Maternal Mental Health:

TRT Briefing

Full report

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The ROBERTSON Trust

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Executive Summary

Introduction

This research has been commissioned by The Robertson Trust to highlight what works, what doesn't work, and why in non-clinical maternal mental health interventions that are delivered by the third sector. It focuses specifically on three areas of practice: **parenting support**, **peer support**, and **counselling/psychological support**. This executive summary provides an overview of the key findings. A copy of the full report is available on request.

Methodology

This research was conducted through desk-based analysis of the national and international policy approach to addressing maternal mental health. A systematic literature review was also conducted to assess what the published evidence shows us about what works, for whom, and why across different third sector interventions.

Although the researcher took a robust and systematic approach to reviewing the evidence, the study focused on a very specific time period for mothers and fathers and the search terms focused on maternal and paternal mental health. This means there might be other published evidence which is relevant to the area of maternal mental health but which didn't fit within the parameters of this study.

The researcher also searched for evidence from Scandinavian countries (i.e. Sweden, Denmark and Norway) but struggled to find much information about how these countries approach maternal mental health politically and/or economically. They also found limited evidence about the third sector and any work it does in this area. This might have been due to the resources not being available in English, or due to different terms being used. As a result, this report focuses on a number of English-speaking countries: Scotland, England, Wales, Northern Ireland, Republic of Ireland, New Zealand, Australia, Canada, and the USA.

Background

Mental ill health during the perinatal period has implications for the wellbeing of the mother, father, and infant. As 20% of mothers in Scotland experience mental health problems during pregnancy and within the first postnatal year, maternal mental health is a public health problem which presents significant costs to society, both financially and in terms of the broader impact on the mothers' emotional wellbeing and the development of their infants.

As well as being a current priority for the Scottish Government, The Robertson Trust has also identified maternal mental as an area in which might be able to add value, within its funding theme of 'improving the wellbeing of women and girls.' However, before making any decisions about potential funding programmes, it wanted to know what the published evidence showed us about what worked and where there might be gaps in the evidence.

Definitions

The research found that in different sectors and organisations, the terms 'perinatal mental health' and 'maternal mental health' can have slightly different definitions and are sometimes used interchangeably. In this report:

Perinatal mental health refers to specific mental health conditions (e.g. depression, anxiety or psychosis) which are experienced by the mother or father during pregnancy or in the first year after birth.

Maternal mental health refers to mental health and wellbeing more broadly. Here, it is viewed as being influenced by a range of psychological factors for the mother and father, e.g. resilience, stress, and emotional needs, as well as the presence or absence of wider social support networks.

Non-clinical interventions are ones that take place in a non-clinical setting, e.g. within the mother's home, a community centre etc.) These are sometimes referred to elsewhere as *'community-based support.'*

National and International Context

Maternal mental health is considered to be a significant public health problem internationally but there is still a lot of variation between around how much political and economic commitment different governments give to the issue. In recent years, governments in England, Wales and Australia have made significant investments in funding which has led to an improvement in the accessibility of specialist services. However, the majority of countries considered as part of this research, including Scotland, had a lack of specialist perinatal services which often resulted in a 'postcode lottery' for accessing support.

Across all of the countries, third sector organisations played an important role in supporting mothers through pregnancy and the first postnatal year and improving maternal mental health. However, new and expectant mothers – and often public sector staff – are not always aware of maternal mental health support available within the community due to a lack of effective collaboration between the public and third sector. Where governments had explicitly committed to improving maternal mental health, e.g. Scotland, England, and Australia, there appear to be stronger links developing between public and third sector organisations.

Summary of what works

Parenting support programmes, delivered in group settings by individuals trained in early childhood development, are beneficial for pregnant women and new mothers. Fathers also benefit from being involved in parenting support programmes. These programmes focus on the importance of forming a secure attachment for the infant's later social, emotional, and cognitive development. These interventions have been shown to decrease parental depression and anxiety, as well as increase parenting confidence and self-efficacy. There is also some evidence to suggest parenting support programmes may be an important form of social support as parents learn from one another.

