Perinatal Mental Health Feedback Report

August 2017

Analysis of outputs from: focus group, interviews and workshop with the voluntary sector.

Contents

Executive summary

South west London does not currently have a specialist perinatal community mental health team that meets national guidance set out by the Royal College of Psychiatrists (RCPsych). The Mental Health Five-Year Forward View sets out national ambitions to increase the numbers of women seen by specialist perinatal community mental health teams. In order to deliver on these ambitions, national transformation funding is being made available but areas have to bid for the money. South west London's draft bid is in development and the deadline for submission is to be confirmed.

In order to ensure that the voice of women and families are at the heart of the bid, in August 2017 we undertook a three-fold engagement exercise to develop what the model of care could like. This was the beginning of the conversation and if the bid is successful, we would seek to build on this early engagement by further involvement in the implementation and delivery of the service.

The engagement exercise comprised: focus group with women affected by these issues; one-to-one interviews with women and a workshop with voluntary sector colleagues.

The feedback from all of these activities are detailed in the report and key themes have been drawn out below:

Overall observations

- Quality of care varied across boroughs and across healthcare professionals
- Continuity of carer was particularly important to enable women to build trust
- Birth reflection service was unanimously supported and felt to be invaluable in understanding and coming to terms with their birth experience.
- Partners need to be included in the work: supporting them and providing them with information so they can support the women affected

Type of support that could be provided by the new service

- Many of the women felt isolated and really valued the idea of having groups to share experiences with, without judgement. There was a lot of support for group sessions – as well as one-to-ones for those who need them.
- Women supported the idea of having a mentor who had experiences of mental health or group support in the community.

Accessibility of the new service

- Should be local and easy to access. Delivered in community settings that are known to the families.
- The environment (what they look like) is less important than the attitude of the people providing the service
- Every contact needs to count. Whoever the woman has contact with should proactively and sensitively ask after their wellbeing – whether that be their GP, health visitor or midwife

Raising awareness of the service

- Need to use existing networks – but ensure that messages are on-going – don't just tell people once about the new service – send reminders
- Public messaging needs to be clear and help people to recognise the signs of postnatal depression, primarily, but also anxiety and other mental health problems that can affect perinatal women
- Consider a dedicated website that has a clinical chat forum for people to access at unsociable hours when needed.

Understanding the needs of particular communities

- The needs of many different communities were discussed. A key thread was the importance of working with community leaders to reach different populations.
- It was suggested that training should be given to different community leaders to enable them provide support to members of their community
- Consideration to be given to how services can be embedded within different communities.

Developing the training package for healthcare professionals

Overall it was felt that a consistent training package, with consistent tools would be very helpful. Suggestions around content included:

- Recognising early signs and knowing where to signpost people
- Impact on children and their development
- Understanding how services work – allaying anxieties around people having their children taken away.

People also suggested that it would be helpful to hold a rolling conference that people could be invited to, including members of the public and interested individuals

1. Focus group (14th August 2017)

1.1 Agenda for the session

Item	Time	Title
1.	15 mins	**Welcome** • Why we are here • Introductions
2.	20 mins	**Hopes and burning issues** Discussions around key issues to consider when planning this new service
3.	20 mins	**Why are we developing a specialist perinatal community mental health service?** • How services work now? • What is the need for this new service? • What could the service look like? **Question and answer**
4.	60 mins	**Helping to shape the service** **Discussions about:** • Where to seek help from initially • Location of service • The type of support should it provide • The needs of particular communities
5.	5 mins	**Next steps**

1.2 Attendees

Name	Borough
AH	Sutton
DP	Sutton
DL-T	Sutton
IM	Sutton
KD	Merton
KP	Sutton
MM	Kingston
SDS	Wandsworth
In Attendance	
Annabel Walker	Assistant Director, NHS
Clare Thomas	Engagement Manager – NHS
Jill Mulelly	Head of Engagement – NHS
Leah O'Donovan	Transformation & Commissioning Manager Mental Health, NHS

1.3 Aim of the session

To hear the views of local women about what a local perinatal mental health community service could look like. Views were sought from women about:

- what support they might need;
- where they might want to access the service; and
- what it should look like and how they could find out about it.

1.4 Hopes and burning issues

Women were asked what they thought the most important considerations were when looking at this new service – drawing from their own experiences.

