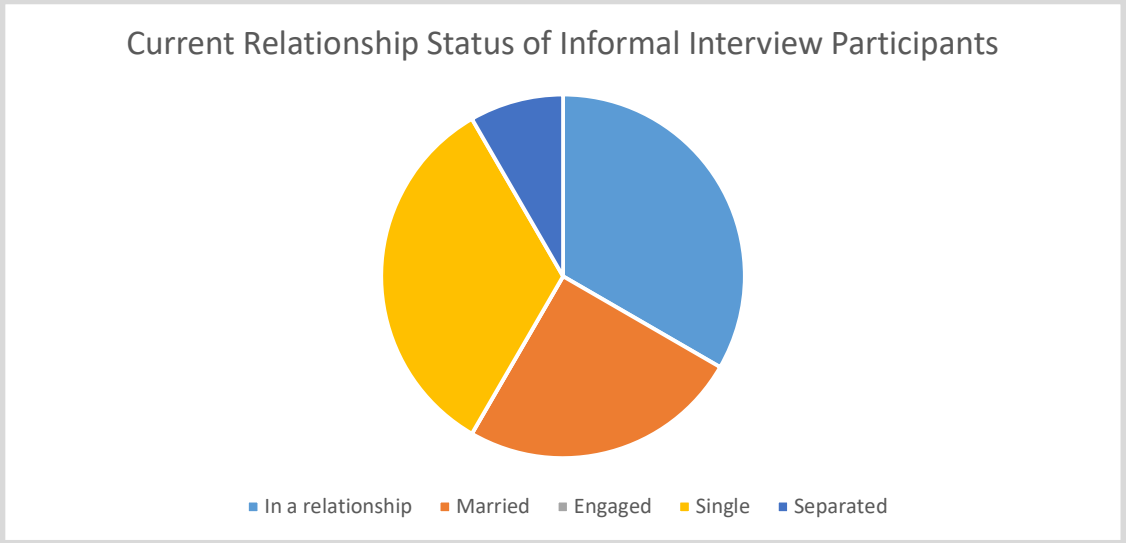
Recruitment was designed to increase accessibility for mothers who might have found filling in an online survey or taking part in a focus group on Zoom rather intimidating. Potential participants were approached directly by MumsAid staff, with whom they already had an established relationship, and the demographics questions were scaled down so that they could be integrated seamlessly into an informal conversation. This enabled more marginalised women to participate, as reflected by the demographics data below.

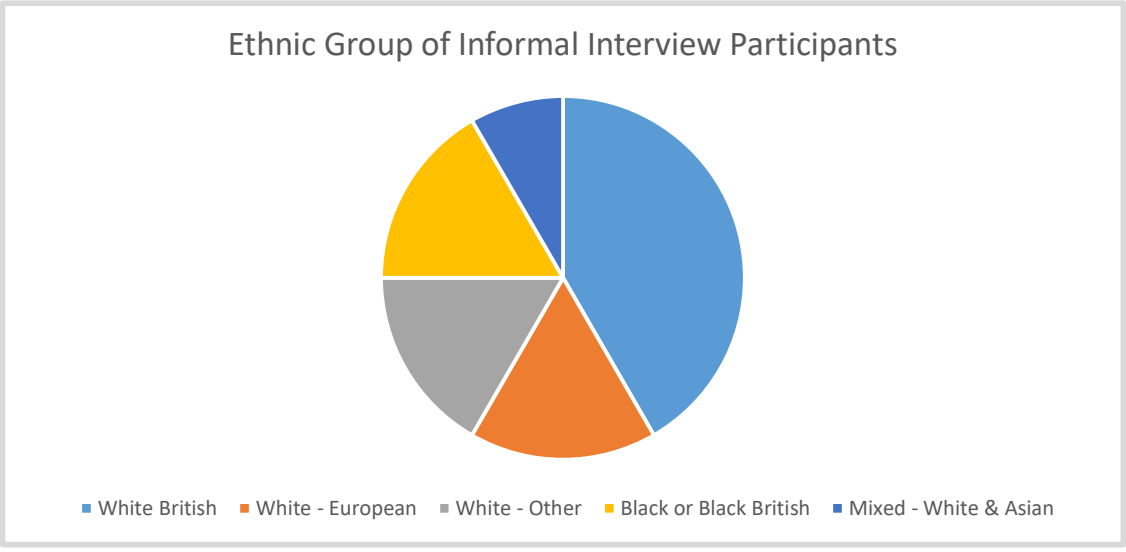
Mothers were also asked about the age of their youngest child to reflect the fact that perinatal mental health provision is rapidly evolving, both locally and nationally. For this reason, it is helpful to have a sense of how recent a woman's perinatal experience is or was as part of a more in-depth conversation.

The twelve participants were aged between 16 and 44 years: the youngest was 21 (with a one-year-old baby) and the eldest was 43. A third were single, and a third were in a romantic relationship. Only 42% were White British, although this was still the largest group. 50% of participants had a baby in the two years before the interviews took place in spring 2020, while 17% of those were in the last 12 months and no participants were pregnant.


Age of Informal Interview Participants
16-24
25-34
35-39
40-44
45-49


Age of Youngest Child of Informal Interview Participants
<1
1
2
3
4
5
over 5


Current Relationship Status of Informal Interview Participants
In a relationship
Married
Engaged
Single
Separated


Ethnic Group of Informal Interview Participants
White British
White - European
White - Other
Black or Black British
Mixed - White & Asian

Summary of Activities Undertaken

In total, the peer researcher conducted two focus groups and twelve informal interviews, while 53 survey responses were gathered.

The two focus groups took place virtually over Zoom during August 2020. Participants were recruited via the Waterways, Discovery, and Storkway children's centres (run by a local leisure charitable social enterprise, Greenwich Leisure Limited), from amongst families who regularly use their services. Four mothers participated on both the 11th and 13th August, a total of eight participants. The peer researcher led the conversation, using open-ended questions to prompt sharing of experiences around seeking and accessing support for emotional and mental health during the perinatal period. A staff member from MumsAid was present to take notes and follow up with anyone in need of support. Participants were sent a £10 Amazon gift voucher as a thank you for their time.

The informal interviews took place between March and June 2020. They were conducted over the telephone to increase accessibility for mothers for whom video calls would have been a barrier to participation. Interviewees were recruited from amongst MumsAid's current and former service users and introduced to the peer researcher by MumsAid's staff. They also received a £10 Amazon gift voucher after the call. The conversations were kept intentionally informal so as not to be intimidating to participants and were not recorded or transcribed, affording increased anonymity and openness in sharing sensitive information such as experiences of domestic violence. Instead, notes and brief quotations were jotted down by the peer researcher during the telephone call. Again, questions posed to participants were open-ended to allow conversation to flow naturally and facilitate broader and more in-depth responses.

The qualitative data yielded by this approach is balanced by the quantitative data from the survey. The survey was designed collaboratively by MumsAid and BLG Mind and reviewed by the peer researcher. It was live on MumsAid's website between 20th March and 10th October, and was promoted both by MumsAid and the peer researcher. It was circulated to local children's centres, Greenwich Maternity Voices Partnership (MVP), numerous relevant Facebook pages and groups as well as relevant Twitter accounts and hashtags.

The peer researcher was known to MumsAid previously and was involved in the expression of interest was submitted to BLG Mind. In 2019, she was recruited by the McPin Foundation, a mental health research charity, to contribute to MumsAid's evaluation.[9] As she was conducting interviews with mothers using MumsAid's services, barriers to accessing support naturally emerged as part of the conversation and highlighted the need for further research. The peer researcher also contacted the local NHS perinatal mental health service, who are currently involved in researching the effectiveness and cost effectiveness of community perinatal mental health services, in order to hear their researcher's perspective on the topic.[10]

[9] The McPin Foundation: MumsAid evaluation report (January 2020): https://mcpin.org/wp-content/uploads/2020/02/MumsAid-evaluation-report_240120.pdf. See also the peer researcher's blog post about the process and findings: https://mcpin.org/evaluation-of-mumsaid/.
[10] National Institute for Health Research: ESMI-II: The EffectivenesS and cost effectiveness of community perinatal Mental health servIces (2019-2022): https://www.fundingawards.nihr.ac.uk/award/17/49/38.

Identified Barriers

Survey Responses

Survey respondents reported needing help and support for their mental or emotional wellbeing during or after their first, second, and third/fourth/fifth pregnancies. First-time pregnancies were most likely to be affected (94.34%), closely followed by second pregnancies (80.65%). The decrease in mothers requiring support in subsequent pregnancies is likely to be a result of mothers only having one or two children, although it is also possible that women became more confident in motherhood as they progressed. Most pregnancies were planned until the third/fourth/fifth, at which point two-thirds (66.67%) were unplanned.

Most respondents were referred for additional mental health support by a healthcare professional (39.62%), closely followed by the 35.85% who self-referred. Most of these (69.77%) accessed support through the NHS alone, followed by the 39.53% who were supported by a charity or third sector group, while a further 18.6% were supported by a mixture of services or organisations.

41% of respondents who accessed NHS perinatal mental health support scored the service 5/5 ('excellent'), while a further 19.44% scored it 4/5 but equally 19.44% only scored it 2/5. Charity or third sector support received a similar proportion of 5/5 ratings (40.91%) but a further 31.82% scored it 4/5 and only 27.27% scored it 3 or less, suggesting that mothers perceived the quality as more consistently good. Support from private companies or individuals received the highest proportion of 5/5 ratings (60%) but is likely to have been accessible to fewer mothers because of cost. The fact that only 11.63% of respondents accessed private support reflects this.

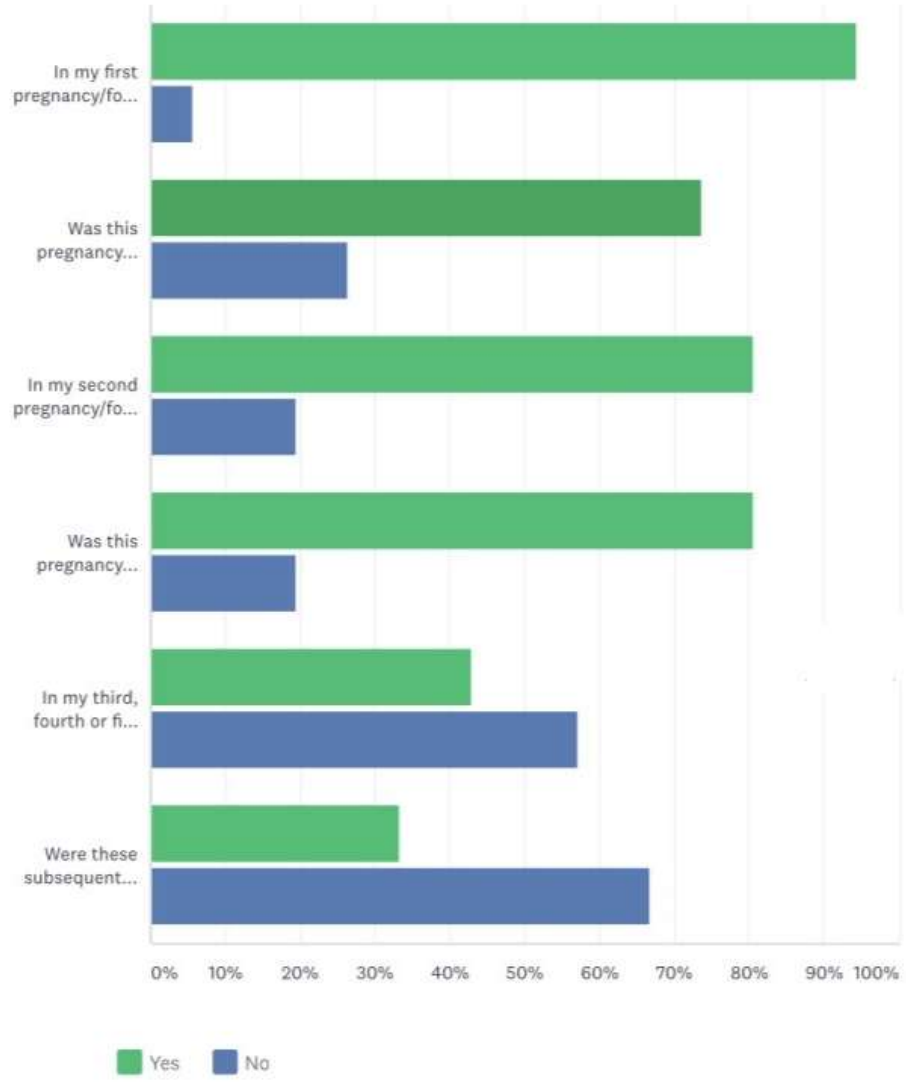
Shockingly, more than a fifth (20.75%) of respondents were unable to access the support that they needed. The most common barrier, selected by more than half of the survey respondents (55.56%), was that their mental health difficulties prevented them from either seeking help in the first place, or from successfully self-referring or being referred. Fear of being judged was the second most common barrier (44.44%), with lack of childcare and long waiting times both cited by 38.89%. A further 33.3% lacked the confidence to seek or pursue help. Several potential barriers were not selected by any respondents at all (0%); these were lack of time, previous unhelpful experiences, no way of getting there, and language/cultural barriers. However, these themes were identified in the telephone conversations and focus groups. Mothers who were prevented from accessing support by language or cultural barriers might have been prevented from accessing the survey for the same reasons.