Peer support, delivered by trained volunteer befrienders within the local community, has been shown to reduce depression, anxiety, and social isolation. Peer support may be particularly effective when tailored to the individual as this builds a relationship of trust which provides mothers with a safe space to discuss worries and anxieties. This form of support appears to be effective for a wide range of women – particularly women who face adverse socioeconomic circumstances - during pregnancy and the first postnatal year.

Counselling, delivered by trained counsellors, may be beneficial for pregnant women and mothers with a history of mental ill health and who are particularly at-risk of suicide and self-harm. In addition, couples counselling may help reduce maternal stress through supporting strong relationship functioning. Support can be tailored to the individual and has been found to decrease depression, anxiety, and stigma. However, in comparison to parenting support and peer support, there appears to be limited publicly available evidence on the effectiveness of community-based counselling support.

What doesn't work

There were limited studies showing what doesn't work. However, whilst women with lived experience have been shown to be effective in providing emotional, informational, and practical support to new and expectant mothers, previous research suggests that volunteers might not be effective in delivering training around maternal-infant interaction. This might be because the mothers feel that they are being judged if the support is delivered by a peer rather than a professional.

Quality of the evidence

Many of the investigations included in this research report *improvements* in aspects of maternal mental wellbeing (e.g. depression, anxiety, parenting confidence) and the qualitative research shows that pregnant women and mothers find a range of non-clinical interventions to be positive and helpful.

Despite this, when considered quantitively none of the studies report statistical significance which means we cannot be sure if the improvements were all due to the intervention or other factors. In addition to this, none of the evaluations were longitudinal and so it isn't possible to determine whether the positive effects of interventions last beyond the 12-month post-natal period being studied.

Recommendations and next steps

Three recommendations are made for next steps. These are primarily aimed at The Robertson Trust and the Scottish Government but are of relevance to other funders, policy-makers and practitioners working in this area.

1. Continue to support cross-sector learning and partnerships.
2. Consider a scoping exercise to determine what activities are happening across Scotland at a local, regional and national level.
3. Consider whether there is a need to address the gaps in the evidence.

1 Introduction

This research has been commissioned by The Robertson Trust to highlight what works, what doesn't work, and why in non-clinical maternal mental health interventions delivered by the third sector. This briefing considers the political and economic context surrounding maternal mental health, both at a national and international level, and aims to improve understanding of the gaps in the current evidence base for the effectiveness of third sector support for mothers and their families.

The report will be used internally by The Robertson Trust to support future decision by helping it to consider ways in which it can best support the maternal mental health third sector. In addition, this briefing will be shared externally for use by other organisations, including the Scottish Government.

1.1 Methodology and Research Questions

This research was conducted through desk-based analysis of the national and international policy approach to addressing maternal mental health. A systematic literature review (see Appendix 1) was also conducted in order to assess what evidence published since 2005 shows us about approaches taken by the third sector in supporting maternal mental health. This information was supplemented by conversations with some third sector stakeholders (see Appendix 3) that were identified by The Robertson Trust and Maternal Mental Health Scotland through existing collaborations as well as internal evaluations and reports provided by these organisations.

Limitations of the research approach

Although the researcher has taken a robust and systematic approach to reviewing the evidence, we recognise that there are some limitations to the research which may have impacted on the volume of evidence being analysed. These include:

- **No formal and in-depth scoping of what is currently being delivered nationally and internationally was conducted.** Instead, this research focused on published evidence and also contacted a handful of relevant national charities that were identified by The Robertson Trust and Maternal Mental Health Scotland (see Appendix 3) to see if they had any relevant but unpublished evidence. It is important to note that these charities were identified based on existing links between The Robertson Trust, Maternal Mental Health Scotland, and the charities. As a result, the charities included in Appendix 3 are not a full representation of third sector organisations with an interest in maternal mental health.
- **The search terms focused on maternal and paternal mental health.** However, over the course of the research it has become apparent that a number of organisations working in this area frame their activities and impact in terms of early intervention with a focus on the long-term benefits to the infant. As a result, there may be some published evidence which did not appear through the chosen keyword searches.
- **The research focused on evidence relating to the period from pregnancy to 12 months after birth.** There were additional published reports which were not included in the analysis because the evaluation and findings included mothers who had given birth more than 12 months previously.