Key points from the discussion included:

- **Experiences varied** depending on who you see – wasn't consistent
- Women weren't routinely asked about their wellbeing – it was up to them to come forward. It was felt that **healthcare professionals should be more proactive** about sensitively asking people how they are – make every contact count!
- People had to **wait a long time** to receive treatment. One person was waiting more than eight weeks for IAPT.
- **Point of access was unclear**. Some people told to see their GP. Some people told to call IAPT directly and self-refer. Some health visitors signposted people to their GP.
- **Services need to be easily accessible** – positive reports given about receiving support at local children's centres – particularly when they didn't know where to turn.
- **Birth reflection service** was felt to be very valuable to help people work through what happened at their birth – and should be offered to all women – although not all women had heard of this service or been offered the support. (This service is only available to women who have given birth at St George's Hospital)
- Issues were raised about **referrals going missing** and needing to be chased up and **notes being lost**.
- It would be helpful if more information could be given to **people's partners** so they are supported and are better able to support their partners. **Include** partners in the discussions as sometimes partners can help pick up signs on how their partner is feeling but also feel pressure to cope with their own mental health.
- **Continuity of care worker** (midwife etc.) was highly valued.
- **More awareness and education** is needed and it was felt that information and advice could be given during the antenatal period highlighting what to expect with your mental health and what signs to look out for just in case. There was a lot of experience shared of not knowing what was "normal" after giving birth.
- Perinatal Mental Health is **not just for first time mums** either, it could happen any time and families need to be made aware of this.
- **Up skilling staff –** for example ensuring Health Visitors do the full checks 100% of the time, rather than just ticking a box and focussing on baby.
- **Take the pressure off** women not to feel like they have to be 100% all of the time. Some people felt that the leaflets and advice given by health professionals could

sometimes make feel people feel inadequate and pressured to be the best which can be stressful.

- **Reduce the stigma** on mental health and get more people to talk about it. It was suggested that children's centres could hold monthly sessions to encourage open conversations.

1.5 Helping to shape the service – feedback from table discussions

Leah gave an overview of the proposed service. People were invited to ask questions and then discuss four key questions on their tables:

1.5.1 Where would you most likely seek help from initially?

People made a number of suggestions about where they would seek help from:

- Midwives (should be able to give options and signpost to other services). Some concerns were noted re midwives not answering their phones.
- GPs – need to ask people how they are feeling – routinely
- Health visitors – but not to just necessarily focus on the baby, also focus on the parents.
- Children's centres – suggestions included holding monthly wellbeing sessions
- Websites – suggestions included a south west London directory which included advice, support services and a clinical blog/chat so people were able to ask questions. It was felt that the website should also have up to date telephone numbers so women could call anonymously and talk about how they are feeling.

Everyone should be proactive in asking women, sensitively, about how they feel.

1.5.2 If you needed to use this service, where would you like to attend appointments?

Overall, most women would feel comfortable attending appointments in an existing community setting. Specific examples included:

- Children's centres
- Community hubs – including where they get their babies weighed.
- GP surgeries

When thinking about if there were any key elements about the environment that they would like to see – people felt that it was more about the individual who saw them rather than what the space looked like. They'd like someone with a good attitude – welcoming and kind. Some women noted that they would prefer the space not to remind them of where they gave birth. Some women felt that home visits in the first instance could be better for those who did not want to leave the house, although there had to be some way of picking up these women in system if they did not come forward for support.

1.5.3 What type of support would you like from this service

Overall there was a lot of support for group sessions – with women who were experiencing similar things. It was noted that it would be great if the group sessions could provide crèche facilities**.**

Other suggestions include:

- CBT
- Providing counselling in pregnancy
- Medication (sometimes) if regularly reviewed
- Post natal NCT classes – noted as very helpful.
- Peer support and mentoring from women who have lived experience of the service.
- Pre-conception advice from someone who understands what medication it is okay to take during pregnancy if needed.

1.5.4 Are there needs of a particular community that we need to bear in mind? If so, what are these and how can we ensure that they are met?

It was noted that women are having babies' later in life and some of the terminology can be offensive – e.g. geriatric mothers.

People also flagged that sometimes appointments can be missed for a variety of reasons – juggling too many of life's balls/sometimes conditions such as dyslexia can compound problems. It would be helpful if text reminders could be sent out – rather than penalising women for missing appointments.

It was noted that women who suffer from addiction and substance misuse are very hard to reach and will usually not come forward to talk and there is a risk that they fall through the gaps.

2. Interviews with women

For women who were unable to attend the focus group or wanted to talk confidentially, the team organised 1:1 phone calls and individual face to face conversations. The team spoke to seven women in total.