Another significant cause for concern arising from the survey responses is that 39.13% of respondents who did access support did not continue with it, and, of those, only 25% no longer needed it. That means that 75% were unable to continue accessing the support. The most common reason for this (37.5%) was that mothers did not feel that they service they had accessed was appropriate or helpful. A further 31.25% had to drop out because they did not have sufficient childcare to allow them to attend. 25% did not have the time due to work and other responsibilities.

Q2

Did you feel that you needed help and support for your mental or emotional wellbeing whilst you were in the perinatal period?

Answered: 53 Skipped: 0

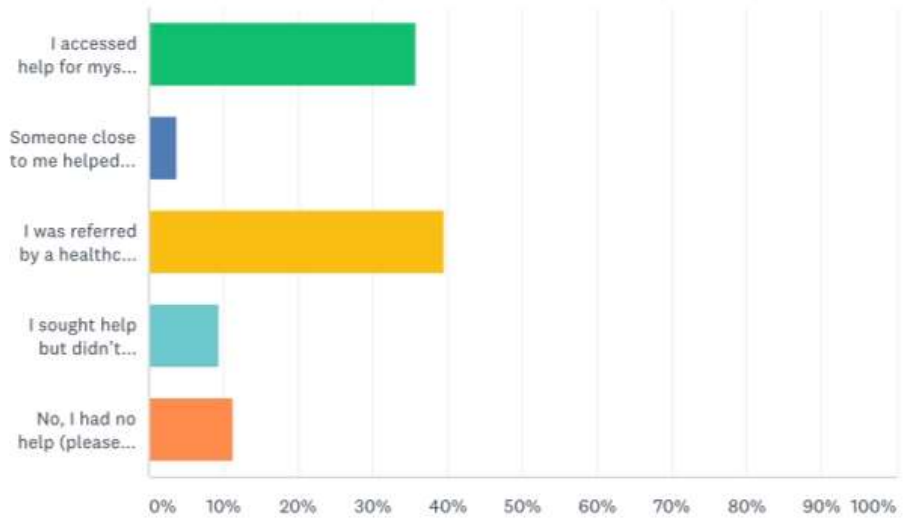


	YES	NO	TOTAL	WEIGHTED AVERAGE
In my first pregnancy/following the birth of my first child	94.34% 50	5.66% 3	53	1.06
Was this pregnancy planned?	73.58% 39	26.42% 14	53	1.26
In my second pregnancy/following the birth of my second child	80.65% 25	19.35% 6	31	1.19
Was this pregnancy planned?	80.65% 25	19.35% 6	31	1.19
In my third, fourth or fifth pregnancy or following the birth of this child	42.86% 3	57.14% 4	7	1.57
Were these subsequent pregnancies planned?	33.33% 3	66.67% 6	9	1.67

Q3

Did you seek or receive help from any support services? Select which option best describes you.

Answered: 53 Skipped: 0



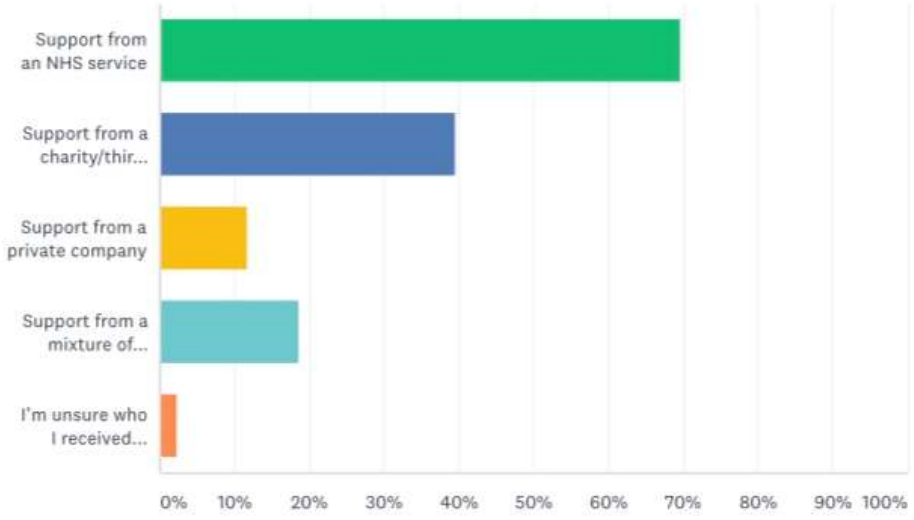
ANSWER CHOICES	RESPONSES	
I accessed help for myself (please go to question 4)	35.85%	19
Someone close to me helped me to access support (please go to question 4)	3.77%	2
I was referred by a healthcare professional (please go to question 4)	39.62%	21
I sought help but didn't receive it (please go to question 5)	9.43%	5
No, I had no help (please go to question 5)	11.32%	6
TOTAL		**53**

Comments (9)

Q4

What kind of support did you access? Please select all that apply then move to question 6.

Answered: 43 Skipped: 10

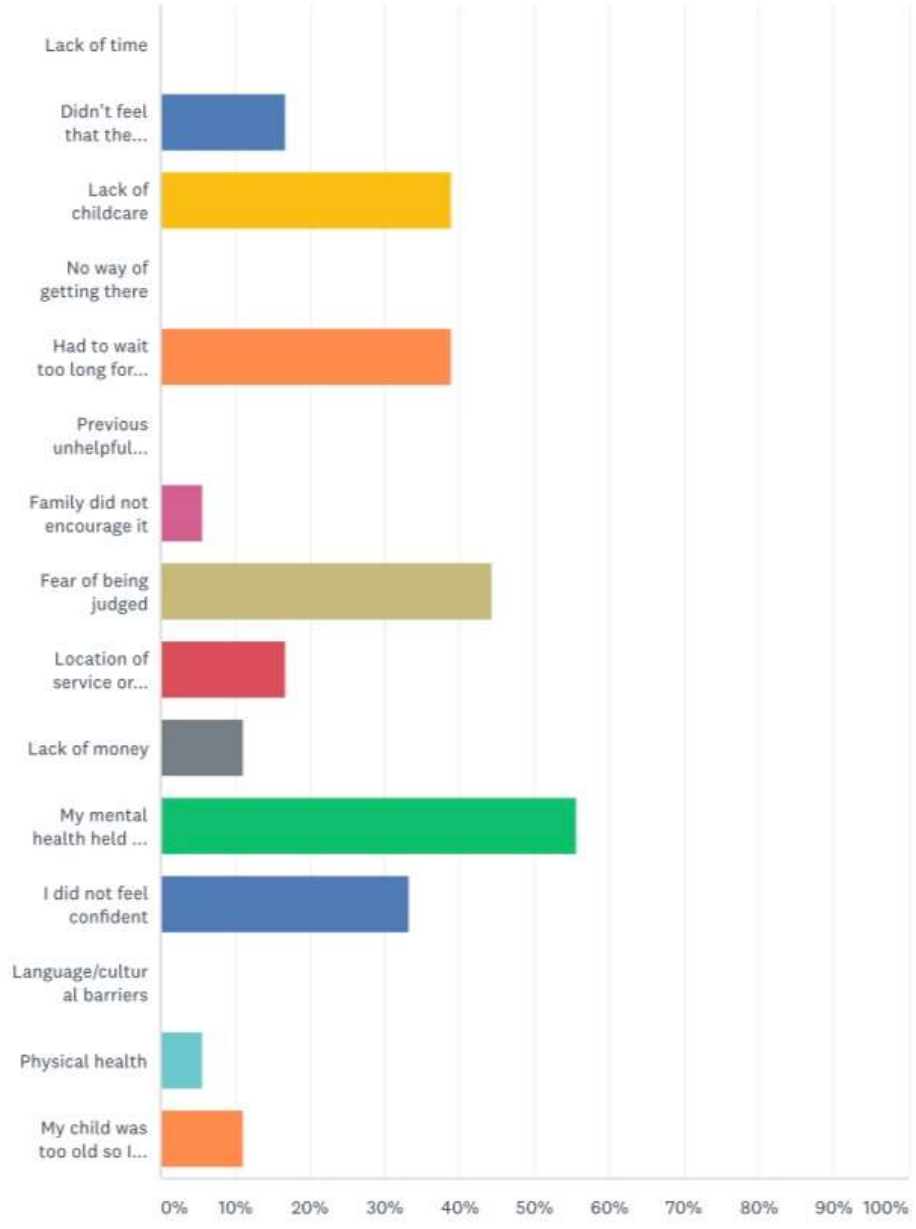


ANSWER CHOICES	RESPONSES	
Support from an NHS service	69.77%	30
Support from a charity/third sector group	39.53%	17
Support from a private company	11.63%	5
Support from a mixture of organisations	18.60%	8
I'm unsure who I received support from	2.33%	1
Total Respondents: 43		

Q5

If you sought help but didn't receive it or didn't attempt to access help at all, what were the reasons for this? Select as many options as you would like and then skip to question 9.

Answered: 18 Skipped: 35

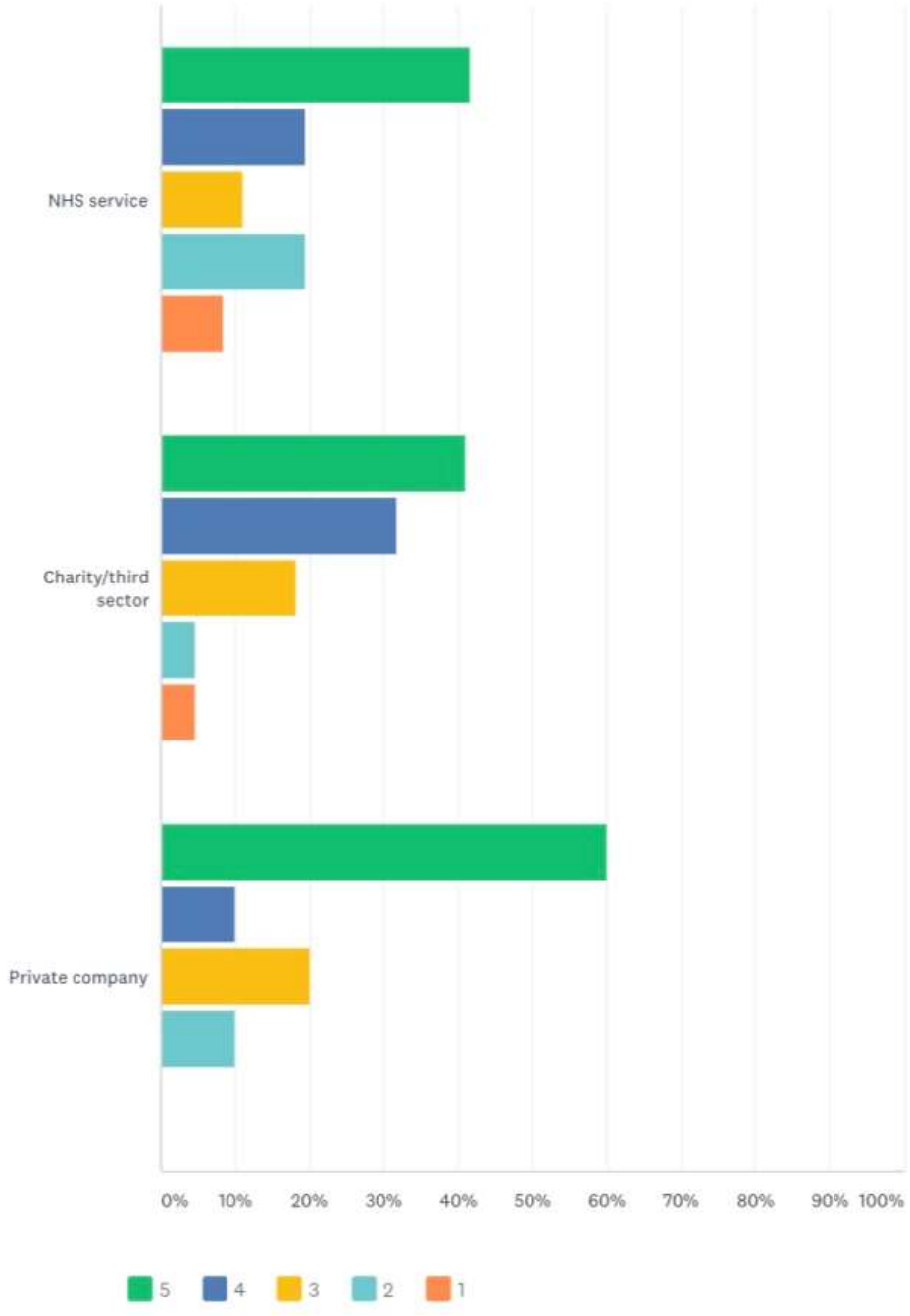


ANSWER CHOICES	RESPONSES	
Lack of time	0.00%	0
Didn't feel that the service was right for me	16.67%	3
Lack of childcare	38.89%	7
No way of getting there	0.00%	0
Had to wait too long for appointments	38.89%	7
Previous unhelpful experience	0.00%	0
Family did not encourage it	5.56%	1
Fear of being judged	44.44%	8
Location of service or distance to it	16.67%	3
Lack of money	11.11%	2
My mental health held me back	55.56%	10
I did not feel confident	33.33%	6
Language/cultural barriers	0.00%	0
Physical health	5.56%	1
My child was too old so I was not eligible	11.11%	2
Total Respondents: 18		

Q6

After attending a support service, please rate your experience on a scale of 1 - 5 where 5 =excellent and 1 =poor.Please use the comment boxes to state the name of the service you used and provide more detail if you want to.

Answered: 44 Skipped: 9

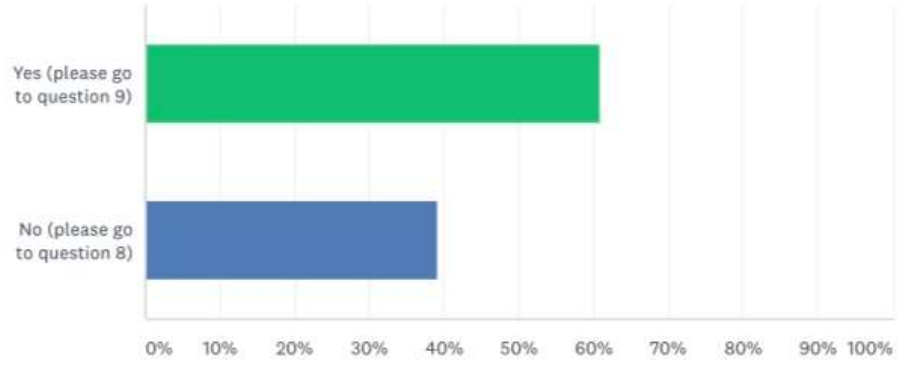


	5	4	3	2	1	TOTAL	WEIGHTED AVERAGE
NHS service Comments (13)	41.67% 15	19.44% 7	11.11% 4	19.44% 7	8.33% 3	36	2.33
Charity/third sector Comments (12)	40.91% 9	31.82% 7	18.18% 4	4.55% 1	4.55% 1	22	2.00
Private company Comments (4)	60.00% 6	10.00% 1	20.00% 2	10.00% 1	0.00% 0	10	1.80

Q7

Did you continue to access that support service?

Answered: 46 Skipped: 7

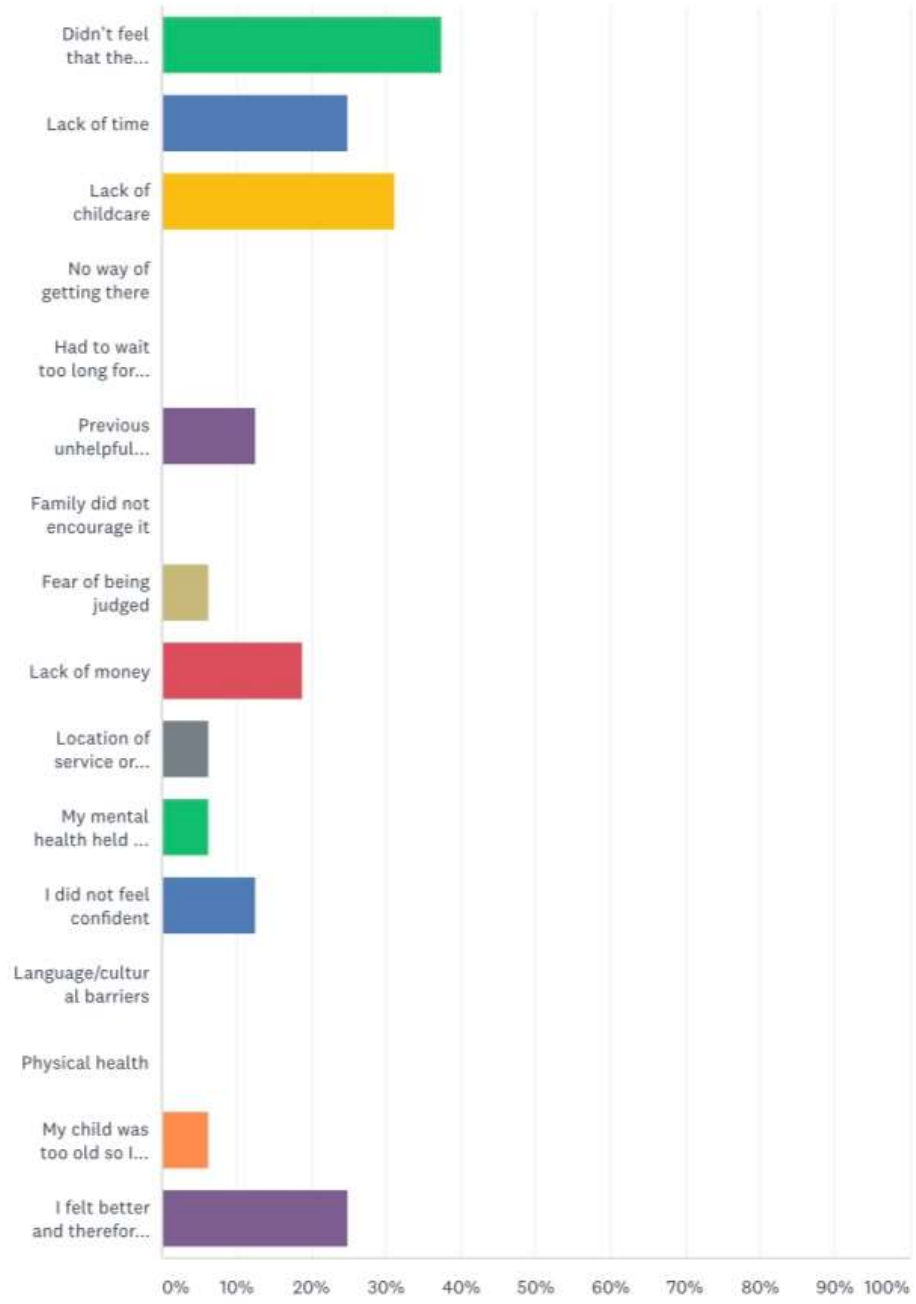


ANSWER CHOICES	RESPONSES	
Yes (please go to question 9)	60.87%	28
No (please go to question 8)	39.13%	18
TOTAL		46

Q8

If No, why not? (Select as many as you like)

Answered: 16 Skipped: 37



ANSWER CHOICES	RESPONSES	
Didn't feel that the service was right for me	37.50%	6
Lack of time	25.00%	4
Lack of childcare	31.25%	5
No way of getting there	0.00%	0
Had to wait too long for appointments	0.00%	0
Previous unhelpful experience	12.50%	2
Family did not encourage it	0.00%	0
Fear of being judged	6.25%	1
Lack of money	18.75%	3
Location of service or distance to it	6.25%	1
My mental health held me back	6.25%	1
I did not feel confident	12.50%	2
Language/cultural barriers	0.00%	0
Physical health	0.00%	0
My child was too old so I was not eligible	6.25%	1
I felt better and therefore no longer needed support	25.00%	4
Total Respondents: 16		

Discussion of Barriers

Childcare and Location

Mothers described the fact that they often need to arrange their own childcare in order to attend appointments and access talking therapies as "a huge barrier". Many had no family or friends nearby, or those they did have were busy with their own small children, so that it felt like too much of an imposition to ask them to babysit: **"I didn't have anyone I could call on."** Some felt that arranging childcare was "too stressful" when they were already struggling with heightened anxiety.

One mother felt unable to disclose that she was suffering from low mood when attending appointments with her midwife and health visitor because her older children were present and she didn't want them to hear about it and become worried or unsettled. The fact that her children were with her all the time meant that she was unable to open up to anyone about how she was feeling.

When lack of childcare was named as a barrier to accessing support, this was often conflated with the location of services or groups. Navigating public transport, car parking, or long walks is complicated by bringing babies and small children along, and these difficulties are enhanced considerably when a mother is feeling anxious to begin with. For example, one mother said that she was unable to attend appointments because she did not

feel confident getting on and off buses with the pram. Another was advised by her health visitor to bring her baby to a clinic "at a centre that was not easy to get to," and this felt too overwhelming to attempt.

Stigma and Self-Stigma

Mothers described how stigma and shame associated with perinatal mental health difficulties in their families and communities prevented them from being honest about how they were feeling and seeking help. Some women found that, when they disclosed how they were feeling to their families and friends, they were met with a lack of understanding and even with disapproval. One admitted that she was struggling after a traumatic birth experience, and the response was: **"Your baby is fine – what are you crying about?"** Another reported that her husband said, "I just don't understand what's wrong with you." She struggled to be taken seriously because the effects of her mental distress were not visible in the way that a physical illness or injury would be. Where mothers had received unhelpful responses from friends and family, they were more likely to suffer in silence and less likely to confide in health professionals or seek help from services.

Stigma can be enhanced for mothers from black and ethnic minority communities, who do not necessarily share western cultural narratives about emotional and psychological wellbeing. One mother said, **"There's no such thing as mental health in African culture."** She added that, within her community, asking for help is often difficult: "You're raised to keep things private and don't tell people your business." She described having been taught from childhood that it is inappropriate to express strong negative emotions and that significant shame is associated with doing so. This is compounded by her community's strong Christian ethos, in which one is encouraged to pray about feelings of distress rather than talk about them. Her family actively discouraged her from seeking professional mental health support, urging her to "have faith" and rely on prayer to improve the situation. Since receiving counselling from MumsAid, she has been able to promote conversations about mental health in her church community, and subsequently she believes that attitudes are changing.