At the beginning of each call, the team would offer a space for the woman to share as much of their story as they felt comfortable with. The team had a set of questions that they asked each woman. The themes of the conversations are listed below.

2.1 At what point did you realise you needed mental health support?

Women shared their experiences of feeling isolated once their partner or family had returned to work and being left alone with a new baby. The majority of the women spoken to, at least 80% of them felt that they needed support after returning home with their baby. The timeframe varied from four weeks to nine months before women sought support.

2.2 For those who have a pre-existing MH condition: would you have wanted to have pre-conception advice available to you? Why or why not? What would have been most helpful to you? Consultation? Leaflets?

The women spoken to who had a pre-existing mental health condition felt the pre-contraception advice would had have been very helpful. One woman felt that **information around the pregnancy and after birth** would have been very helpful so she would know what to possibly expect with her mental health.

2.3 From where did you seek help initially?

Out of the seven women spoken to

- 3 spoke to their GP
- 2 spoke to their midwife
- 1 spoke to their health visitor
- 1 spoke to a private lactation consultation

2.4 How did you feel about seeking help? What, if anything, would have helped you to seek support earlier?

Many of the women felt comfortable talking to a health professional, however some women felt that there is an assumption that GPs will only prescribe anti-depressants rather than refer to other services such as talking therapies. When women were referred or self-referred to IAPT services, there was usually a very long wait to be seen and nothing was offered in between which sometimes meant that the woman could feel worse.

2 What support did you receive, if any?

Out of the seven women spoken to

- 3 were referred to IAPT
- 2 received support through the Perinatal Mental Health team (SWLSTG & SLaM)
- 1 received support via a lactation consultant
- 1 didn't access support

2.5 With whom would/did you feel most comfortable discussing your mental health? And why?

Out of the seven women spoken to

- 2 felt most comfortable talking to their health visitor
- 2 felt most comfortable speaking to their midwife

Each woman's experience varied and the quality of care they felt they had received also varied. It was felt that some health visitors are more focussed on the baby rather than the mother and this can be off-putting. Some women felt that there needs to be a greater continuity of care with midwives as you are not always guaranteed to see the same person throughout your pregnancy. This can impact on building relationships and being able to trust someone to confide in.

2.6 Based on your experience, if it were to happen again and a specialist service was available, from who would you seek help in the first instance? And why?

Most women spoken to felt that they would try to speak to their health visitor or their GP. There were suggestions to include a mental health section to the obligatory discharge video at St George's Hospital and leaflets given to women before they leave hospital which could signpost people to services.

2.7 If you were to use this type of service, where would you most like to do so?

The majority of women spoken to felt that this type of service should be provided in the community possibly at a Children's Centre. Some women liked the idea of home visits however it was noted that this might not be suitable for all and would not help to reduce isolation that some women feel. Some women also felt comfortable visiting an acute hospital or local GP practice; however, it was felt that this service should not be provided at a Mental Health Hospital because of the inherent stigma.

2.8 What type of support would have been most useful to you:

During pregnancy?

- Antenatal classes either provided at the Hospital or by NCT. It was felt that there should be a discussion around mental health and what signs to look out for.

After birth?

- Women supported the idea of having a mentor who had experiences of mental health or group support in the community. Many of the women felt isolated and really valued the idea of having groups to share experiences with, without judgement. It was felt that Dads also need to be involved in these conversations and that health professionals should ask them how they are doing and not only focus on the woman.

3 Workshop with voluntary community sector (22nd August)

3.1 Agenda for the workshop

Item	Time	Title
1.	15 mins	**Welcome and why we are here** **Introductions** (round robin)
2.	20 mins 10 mins	**Context** • Background • Key elements of bid • Fixed points • What's open to influence **Question and answer**
3.	50 mins	**Table discussions** • Accessing support • Linking in with other services • Educating healthcare professionals • Understanding the needs of different communities **Feedback from each table** (key points)
4.	15 mins	**Insight from service users** • Feedback from focus group and 121interviews
5.	10 mins	**Next steps**