Women were also prevented from seeking perinatal mental health support by fears of being judged and a reluctance to burden other people. This led some to disguise how they were feeling or to conceal the extent of their difficulties. For example, one mother commented on the survey: "I went to baby groups but couldn't speak with people and just put a mask on to hide my feelings." Another woman said, **"There's so much pressure to be OK and often people aren't."** Mothers described pervasive expectations that they should be grateful, rather than traumatised, after a difficult birth: that they should be thankful to have survived and to have a healthy baby. Similarly, they thought that they would be considered "moaning and ungrateful" if they talked about any negative feelings.

Fear of Social Services

In addition to the concerns outlined above, some mothers were afraid that if they disclosed how they were feeling, people would assume that they did not love their babies. Mothers feared being perceived as **"not a good mum"** or unable to parent effectively, some to the extent that they kept silent in case they might be referred to social services and even have their children removed.

Sadly these fears are not wholly unfounded: health professionals do sometimes make inappropriate referrals for child protection in response to a mother's experience of perinatal mental health difficulties.[11] The peer

[11] Gupta, S., & Kiran, S. (2019) Obsessive–compulsive disorder and child safeguarding. *BJPsych Advances,* 25(3), 185-186. doi:10.1192/bja.2018.60.

researcher undertaking this research was referred to social services by her midwife when she disclosed her diagnosis of bipolar disorder at a booking in appointment. Women suffering from postnatal depression, PTSD, or anxiety disorders such as obsessive-compulsive disorder can experience distressing intrusive thoughts about harming their babies and this can lead to worries that they could act on those thoughts. Such worries are part of the illness and pose no safeguarding risk, but they can be mistaken for intent by well-meaning professionals who have not had sufficient training in perinatal mental health.

Financial Barriers

Several mothers described cost as a barrier to accessing ongoing perinatal mental health care, particularly talking therapies beyond the six or eight sessions usually offered. One who felt that she needed more than this researched her options for continuing and concluded, **"I just can't afford to do it."**

Another described embarking on couples' counselling for the damage that her perinatal mental health problems had inflicted on her marriage but, after two years on a waiting list, the couple had to drop out after two sessions because of the cost. She felt that it contributed to the fact that the marriage did not survive and that this had been detrimental to their children.

Mothers also emphasised that financial difficulties posed a barrier even when the service was free. For example, one was discharged from a talking therapies service because she was unable to telephone them due to not having the money to top up the credit on her mobile phone. Additionally, housing issues and the stress of poverty, worrying about how they would buy clothes, nappies, and food for their babies, all worsened mothers' mental health and reduced their capacity to engage with services.

Lack of Mental Health Knowledge

Mothers reported a lack of understanding about perinatal mental health which meant that neither they nor those around them were easily able to recognise that they were experiencing a mental health issue. One mother commented on the survey: **"I didn't think there was anything wrong and that these feelings were normal but looking back I was very flat for a long time and probably should've accessed some form of help."** Another said, "It took me a long time to either realise or admit …that it was postnatal depression… that I was in need of something other than my own willpower to make things change." Postnatal depression, in particular, was often not identified until it had passed, or until it returned, sometimes much more severely, after subsequent pregnancies.

Even where mothers were acutely aware that they needed mental health care, often they did not know what support was available to them: **"I wish we knew who to ask and where to find help."** They said that finding out where to go and who to ask was "tricky"; subsequently some found themselves searching fruitlessly online and becoming more anxious as a result. Mothers cited numerous examples of services and support that they had not known existed, let alone how to access, until too late, including: antenatal visits from the health visiting team, support from children's centres, and post-birth debriefs with a midwife. One reported that, even after she had been referred to the specialist community perinatal mental health service, "I didn't understand what it was and what it was for."

Domestic Abuse

There is a significant overlap between mothers who experience perinatal mental health difficulties and those who are victims of domestic violence and abuse, and this was reflected in the participants with whom we had telephone conversations and could speak to in more depth individually.[12] These women reported that having babies and young children made it more difficult to escape an abusive partner**: "I had to keep going back to him because of finances and childcare."** Mothers whose partners were controlling and who feared for their own safety were much less able to engage with services of any kind and, as a result, they struggled to access support for their mental health.

Greenwich has a dedicated support service for women who are experiencing abuse, Her Centre. In addition, there are national domestic abuse services and helplines and Greenwich's adult social care services. Unfortunately, some mothers find these just as difficult to access as the specialist perinatal mental health care to which the domestic abuse is a barrier.

One woman said, **"I did feel like I was reaching out a lot of the time and no one would take me seriously so then incidents kept happening."** The police were called to her home but, as the family had moved cities, they had no record of previous incidents. She spent three or four months trying to call a domestic abuse helpline but the phone lines were overwhelmed with calls. When she did finally get through, she "couldn't get them to take it seriously". Her health visitor referred her to a service in Lewisham which offers counselling to victims but she felt that they were "useless" and the six sessions offered wholly inadequate to address her situation. The family was assigned a social worker, whom she described as "completely oblivious to what domestic violence is about". Another mother who was in a similar situation, with the police called to her home on multiple occasions, was put in touch with multiple services at once, which she described as "baffling and overwhelming". It is unrealistic to expect women to safely engage with therapeutic mental health support while they are in constant danger from violent and abusive partners.

Lack of Time and Continuity in Primary Care

Women who access perinatal mental health services are most commonly referred after an initial conversation with a GP, health visitor, or midwife. Pressures on primary care, such as understaffing and underfunding, mean that these professionals are often unable to give mothers enough time and attention to enable them to disclose that they may be struggling emotionally. One mother explained that she felt unable to visit her GP to discuss her mental health because **"they just want to get you out; they don't have time."**

Some mothers felt that midwives did not ask enough questions about their emotional and mental wellbeing during antenatal, delivery, and postnatal care. They believed that the emphasis was on their physical health, rather than their mental health, and felt that their anxieties were dismissed. They cited midwives' high caseloads as a reason for this; one said, **"You can see that the health visitors and midwives are just so pushed for time and resources."** Mothers tended to feel reluctant to add to this pressure: "I thought they had too much else to do so I didn't push for help."

One mother described the midwives involved in her postnatal care as "quite absent" when she was struggling in the early days after her child's birth. Mothers reported that contact with their midwives was greatly reduced

[12] Howard, L.M., Oram, S., Galley H., Trevillion K., et al. (2013) Domestic Violence and Perinatal Mental Disorders: A Systematic Review and Meta-Analysis. *PLoS Med*, 10(5). doi:10.1371/journal.pmed.1001452. Available from: http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.1001452.

when they were having their second, third, or even fourth baby, which made it more difficult to have conversations about mental health. Some also felt "turfed out" of hospital before they were ready, in order to free up the bed.

Mothers also cited a lack of continuity of care from midwives, health visitors, and GPs as a barrier to opening up about their mental health: **"I asked the midwife for help but every appointment it was a different midwife so I didn't want to keep bringing it up again."** When every appointment was with a different person, they felt unable to build a relationship and the necessary trust to disclose sensitive information and raw emotions. This was reflected in the experiences of mothers who were able to access talking therapies: "I needed to take it slowly and gently". They were only able to be fully honest about their feelings after a few sessions to get to know their therapist without any pressure.

Lack of Mental Health Knowledge in Primary Care

Pressures on primary care and limited awareness of mental health in those professions can result in a lack of compassion and understanding when mothers attempt to open up about how they are feeling. This leads to missed opportunities to help mothers who are struggling, necessary referrals not being made, and mothers resolving not to speak up again in future.

One woman who made a GP appointment to discuss her mental health found the GP to be "dismissive", having described what she was experiencing as "baby blues". She understandably felt this to be "minimising" her suffering and added, **"I just closed up after that."** Another reported that her GP gave her a leaflet about mental health and told her that she would feel better in a couple of months. Another was told by her GP that she might have postnatal depression but was offered no treatment options or follow up support.

A significant number of participants reported that health professionals in primary care were not able to recognise that they were experiencing a mental health problem because they did not appear obviously distressed or dishevelled. Several women said that midwives, health visitors, or GPs did not seem to understand that there can be a difference between external presentation and the internal reality: **"you can look fine but be really not OK."** This was particularly the case when women made a concerted effort to appear composed because of mental health stigma and the associated fears described above.

In some cases, this lack of mental health awareness is combined with a lack of interpersonal skills which further hinders mothers' ability to talk about their emotional wellbeing. Several women described their health visitors as impersonable, "very clinical", and preoccupied with the baby's health at the expense of the mother: "the baby was the focus". One said that she felt "neglected". Another described a lack of compassion and consideration when receiving postnatal care in hospital: **"we felt like the day job".** One woman tried to talk to her midwife about the fact that she was struggling to feed her baby but felt that the midwife was "minimising" her experiences by repeatedly comparing them to when her own child had been unwell. Another visited the GP to discuss her baby's reflux but "felt challenged by everything she said" and "not supported at all". Although these interactions are not specifically about the mother's mental health, they create an environment of fear and mistrust which prevents mothers from raising mental health concerns.

Pressure to Breastfeed

Another issue which can erode mothers' trust in health professionals concerns infant feeding. The NHS, UK Department of Health,' and the World Health Organisation (WHO) recommend exclusive breastfeeding for the

first six months of a baby's life, followed by breastfeeding alongside the introduction of complementary solid foods.[13] On a population level, not breastfeeding and a shorter duration of breastfeeding are associated with comparatively poorer health outcomes for mother and baby.[14] For this reason, public health policy is to promote and support breastfeeding in the UK.[15]

However, breastfeeding can be difficult and painful. Problems such as reflux, allergies, tongue-tie, and colic can be very distressing and can impact on parents' mental health.[16] Following a traumatic birth, breastfeeding can have therapeutic benefit or it can be associated with further distress.[17] While mothers who meet their personal goals for breastfeeding duration have been shown to be at lower risk of postnatal depression, mothers who plan to breastfeed but do not go on to do so are at higher risk.[18] The relationship between infant feeding and maternal wellbeing is both significant and complex.

Several mothers emphasised that they experienced the intention to promote and support breastfeeding as pressure to breastfeed when this was not necessarily best for them as individuals or for their mental health. One woman said, "The midwives were like, BREASTFEED, BREASTFEED, BREASTFEED, the whole time. They're just on you." She felt that she was "constantly being told what to do". Another said, **"I felt incredible pressure."** This feeling of pressure was harmful to their mental wellbeing, to their relationship with their midwives and health visitors, and to their ability to disclose experiencing low mood or mental distress.

Another woman described being unable to access treatment for feeding difficulties caused by her baby's tongue-tie because she was not breastfeeding. The exclusion of formula-fed babies from infant feeding support is a problem not limited to the Greenwich borough: the peer researcher had an identical experience whilst living elsewhere. Both mothers felt overwhelming guilt, not just because they were unable to breastfeed, but because they were unable to arrange the professional care that their babies needed to stay well. This situation was detrimental to their mental health and to their ability to seek help from professionals.

An Emphasis on Medication

Another common theme amongst mothers who spoke to their GP about anxiety and low mood was that the GP prescribed medication, such as antidepressants and sleeping tablets, before considering other treatment options, and that women were reluctant to take this medication. This caused women to disengage or to give up on the GP as a route to accessing support.

Reasons for being unwilling – or unable – to start taking medication varied amongst individuals. One woman was prescribed sleeping tablets, but she was a single mother and had a baby with health issues who needed a

[13] NHS: Benefits of Breastfeeding (reviewed 2017): https://www.nhs.uk/conditions/pregnancy-and-baby/benefits-breastfeeding/; UK Department of Health: Infant Feeding Recommendation (2003): https://webarchive.nationalarchives.gov.uk/20120503221049/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4097197; WHO: Infant and Young Child Feeding Fact Sheet No. 342 (updated 2018): https://www.who.int/en/news-room/fact-sheets/detail/infant-and-young-child-feeding.
[14] Unicef UK: Preventing Disease and Saving Resources: the potential contribution of increasing breastfeeding rates in the UK (2012): https://www.unicef.org.uk/babyfriendly/about/preventing-disease-and-saving-resources/.
[15] Public Health England: Infant Feeding: Commissioning services (2016): https://www.gov.uk/government/publications/infant-feeding-commissioning-services; Public Health England: Health Matters: Giving every child the best start in life (2016): https://www.gov.uk/government/publications/health-matters-giving-every-child-the-best-start-in-life/health-matters-giving-every-child-the-best-start-in-life.
[16] GP Infant Feeding Network: Maternal Mental Health (2017): https://gpifn.org.uk/maternal-mental-health/.
[17] Beck, C., & Watson, S. (2008) Impact of Birth Trauma on Breast-feeding. *Nursing Research,* 57(4), 228-236.
[18] Borra, C., Iacovou, M., Sevilla, A. (2014) New Evidence on Breastfeeding and Postpartum Depression: The Importance of Understanding Women's Intentions. *Maternal and Child Health Journal*, 19(4), 897-907.

lot of night-time care: she may not have been able to rouse herself sufficiently to provide that care if she was sedated. Another mother was reluctant to take the antidepressants she had been prescribed because she was unsure if they were safe to take whilst breastfeeding. Another had found, in the past, that antidepressants increased her anxiety in the short term and that felt like too much of a risk. Several other mothers expressed a vaguer, or more instinctive, reluctance to take medication: "I wasn't up for tablets." One mother explained, **"It didn't feel right for me at that moment."**

These women tended not to have the confidence to discuss their concerns about medication with the GP. More often, they took the prescription and threw it away when they got home. One mother explained her reasons for this: "It was a very brief conversation. There's no consistency in terms of who you get so I was talking to a stranger. We had no relationship." Raising concerns also seemed pointless: when GPs did not mention any alternatives to medication, women concluded that no alternatives were available. One woman said, **"Medication being the first option didn't feel right… It put me off going to the GP. Every time I go it's about medication and I just feel like there should be other options."**

Referral to Non-Perinatal Talking Therapies

Another intervention which was intended to provide perinatal mental health care but became a barrier to mothers' accessing appropriate support was referral to generic talking therapies offered by the national Improving Access to Psychological Therapies (IAPT) programme. The local service is called Greenwich Time to Talk. Although one mother did describe a positive experience of Time to Talk, this was significantly outweighed by the number who found it to be more of a hindrance than a help. Referral to this IAPT service consistently either delayed or prevented mothers' accessing support that was beneficial.

Mothers cited a range of problems with the accessibility of Time to Talk, including:

- "a horrible triage" involving a lengthy and detailed discussion with a receptionist – "I absolutely hated it"
- having to explain about their personal history and the difficulties they were having five or six times to different people in order to access the therapy
- appointments too far from home to be able to reach
- no childcare provision
- long waiting times (some women reported being prioritised as new mothers, others did not)
- a sense that the environment and the therapist were "clinical" and "very cold"
- lack of flexibility in timing and number of sessions
- only telephone appointments offered when mothers were afraid of being overheard

Mothers who were able to access this service felt that IAPT staff did not have the specialist knowledge to support women whose distress was related to pregnancy, birth, and parenthood. One mother described this as "a common but very specific experience". She said, of Time to Talk: **"It didn't really feel like they had any specialist understanding of a mum's experience… It was all so tied up with my children… Literally I felt like the person I spoke to didn't even know anything about postnatal depression."**

A number of others expressed similar views: **"The therapist was nice but it was the wrong support."** One described being told to recount her traumatic childbirth experience in detail, which she found triggering. She said that it achieved nothing except to make her feel much worse. Several mothers had undergone sessions of CBT (cognitive behavioural therapy) with IAPT which they had not found effective. They believed this to be

because it was not suited to address the complex nature of their perinatal mental health difficulties and their feelings about birth and motherhood.

Falling Through the Gaps

Finally, mothers reported problems with referral pathways and frustration at health professionals' not following up or getting back to them. For example, one described disclosing to her health visitor that she was struggling: the health visitor said that she would follow this up and then failed to do so. Similarly, one mother commented on the survey: **"I initially sought help from my health visitor… called twice in desperate need of support. Both times reception told me a message would be passed on. I never heard back."**

Another comment reported a similar experience with a local GP surgery: **"I spoke to my GP about being referred to mental health services. She said she would call me back with next steps, but I never received a call back and wasn't referred."** Several mothers saw their GP to discuss mental health and described those interactions as "very supportive" but lamented the lack of a follow up appointment which would have enabled them to establish and monitor treatment.

Sometimes referrals were made for mental health support, but the process was dangerously slow: one mother said, **"It took a long time for me to see an NHS psychiatrist having been referred by my hospital at the start of my pregnancy, by which time I was very ill."** Another described how her midwife had referred her to the perinatal mental health service because she was struggling antenatally, but by the time the service picked up the referral, her baby had already been born. Usually mothers did not know the reasons for delays, although one realised that, in her case, the referral process was "hugely complicated" by the fact that she gave birth out of area.

Women lamented that they are expected to pursue – and chase up on – referrals, to keep making appointments, and even to make a nuisance of themselves in order to get their needs met. This is almost certainly a result of the pressures on primary care described above: heavy caseloads, and a general lack of time and resources. However, it is unrealistic to expect someone who is mentally unwell to be sufficiently proactive or to have the confidence to repeatedly pursue treatment in this way. These women were also pregnant or caring for at least one baby or small child; for many of them, just getting through the day was a struggle. They did not have the energy or the spare mental capacity to self-refer, or to keep seeking contact with health professionals or to remind them of what they had promised, especially after poor mental health had knocked their confidence and self-esteem.

To cite some examples, one mother struggled to self-refer for talking therapies because she found the process "very daunting". Another commented on the survey: "Giving a hastily scrawled phone number on a bit of paper and dismissing me was not enough, no way would I have called the number, I didn't have the strength." Another wished to join the groups offered by her local children's centre but felt too "shy" to attend on her own. Another said that, because of a lack of availability at her local GP practice, she struggled to get an appointment and this undermined her confidence: she couldn't face going through the process again to follow up even though she had decided against taking the antidepressants she was given. Another was offered a debrief with a midwife after her traumatic birth experience, but it "didn't happen". She was told to follow it up but felt unable to do so: **"It would've been useful if the hospital staff arranged it for me… They need to be more proactive."**

Summary

The themes of the qualitative data yielded by the focus groups, telephone conversations, and survey comments strongly echoed the barriers identified in the quantitative survey data. Mental health difficulties often result in anxious feelings, low mood, lack of energy, lack of confidence, and low self-esteem. These, combined with the demands of caring for an infant, often prevent mothers from initiating conversations about mental health with professionals working in primary care, from self-referring to other services, from self-advocating, and from chasing up and pursuing care in a system that is often overstretched. Mothers also experience mental health stigma; they fear being judged and perceived as unloving, incompetent, or ungrateful. Long waiting times are another hindrance, and lack of childcare renders many services completely inaccessible, especially if they are more than short walk from home.

The focus groups, telephone conversations, and survey comments also highlighted barriers that were not cited in the quantitative survey data; some of these were not listed amongst the options for survey respondents to select. Fear of social services, pressure to breastfeed, and domestic violence were strong themes of the telephone conversations especially. Failures and shortcomings in primary care, such as rushed appointments, lack of continuity of carer, lack of perinatal mental health training, failure to follow up or refer as promised, and a preference for medication amongst GPs specifically, were extremely prevalent and were cited by women amongst the main reasons that they did not receive the help that they needed. Some mothers had very positive experiences, but, as one said: "It's the luck of the draw with health professionals."

Although no survey respondents selected language/cultural barriers as an issue, it is possible that the same barriers would have prevented them from filling in the survey, and this seems more likely since cultural barriers were described by several participants in the informal interviews. Women from black and ethnic minority backgrounds, particularly those from faith communities, described enhanced mental health stigma. This is in keeping with the findings of national research into differences in access and utilising of perinatal mental health services for women from ethnic minorities. These women are less likely to access NHS perinatal mental health support in the community, and the research paper suggests that access to community mental health services for Black African, Asian and White Other women during the perinatal period should be facilitated.[19]

The qualitative data yielded by the focus groups, telephone conversations, and survey comments also sheds further light on the shocking statistic from the survey that almost 40% of mothers who are referred for mental health support drop out, and, of these, 75% do so while they still need that help. The most common reason cited was "I didn't feel that service was right for me." This theme was continued in the survey comments and featured particularly in the telephone conversations, in which mothers were able to describe their (often complex) experience of navigating services in more detail.

Of the twelve women interviewed, all of whom were current or former MumsAid service users, nine had previously been referred to Greenwich Time to Talk and only one described that service as helpful or relevant to their needs. They all found that the service offered by MumsAid improved their wellbeing but experienced a delay in accessing that support while they were referred to Time to Talk and then either disengaged or completed the sessions without improvement. Of course, this picture will be coloured by the fact that research

[19] Jankovic, J., Parsons, J., Jovanović, N. et al. (2020) Differences in access and utilisation of mental health services in the perinatal period for women from ethnic minorities—a population-based study. *BMC Med.,* 18. doi:10.1186/s12916-020-01711-w. See recommendation 7.

participants were not recruited from amongst Time to Talk's service users and mothers who had benefitted from Time to Talk would be less likely to need MumsAid's services afterwards. Nonetheless it is clear that resources are being wasted and women are suffering as a direct result of referral to a service that is not designed for their unique needs as new mothers.

Ten Recommendations to Improve Access to Perinatal Mental Health Services in Greenwich

1. Perinatal mental health needs to be prioritised during the pandemic as a matter of urgency.

Currently this is not happening in Greenwich and mothers are struggling with isolation and lack of support. The results are devastating for families. Video or telephone calls are not an adequate substitute for face-to-face care and not everyone has the resources to access them. Options for safely reopening children's centres, baby and toddler groups, health visiting clinics, and face-to-face appointments with health professionals need to be explored urgently. This may mean meeting outside in good weather, putting social distancing measures in place, etc. Mothers need to be kept informed about discussions and plans.

This recommendation is in line with the national rapid response report from Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries across the UK (MBRRACE-UK), investigating maternal deaths related to and associated with SARS-CoV-2 (COVID-19) during May–August 2020.[20] 25% of these deaths were a result of suicide. MBRRACE-UK said**: "Changes to service provision as a direct consequence of the pandemic meant that women were not able to access appropriate mental health care."** They also suggest that "receipt of the specialist care they needed may have prevented their deaths."

MBRRACE-UK emphasise the need to:

- **Establish triage processes** to ensure that women with mental health concerns can be appropriately assessed, including face-to-face if necessary, and access specialist perinatal mental health services in the context of changes to the normal processes of care due to COVID-19.
- Consider **repeat referrals** for mental health concerns **a 'red flag'**, prompting a clinical review, irrespective of usual access thresholds or practice.

See also the Maternal Mental Health Alliance's plea to national and local decision makers to **PLAN for perinatal mental health care during and beyond COVID-19**, which outlines four key steps for protecting access to perinatal mental health care during the pandemic.[21]

2. Mothers in Greenwich need greater provision of perinatal-specific talking therapies to support their mental health.

Greater provision of talking therapies is required to reduce waiting times, which are currently unacceptable for mothers who are often quite acutely distressed. Lengthy waiting lists reduce accessibility and can result in preventable escalation of mild or moderate mental health difficulties into more severe problems which require more intensive (and more expensive) support from the perinatal mental health service. Women also reported

[20] MBRRACE-UK: Saving Lives, Improving Mothers' Care: Rapid report: Learning from SARS-CoV-2-related and associated maternal deaths in the UK (March – May 2020): https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/MBRRACE-UK_Maternal_Report_2020_v10_FINAL.pdf.