3.2 Attendees

Name	Organisation	Borough
Carol Jacques	Sutton Mental Health Foundation	Sutton
Fiona Denton	Sutton Mental Health Foundation	Sutton
Heather Mathew	Richmond Council for Voluntary Service	Richmond
Janet Deboo	Homestart Richmond	Richmond
Linda Dell'Avvocato	Healthwatch	Wandsworth
Lisa Harmer	Anyone Everymum	Sutton
Maureen Bailey	Inner Strength Network CIC	Merton
Patsy Ferreira	Destiny 7	Merton
In attendance		
Akvinder Bola-Emerson	South West London & St George's Mental Health Trust	
Annabel Walker	SWL STP	

Clare Thomas	SWL STP	
Ife Ogunturoti	South West London & St George's Mental Health Trust	
Jennifer Goddard	South West London & St George's Mental Health Trust	
Jill Mulelly	SWL STP	
Leah O'Donovan	SWL STP	

3.3 Aims of the workshop

The Voluntary Community Sector is a key partner in health and social care. They also have a huge amount of insight into the needs of local people. The aim of this workshop was to begin an early conversation with key VCS stakeholders to help shape the bid for perinatal mental health community services. We wanted to raise awareness of this piece of work and draw on their experience to help inform the development of the bid.

3.4 Feedback from table discussions

3.4.1 How can we ensure women know about perinatal mental health and the support available? How can we help them to get the support they need?

Key themes that came out of the table discussions were:

<u>Raising awareness of the service</u>

- Promoted through Children's Centres; coffee mornings; healthcare professionals such as health visitors and midwives; Homestart volunteers.
- Public messaging needs to be clear and help people recognise the signs of postnatal depression, as the most common perinatal mental health condition
- Need to use existing networks – but ensure that messages are on-going – don't just tell people once about the new service – send reminders
- Extend the existing Community Navigator role (based in Merton) across south west London to signpost people to different support services.
- Start the discussion early on with young people in schools. This will help raise awareness and also reduce the stigma.
- Have a dedicated website that has a clinical chat forum for people to access at unsociable hours when needed.

<u>Working with partners</u>

- Work with partners so they know to seek help early
- Provide support for partners – not only can they be affected by stress but it can also be very lonely supporting people with postnatal depression.
- Consider providing forums for fathers
- Consider working with local authorities to have a session in schools.

3.4.2 What key services does the new perinatal mental health team need to link into? What considerations are there to ensure the links between the services are clear?

Key services to link into are:

- Homestart
- Family nurse partnerships (which work with vulnerable young women)
- Children's centres
- Family support services – including family recovery centres
- Parent-infant provision
- Voluntary sector – of note organisations that support families whose children have physical disabilities (MH needs can be overlooked as the focus is on the physical condition)
- Homeless hostels and refuges
- Prisons
- NHS Websites and other mums chat forums

3.4.3 A key role for the service will be education for other health and care professionals. Who should be trained? And what should the core content of the training cover?

Overall it was felt that a consistent training package, with consistent tools would be very helpful.

<u>Who?</u>

- Health visitors
- GPs
- Voluntary sector – tapping into 'achieving for children' and safeguarding training
- Community leaders, such as Imams, so that they can reach their local communities
- Dads/Partners

<u>Content</u>

- Recognising early signs and knowing where to signpost people
- Impact on children and their development
- Understanding how services work – allaying anxieties around people having their children taken away.

<u>How?</u>

- Consider a rolling conference that people could be invited to.
- A clinical chat forum led by a clinician

3.4.4. Are there needs of any particular communities that we need to bear in mind? If so, how and what provisions can we make to meet these needs?

<u>Needs of particular communities</u>

- Gypsy Roma Travellers – generally like to see the same person. Trust is very important. Need to go into their communities to provide services
- Korean population in Kingston – can have language barriers and cultural barriers in which some single mums feel ostracised by their families.
- Barracks and army communities can be difficult to reach

- Refugees may not want to access services as they feel they might be reported
- Substance misuse – people who use drugs or alcohol may not use the service as they feel the baby could be removed from their care.
- Women in refuges – new to the community and may not know what services are out there.

Provisions to meet needs

- Work with community leaders, build on relationships and embed services within communities
- Train community leaders to provide support to other members of their communities.
- Co-produce and deliver services by people who have used them
- Go to those community groups who do not usually access services and run an activity that they would find fun.

4 Next steps

The feedback from the focus group, interviews and workshop will inform the development of the bid. All participants were asked if they would like to continue to be involved – the vast majority agreed and will be invited to contribute to the next phase of work. Outputs from this piece of work will also feed into the maternity work stream (under the SWL STP).

We are very grateful for the time and contributions of everyone who took part in this piece of work. We know that our work will better meet the needs of service users because of it.