[21] Maternal Mental Health Alliance: Plea to national and local decision makers to PLAN for perinatal mental health care during and beyond COVID-19: https://maternalmentalhealthalliance.org/wp-content/uploads/MMHA-PLAN-for-perinatal-mental-health-during-COVID19.pdf.

long term damage to their relationships with their children and partners as a result of delays in accessing talking therapies.

Referrals to generic IAPT services are not usually appropriate for women suffering from perinatal mental health problems, and medication alone is not a solution for most women. Although Greenwich Time to Talk has a perinatal lead, the mothers who participated in this research overwhelmingly decried that service as inaccessible and inappropriate for their needs. Anyone offering talking therapies to new mothers needs an enhanced level of specialist perinatal mental health training. They must be able to support with issues such as tokophobia (fear of childbirth), birth trauma / PTSD, feeding difficulties, parent-infant attachment difficulties, and perinatal depression and anxiety. The service also needs to consider and plan for mothers' unique access needs, such as childcare (see recommendation 4).

It seems that significant investment would be required to endow Time to Talk with adequate capacity, accessibility, and expertise to be consistently beneficial for new mothers. MumsAid are already operating more successfully in this field: a recent evaluation shows that the counselling improves mothers' mental health significantly and women who have used the service praise it very highly. Their only regret is that MumsAid do not have the resources to offer more ongoing support.[22] The service has been featured on Public Health England's website as an example of best practice in perinatal mental health; it was recognised by the Parent-Infant Partnership as an 'Exceptional Infant Mental Health Service' (2017); and it won the Diversity and Inclusivity Award from the Maternal Mental Health Alliance (MMHA) in 2018.[23] Therefore it seems that the most efficient way to increase accessibility of talking therapies for mothers in Greenwich would be to replicate or expand MumsAid's service model.

The ENRICH studies into pathways to mental health care for black and minority ethnic service users found that the best way for statutory healthcare organisations to improve accessibility for these people is to work closely with community and voluntary organisations.[24] For this reason, partnership working with organisations like MumsAid and BLG Mind should be preferred when expanding service provision, especially when catering to an ethnically diverse population such as in the Greenwich borough.

3. Mothers in Greenwich need greater provision of perinatal-specific peer support for their mental health.

Mothers emphasised the importance of peer support. For example, those who attended breastfeeding groups cited how helpful the peer support aspect of them had been: one said that she was "very lucky" to go specifically because she **"met other mums and it really helped."** Another said that the breastfeeding group was "amazing" and that she went "for the help but also the social aspect". She said that she felt more able to talk freely about how she was feeling in a peer support environment than with a health professional. Peer

[22] The McPin Foundation: MumsAid evaluation report (January 2020): https://mcpin.org/wp-content/uploads/2020/02/MumsAid-evaluation-report_240120.pdf. See also the peer researcher's blog post about the process and findings: https://mcpin.org/evaluation-of-mumsaid/.
[23] Public Health England: Perinatal counselling: early intervention for new and expectant mothers: How MumsAid's perinatal counselling service is supporting mothers experiencing mental health difficulties (2016): https://www.gov.uk/government/case-studies/perinatal-counselling-early-intervention-for-new-and-expectant-mothers; Maternal Mental Health Alliance: Perinatal Mental Health Awards (2018): https://maternalmentalhealthalliance.org/tag/mmhaconf2018/.
[24] Singh, S.P., Islam, Z., Brown, L.J., et al. (2013) Ethnicity, detention and early intervention: reducing inequalities and improving outcomes for black and minority ethnic patients: the ENRICH programme, a mixed-methods study. *NIHR Journals Library* (Programme Grants for Applied Research, No. 1.3). doi:10.3310/pgfar01030. Available from: https://www.ncbi.nlm.nih.gov/books/NBK373873/.

support should be available to mothers, however they feed their babies. Peer support is built in to the 'Mindful Mums' group hosted by BLG Mind and into MumsAid's outreach service, as well as the online groups they have started in response to COVID-19. Nonetheless, considering the number of young families in the borough, there is still a considerable lack of peer support specific to mothers' mental health.

As per the findings of the ENRICH studies described above, peer support is often more accessible than clinical support for mothers whose cultural background renders them reluctant to embrace the medicalised approach which naturally tends to dominate in NHS services. Partnership working with third sector organisations is key, as are the community links already established by children's centres. One mother suggested that the children's centres might run and moderate a Facebook group for local parents, and also said that she would like to see more face-to-face groups at the children's centres, with an outreach aspect so that staff would support mothers to have the confidence to attend. In some areas, such as Andover, Hampshire, health visitors have set up perinatal mental health support groups in partnership with local services.[25] National Mind have created some valuable resources for establishing perinatal peer support groups, services, and projects, including the perinatal peer support principles.[26]

4. All relevant local services should evaluate how feasible it is for mothers to attend appointments/groups and make adjustments accordingly.

Considerations should include:

- Childcare – Is there the option of a creche?
- Location – Is the venue a short walk from where the majority of mothers using the service live? Is it easy to find? Is it accessible on public transport?
- Venue – Is it breastfeeding-friendly? Is there a baby change area? Is it suitable for mothers using the service? (For example, women affected by birth trauma should not be made to sit in a waiting area full of expectant mothers or in the same physical space as they would have had their own natal care.)
- Flexibility – Is there a choice of appointment times? Can mothers engage without disrupting their babies' schedule?
- Digital and technological exclusion – Do mothers need an internet connection to be able to engage with the service? Do they need credit on a mobile phone?
- Have local mothers been consulted in the design of this service?

Mothers who benefitted from MumsAid's counselling service have explained the difference that some of these measures can make:

> **"They're really, really good in terms of actually accessing the counselling, because the children's centre helped me with my daughter when I was in the sessions, but I could have brought her in with me as well. I did have that option. So having that flexibility was really good because otherwise you wouldn't have been able to attend all the appointments."**
>
> **"I think being in an accessible location, that was in a children's centre and not too far from us, that was near my son's school and local to us…. that was really good. And the childcare element, I think,**

[25] Institute of Health Visiting: Knowing Me, Knowing You (2016): https://ihv.org.uk/news-and-views/voices/knowing-me-knowing-you/.
[26] Mind: Perinatal Peer Support (2020): https://www.mind.org.uk/about-us/our-policy-work/side-by-side/perinatal-peer-support/.

is really important. I mean, even with it being so easy and provided, I still found that quite stressful, because… I found everything stressful at that point. So… they made it as easy as possible… removed barriers."

5. Midwives, maternity support workers, health visitors, and children's centre staff need more perinatal mental health training.

Midwives, maternity support workers, health visitors, and children's centre staff need to understand the importance of perinatal mental health and must know how to recognise signs that a mother may be struggling. They must know how to respond sensitively when a mother discloses a mental health difficulty and how to monitor the situation. They must know when and where to refer and how to chase up that referral on a mother's behalf.

Currently maternity and early years professionals in Greenwich are not consistently equipped to recognise mental health concerns and respond appropriately. Scoping studies have shown that this reflects the national – and indeed the global – picture.[27] The problem is widely acknowledged, and in recent years several initiatives have begun to tackle this.

From 2015-17, the Royal College of Midwives led the Specialist Maternal Mental Health Midwives project to develop the role of the specialist mental health midwife.[28] These midwives play a vital role in co-ordinating the best possible care for mothers affected by mental health problems and supporting their maternity team colleagues to do likewise. However, there are still maternity services without anyone in this important role, and, where specialist midwives have been appointed, there are differences in their role, skills, and experience.

Since 2015, the Institute of Health Visiting (iHV) has been delivering perinatal and infant mental health training to health visitors and other practitioners through the Perinatal and Infant Mental Health Champions project. Champions are expected to cascade the training to other colleagues in their area.[29] A member of MumsAid's staff team was able to access the iHV PIMH Champions training and, funded by The National Lottery's Building Connections Fund, has trained some staff and volunteers at Home-Start Greenwich, who support families in seven of the local children's centres.[30] However, mothers' mixed experiences of care testify to the fact that comprehensive perinatal mental health training has not yet reached many maternity and early years professionals in Greenwich.

Mothers have described the difference that it makes when professionals are able to recognise a perinatal mental health difficulty and respond appropriately. One said, "I went to the children's centre, and I was still feeling really depressed when I went there, and one of the workers actually really picked up on it, and she really helped me." Another commented on the survey: **"Thankfully my excellent midwife and health visitor listened to me and saw I needed more help, and supported and referred me. They put me on a plan of extra**

[27] Viveiros, C.J., & Darling, E.K. (2019) Perceptions of barriers to accessing perinatal mental health care in midwifery: A scoping review. *Midwifery*, 70. doi:10.1016/j.midw.2018.11.011. Available from: http://www.sciencedirect.com/science/article/pii/S0266613818303383.
[28] Maternal Mental Health Alliance: Specialist Maternal Mental Health Midwives: https://maternalmentalhealthalliance.org/projects/specialist-maternal-mental-health-midwives/; Royal College of Midwives: Specialist Mental Health Midwives: What they do and why they matter (2013): https://www.rcm.org.uk/media/2370/specialist-mental-health-midwives-what-they-do-and-why-they-matter.pdf.
[29] Institute of Health Visiting: PIMH Training Programmes: https://ihv.org.uk/training-and-events/training-programme/pimh-training-programmes/.
[30] The National Lottery Community Fund: The Peer Support and Social Integration Project: https://www.tnlcommunityfund.org.uk/funding/grants/0010345710.

appointments/extended care/more visits, which really helped postnatally." Another woman said, "I saw a health visitor… and they saw I was having problems at the time and… within two weeks they got me set up to see somebody." There were numerous positive examples of care as well as the many negative, but a lack of consistency. A review of perinatal mental health training for maternity and early years professionals in Greenwich might clarify why this is and highlight where additional training is most needed.

6. GPs need more perinatal mental health training and an up-to-date understanding of local service provision and referral pathways.

Mothers who recognised that they were suffering from a mental health problem often sought help from their GP in the first instance but were deterred by inadequate or unhelpful responses. GPs need the same knowledge as maternity and early years professionals about the importance of perinatal mental health, signs that a mother may be struggling, how to respond and monitor the situation, and when and where to refer. They also need to appreciate why medication may not be an appropriate intervention, or why mothers may not wish to take medication, and which drugs are safe to take whilst breastfeeding.[31] They should offer a range of treatment options and actively encourage mothers to voice any concerns. They should be familiar with the Perinatal Mental Health Toolkit, developed by the Royal College of GPs, which contains resources that GPs need to provide the best possible care.[32]

Mothers in Greenwich stressed that GPs must offer to make referrals rather than relying on unwell women to self-refer. One woman described how this enabled her to access counselling from MumsAid: **"The service was recommended by my GP, as I was suffering postnatal depression. And my GP gave me a leaflet but I couldn't really, you know, get myself to calling them, so the GP called on my behalf."**

A strategy is needed to ensure that key messages around perinatal mental health reach GPs across the borough. The GP Spotlight project, which was piloted in Wessex in 2017 and has since been rolled out in some other parts of the country, uses GP champions to deliver peer-to-peer training to other GPs.[33] Greenwich did have a GP champion for a year, but evidently further dedicated time and resources are needed to reach and engage GPs who have many competing demands on their time and attention.

7. Targeted outreach is required to ensure accessibility for mothers from diverse ethnic and cultural backgrounds.

NHS services need to work collaboratively with local faith communities and groups from different ethnic backgrounds to de-stigmatise mental illness and promote conversations about perinatal wellbeing. Representatives from services need to form strong relationships with local faith and community leaders and earn their trust. Women from these communities who have accessed perinatal mental health care should be supported to share their stories, if they wish to do so. Peer support initiatives within communities should be encouraged and nurtured, functioning independently while maintaining links with the NHS.[34]

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[31] GP Infant Feeding Network: Prescribing Information (2017): https://gpifn.org.uk/prescribing-information/.
[32] Royal College of GPs: Perinatal Mental Health Toolkit: https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/perinatal-mental-health-toolkit.aspx.
[33] NHS Surrey and Borders Partnership Foundation Trust: GP Spotlight project rolls out across Kent, Surrey and Sussex (2019): https://www.sabp.nhs.uk/news-and-events/gp-spotlight-project-rolls-out-across-kent-surrey-and-sussex-kss.
[34] Wood, L.M., Peer Workers in NHS Perinatal Mental Health Services: A values-based approach (2020): https://www.mind.org.uk/media-a/6334/perinatal-mental-health-peer-support-thought-piece-final.pdf.

This will promote access to services, but it is equally important that, when women do access services, the care they receive is therapeutic and effective. This requires services to be culturally relevant. Research shows that healthcare professionals in the UK lack the training and the confidence to identify the specific needs of black women and that this causes black mothers to 'fall through the net'.[35] A scoping review of perinatal mental health care for black and minority ethnic women found that the cultural and specific needs of some of these women remain unmet by services which are not designed with those needs in mind.[36] As that review is now ten years old and predates the arrival of the specialist community perinatal mental health service for women in Bexley, Bromley, and Greenwich, another review which focuses specifically on perinatal services in Greenwich would be extremely valuable.

Cultural barriers contribute to significant racial disparity in access to perinatal mental health care, and this needs to be addressed urgently. To help ensure that services remain culturally relevant and accessible, wherever possible their development should be co-produced with a diverse range of local families. One way to achieve this is to adopt a model like Maternity Voices, in which working groups of mothers and families, commissioners, and staff collaborate to review and develop local maternity care.[37] Greenwich Maternity Voices Partnership might be a useful ally in considering how to bring faith communities and minority ethnic groups 'on board' so that all mothers are represented and able to contribute to decision-making.

8. Young mothers, and others identified as vulnerable, should receive specialist holistic support.

Until April 2020, Greenwich's Family Nurse Partnership (FNP) team supported parents aged 24 and under, partnering them with a specially trained family nurse who visited them regularly from early pregnancy until their child was two years old. The FNP programme is delivered by local teams in almost 60 areas across England and makes a significant difference to outcomes for mothers, babies, and families.[38]

Family nurses played an important role in helping young mothers to access and engage with other local services. Pressures on primary care mean that midwives, health visitors, and GPs do not have the time or the resources to provide the individualised, relational support required. They often do not manage to make referrals in a timely manner or to support women to self-refer. A lack of continuity of carer also makes it harder for mothers to establish trust and disclose any difficulties. As a supplement to routine perinatal care, family nurses in Greenwich used to plug these gaps for young mothers and make mental health support more accessible to them.

One young woman in Greenwich explained how her family nurse had recognised that she was struggling with her mental health and made a quick referral to YoungMumsAid so that she could access the talking therapy that she needed. She found the continuity of carer and home visits offered by the FNP service invaluable: these enabled her to talk openly about how she was feeling. Unfortunately, due to recent funding cuts, the support she was receiving from the family nurse was stopped prematurely.

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[35] Edge, D. (2010) Falling through the net — Black and minority ethnic women and perinatal mental healthcare: health professionals' views. *General Hospital Psychiatry*, 32(1), 17-25. doi:10.1016/j.genhosppsych.2009.07.007. Available from: http://www.sciencedirect.com/science/article/pii/S0163834309001406.

[36] Edge, D. (2010) Perinatal mental health care for black and minority ethnic (BME) women: A scoping review of provision in England. *Ethnicity and Inequalities in Health and Social Care*, 3, 24-32. doi:10.5042/eihsc.2010.0507.

[37] National Maternity Voices: Networking Maternity Voices Partnerships Across England http://nationalmaternityvoices.org.uk/.

[38] Family Nurse Partnership (2020): https://fnp.nhs.uk/.

The closure of the FNP service in Greenwich has left a gap in care which must be addressed urgently, and a similar model of holistic, supplementary support should be devised for other vulnerable mothers and those who are identified as being at increased risk of a perinatal mental health issue. One woman said, "I need to talk with someone. I don't like to bother my husband too much or my mum. **I don't want leaflets or fliers, just someone to come round and talk to you.**" This individualised, relational approach helps to both prevent and mitigate perinatal mental health difficulties, and it ensures that mothers who need additional care are supported to access it.

9. A local perinatal mental health awareness campaign should be launched, with three distinct aims: helping families to identify signs of a potential perinatal mental health problem, de-stigmatising, and signposting to appropriate support.

Several mothers praised national awareness campaigns and the role that celebrities have played in highlighting mental health, but these were not sufficient to enable them to identify their own perinatal mental health difficulty and seek appropriate help. Mothers called for greater visibility for organisations that offer support to new parents: one woman said, "Cancer charities are everywhere, but **you never hear about perinatal mental health**."

A careful communications strategy is required to validate and normalise experiences of distress in the perinatal period, while explaining when and where to seek specialist help. It should include information about how to self-refer and whom mothers can ask to refer on their behalf. Some reassurance about social services might be included. It needs to be intelligible and culturally relevant to mothers from a range of different backgrounds and accessible to those who do not use the internet. The only way to get this right is to co-produce with a diverse group of mothers with relevant lived experience.

10. Mothers' mental health should be assessed along with their physical health as part of routine maternity care.

Currently most mothers in Greenwich do not feel that there is parity of esteem for their mental and physical health: while they receive regular check-ups on their physical health during pregnancy and the early weeks of parenthood, any enquiries about their mental health often feel like an afterthought.

Two of the women interviewed as part of the research suggested that routine use of a mental health self-assessment tool should be offered to pregnant women and postnatally. Questionnaires like the Edinburgh Postnatal Depression Scale (EPDS) are imperfect and need to be used in the context of care from an approachable and appropriately trained healthcare professional, but they are a useful starting point for essential conversations about mental health.

Appendices

First Focus Group Notes

Time: Tuesday 11 August 2020, 10am

Location: Zoom

Present: Laura Wood (peer researcher), staff from MumsAid and Storkway children's centre, 4 participants

Notes made by staff on behalf of MumsAid.

Welcomes and introductions.

Group agreement – kids will interrupt and that's OK; can turn off camera; wellbeing is the most important thing; may discuss sensitive topics so feel free to duck out at any time; keep everything confidential; be respectful of everyone's confidentiality; report will be written, but no personal information shared; reiterated privacy and confidentiality agreement; listen respectfully even if you've had a different experience; silences are OK!

Laura explained about the research and about herself.

Discussion questions on Powerpoint slide:

- Did you seek support with your mental health or emotional wellbeing from anyone when you were pregnant or had a baby?
- Were you able to get the support that you needed from them? How helpful were they?
- If you didn't get the help that you needed, why do you think that was?

Discussion:

- Nearly lost son, struggling. Spoke to GP but wasn't very helpful; anti-depressants were what she was advised to do immediately. Reluctant because she was breastfeeding.
- Lucky that she could go to a breastfeeding group; met other mums and it really helped.
- Breastfeeding groups were helpful for a couple of mums.
- Hard time in pregnancy: younger parent, was alone, no family around, 3 small children, husband out at work. After 1 month no sleep, not eating, got depressed. Discussed with GP, gave a leaflet on mental health support. Told that after a couple of months she would feel better. Second pregnancy, experienced homelessness, very difficult, got gestational diabetes. Then had other children diagnosed with autism. Had a really hard time (very upset), finding being locked in with 4 kids very difficult. GP told her she that it could be PND. Husband working full time. No real support. Would like help.
- Had the odd bad day, used breastfeeding group. Hospital were most unhelpful: gave lots of incorrect information. Pregnancy difficult. QE2 people at the hospital were amazing when he was born.
- Support from hospital post birth isn't great.
- Bottle fed immediately. No help with a tongue tie because not breastfeeding. Feelings of guilt, felt bad for the child as he wasn't getting the help he needed.

- When at home community midwife visited 7pm (bit late), didn't get on with her at all. Struggling to feed, but she kept saying "my little one was in SCBU" and almost belittling what she was saying like it was no big deal. Trainee was fine but community midwife was giving out orders. Didn't feel confident getting on and off buses. Felt like there was lots of pressure on me. Said she didn't want that lady again and she didn't get her which was good. Didn't like the way she was being spoken to and felt incredible pressure. Didn't want to leave the hospital as the hospital was so lovely and so were the staff.
- Different hospital experience: "we felt like the day job" – baby born emergency c-section after a long labour; then woken up through the night to do bloods etc, and not allowed to sleep. Had a birth review which was really helpful; fed back that the way you are spoken to is "day job", need to do this and this etc; could've done with more compassion. "This is my new baby. I need help."
- Got home from hospital and it was very quiet. Midwife who came the next day was lovely, but there were gaps in care. Baby was mucus-y, caused lots of anxiety. Depended on husband a lot; they were each other's support. Midwife went above and beyond and signed off quite late to give extra support.
- Health visitor was great. If it wasn't for her, she would've been a bit lost.
- "Luck of the draw" with health professionals.
- Struggled with GP – went because of reflux. Told that breastfed babies don't usually get reflux. Felt challenged by everything she said, not supported at all.
- Experience with health visitor was very good in both pregnancies. Arranged home visits every week for a couple of months, as she had 3 babies, and did the weighing at home. With second pregnancy she also came to the house and called in a lot. During lockdown she called regularly and has offered lots of help.
- Breastfeeding groups were amazing; went for breastfeeding help but also for the social aspect. Lots of advice even when baby was older. Able to talk more freely in that kind of peer supported environment rather than a "sit down situation" with a health professional.
- 1st three months felt fine but after that felt like she had PND, visited GP. Medication being the first option didn't feel right, wanted to manage without it. GP thought she had PTSD but didn't feel like that was acknowledged so never really got the help with it. Put her off going to the GP: "every time I go it's about medication and I just feel like there should be other options." Wasn't offered alternatives. Not sure if it's because they are pushed for time. She should've had a debrief after the birth because it was so difficult but it didn't happen and she was told to follow it up, would've been useful if the hospital staff arranged it. Still wants it; wants to have some explanation of what happened to her son; feels it would help. They need to be more proactive.
- This service should be advertised (post birth session with midwife).
- Going into an antenatal area again can be quite triggering, not the nicest area to go back to.

Thanks for taking part. Reminder about Amazon voucher and anonymity: report will be published without any names. If it's brought up any difficult feelings, do feel free to get in touch.

How is everyone feeling? Acknowledgement that lots of emotions can be brought up in sessions like these.

- I want to go to a group where I can share my experience. I feel lighter for sharing my experience. I can't go because I have 4 children.
- It's great to listen to other people: "It's not just me". Mum camaraderie.
- Brought up by a single mum so I feel really grateful right now not to be doing this alone.
- Find children's centres as they are open all the time and can help with support.
- Good to talk about it rather than sit and think. Need baby groups to open again.

Second Focus Group Notes

Time: Thursday 13 August 2020, 10am

Location: Zoom

Present: Laura Wood (peer researcher), staff from MumsAid and Waterways children's centre, 4 participants

Notes made by staff on behalf of MumsAid.

Welcomes and introductions.

Group agreement – kids will interrupt and that's OK; can turn off camera; wellbeing is the most important thing; may discuss sensitive topics so feel free to duck out at any time; keep everything confidential; be respectful of everyone's confidentiality; report will be written, but no personal information shared; reiterated privacy and confidentiality agreement; listen respectfully even if you've had a different experience; silences are OK!

Laura explained about the research and about herself.

Discussion questions on Powerpoint slide:

- Did you seek support with your mental health or emotional wellbeing from anyone when you were pregnant or had a baby?
- Were you able to get the support that you needed from them? How helpful were they?
- If you didn't get the help that you needed, why do you think that was?

Discussion:

- With 1st child. "I wouldn't wish it on anyone." Baby born 10 weeks early and spent first 3mths in hospital. Didn't know who to ask. With hindsight, she wishes she had known who to ask and where to find help. "There were days where I could've gone crazy." Finding out where to go is hard; finding out who to ask is tricky; not always easy to find on the internet and that can make you more anxious. There are things that people need that they just can't access. Felt like she suffered in silence. No parents around to help, had to just get on with it. Children's centre were amazing but didn't go until after 18mths. This experience coloured the birth of her 2nd child: "Is it going to be the same again? Who do I ask? Where do I go?" Didn't mention fears to her husband. Drew on past experience to get herself through. Always thought she couldn't complain as others are worse off. Not having the joy of motherhood with 2nd child; always questioning each stage of progression. This call is a welcome break.
- No family support and it was a struggle. Aware of routes but was apprehensive to begin with. Groups and things were helpful, connected with local mums. She knew about the services at the children's centres from an early stage but she is quiet shy and did not have the confidence to attend on her own. She downloaded an app called Peanut where you meet other local parents and this was a lifeline, enabled her to meet others for mutual support. She wonders if the children's centre could do something similar with a parents' Facebook group. More peer support services would be good.
- Didn't know where to go. Always went to children's centre so really missing it now due to lockdown.

- Midwife was amazing when 2nd child was born. With the 1st, she had pre-eclampsia. With the 2nd, she just kept thinking, "I need to get home." Baby discharged first. She had to stay in for 9 days. "I wanted my mum." Getting on with it, thought that in a few years' time things will change. GP isn't really involved. Family all live abroad. Does have one set of friends who are amazing, like surrogate parents and they are in the medical field. Feeling like a swan, serene on the surface but feet paddling rapidly underneath.
- Has lots of family support. Always someone to call, especially auntie who is always around to help. Some of her children are older so they help out. Can talk to colleagues. Labour was induced: she didn't want this but agreed to it. Induction was stressful: in excruciating pain but wasn't given pain relief. Colleagues were there as she was a midwife. Gave her an insight into how some of the other women she's treated felt. She's more honest with her patients now and feels she really listens to them. Feels supported by colleagues. Good husband who comforts her, reminds her to think of herself as a patient, to take meds on time.
- Difficult when she had her 1st child. Able to talk to a family friend; ended up moving in with her to get help; she supported her so well. Spoke to health visitor and midwife as well. They recommended joining some groups to feel less alone, to help her feel more supported and less depressed. Doing well with 2nd child for now.
- "Today has been amazing for me. I need to talk more as I already feel so much better."
- The help we need should be there immediately like the Bounty lady who comes round to take your picture in hospital.
- "I need to talk with someone. I don't like to bother my husband too much or my mum."
- Don't want leaflets or fliers, just someone to come round and talk to you. When doctors come round, they just want to tell you what's wrong.
- "I am thankful for how I've managed to cope but I would like to be able to talk more and find out about sessions like this more easily."

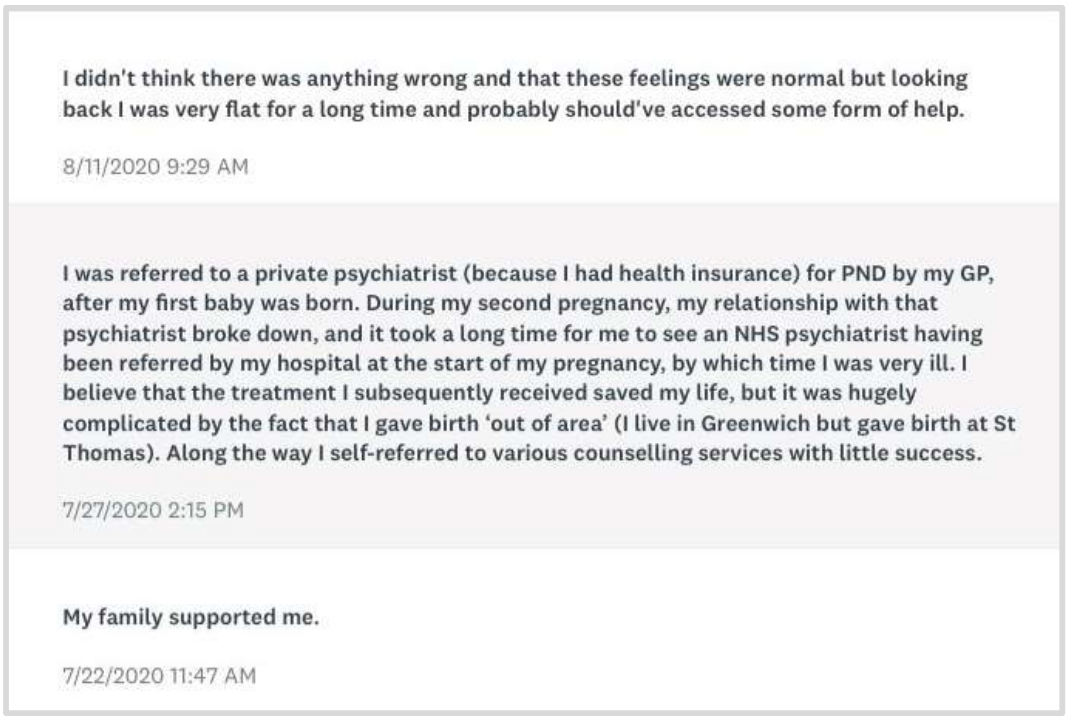
How is everyone feeling? Acknowledgement that lots of emotions can be brought up in sessions like these.

- The session had been quite moving.
- Some participants visibly upset (followed up subsequently).
- Feels good to share.
- Feeling good to be on the call.
- Thanks to the children's centre representative. They are always supportive and lovely.
- Good to talk, good therapy. Need to talk as if you don't let it out you feel depressed. Find someone who you can talk to.

Thanks for taking part. Reminder about Amazon voucher and anonymity: report will be published without any names. If it's brought up any difficult feelings, do feel free to get in touch.

Survey Comments

The following are the more detailed of the comments posted to the survey, in which women share their views and snapshots of their experiences in their own words. Where answers were very brief – for example, "MumsAid" in response to "Did you have someone to talk to and get support from during the perinatal period? If so, who were they?" – these have been incorporated into the other data.



I didn't think there was anything wrong and that these feelings were normal but looking back I was very flat for a long time and probably should've accessed some form of help.

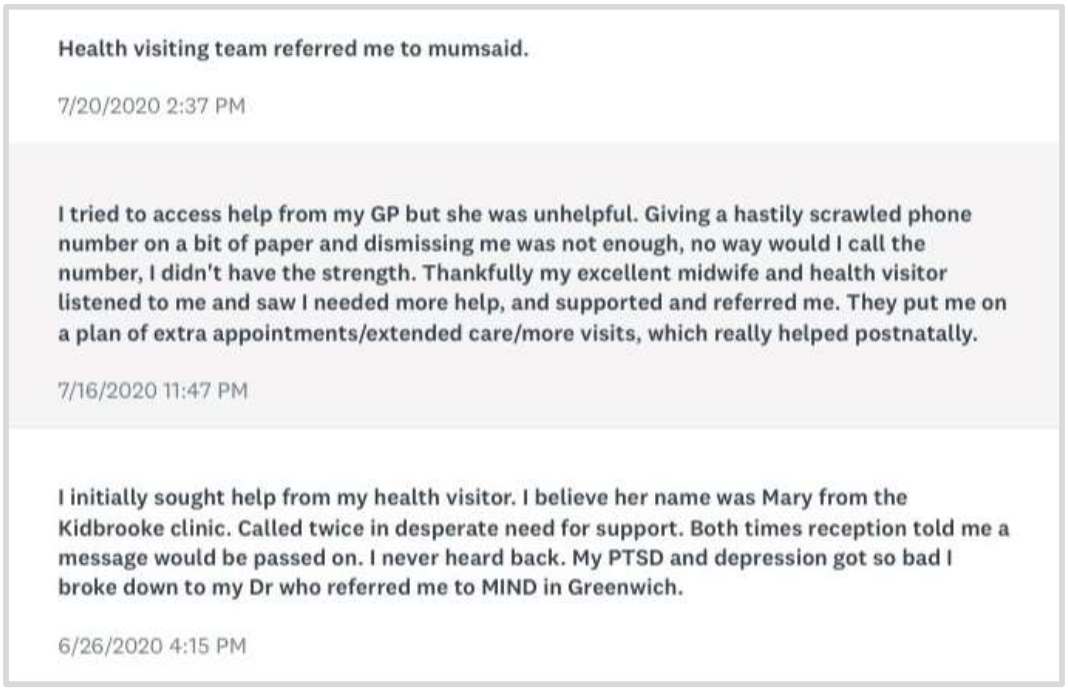
8/11/2020 9:29 AM

I was referred to a private psychiatrist (because I had health insurance) for PND by my GP, after my first baby was born. During my second pregnancy, my relationship with that psychiatrist broke down, and it took a long time for me to see an NHS psychiatrist having been referred by my hospital at the start of my pregnancy, by which time I was very ill. I believe that the treatment I subsequently received saved my life, but it was hugely complicated by the fact that I gave birth 'out of area' (I live in Greenwich but gave birth at St Thomas). Along the way I self-referred to various counselling services with little success.

7/27/2020 2:15 PM

My family supported me.

7/22/2020 11:47 AM



Health visiting team referred me to mumsaid.

7/20/2020 2:37 PM

I tried to access help from my GP but she was unhelpful. Giving a hastily scrawled phone number on a bit of paper and dismissing me was not enough, no way would I call the number, I didn't have the strength. Thankfully my excellent midwife and health visitor listened to me and saw I needed more help, and supported and referred me. They put me on a plan of extra appointments/extended care/more visits, which really helped postnatally.

7/16/2020 11:47 PM

I initially sought help from my health visitor. I believe her name was Mary from the Kidbrooke clinic. Called twice in desperate need for support. Both times reception told me a message would be passed on. I never heard back. My PTSD and depression got so bad I broke down to my Dr who referred me to MIND in Greenwich.

6/26/2020 4:15 PM

In my first pregnancy my caseloading midwife (Southwark borough) knew o needed help. I was referred to the slam and in my second pregnancy I asked for help (Greenwich borough) but I didn't get any.

4/27/2020 8:06 PM

My GP referred me for support services but I never heard anything more following that referral. I could have chased this up but had found MumsAid in the meantime (via a leaflet in the GP waiting room)

4/5/2020 6:33 PM

social services referred me to mumsaid

3/24/2020 8:51 PM

Family and friends were great

8/11/2020 9:29 AM

My family, I didn't receive professional help.

7/22/2020 11:47 AM

Referred by NHS health visitor to a group at the children's centre, not sure if group was NHS run?

7/16/2020 11:47 PM

No one seemed to be able to realise it was because I had had a baby

5/6/2020 11:54 AM

I asked the midwife for help but every appointment it was a different midwife so I didn't want to keep bringing it up again. They always told me I'd be contacted by the right team but I never was. After the birth a midwife came to see me at home once the day after my baby was born and a bank midwife came on day 5 I never heard from the maternity service again. I thought they had too much else to do so I didn't push for help.

4/27/2020 8:06 PM

Before seeking help for myself I spoke to my gp about being referred to mental health services, she said she would call me back with next steps, but I never received a call back and wasn't referred. I then sought help myself through mumsaid on the recommendation of my health visitor and staff at a breastfeeding clinic.

3/26/2020 9:54 AM

Worries that my children would be taken away if I disclosed how I was feeling

3/25/2020 8:40 PM

I received crisis counselling which was only available for 6 weeks. I am now currently awaiting an appointment to continue therapy sessions.

6/26/2020 4:15 PM

They just wanted me to fit in their box of diagnosis

5/6/2020 11:54 AM

Needing to attend weekly which was difficult when managing childcare, work etc

3/25/2020 10:56 PM

This is a tricky question to answer. I had a partner but he was not helpful. I have parents but I couldn't talk to my dad and my mum didn't know how to help me. I went to baby groups but couldn't speak with people and just put a mask on to hide my feelings.

4/27/2020 9:47 PM