Whilst we recognise that these limitations may have impacted the amount of evidence being considered we do not think that it undermines the findings and the subsequent recommendations within this report.

Research questions

During the research process, each of the following research questions was considered in turn:

1. What do we mean by 'maternal mental health'? What do we mean by 'non-clinical intervention'? What terms do other people/organisations use?
2. How are countries – such as Scotland, England, Wales, Northern Ireland, Republic of Ireland, New Zealand, Australia, Canada, and USA – addressing maternal mental health both politically and economically? Who delivers support in these countries (e.g. third or public sector)?
3. What approaches does the evidence base show us work for non-clinical interventions on: a) Parenting support? b) Peer Support? c) Psychological Services?
4. Who benefits from these approaches and when?
5. What are the fidelity elements required for replication?
6. What approaches does the evidence base show us don't work for non-clinical interventions on: a) Parenting support? b) Peer Support? c) Psychological Services?
7. What is the quality of the evidence?

These research questions were formulated on the basis of wanting to gain a better understanding of what the current evidence base is for third sector interventions in maternal mental health, and what this tells us about what works and why, in order to identify gaps in the research and determine whether The Robertson Trust can help in addressing these gaps. The Robertson Trust was also interested in whether there was well-evidenced practice across countries that could provide useful learning to draw into current practice in Scotland. The research focuses the evidence base for nine English speaking countries, including Scotland. At the start of the research, a quick scoping exercise was conducted to identify what evidence we could find from Scandinavian countries (Denmark, Norway and Sweden). However, very little was found which met the parameters of the research. This was true both of the political and economic context and third sector activities and may be due to relevant materials not being published in English or the use of different terminology in these countries. As a result, no further analysis was done for these countries.

The Robertson Trust was also keen to understand the terminology surrounding maternal mental health and wellbeing in order to determine whether its usage differed between the public and third sector, and what the implications of different terminology could be.

1.2 Briefing Structure

This briefing will firstly highlight how The Robertson Trust became interested in the area of maternal mental health within the wider theme of Improving the Wellbeing of Women and Girls. Secondly, definitions of key terms within this briefing - such as 'maternal mental health' and 'non-clinical interventions' – will be provided. The role of the third sector in providing maternal mental health support will then be highlighted within a national (i.e. Scotland) and international political and economic context. In turn, key findings and recommendations will be discussed.

2 Background

The Robertson Trust has an interest in improving the well-being of women, and particularly women who are experiencing tough times. This interest was borne out of the Trust's involvement in the criminal justice sector, and in particular, the 2012 Commission on Women Offenders. As a result of the Trust's work in this area, it is working with local communities in Cumnock and Johnstone to establish two Women's Centres, investigating the impact a community-led development approach might have on women, the wider community and multi-agency delivery working with women. Beyond this programme of work, the Trust wished to expand its work under the broader theme of Improving the Wellbeing of Women and Girls and consequently further research (Improving the Wellbeing of Women and Girls, 2018) was conducted in 2018 to explore whether there is a role for the Trust to develop other programme areas around this theme. This research examined inequalities within three dimensions – political, economic, and social and cultural. Whilst the Trust recognises the complex interplay between each of these, it focused specifically on social and cultural inequality as this area is the best fit for its experience and expertise. Within the dimension of social and cultural inequality the Trust explored a broad spread of issues and, of these, maternal mental health stood out as the strongest area where the Trust felt it could add value.

55,000 women give birth in Scotland each year with 5,500-8,000 of these women experiencing anxiety and/or depression during pregnancy and the first postnatal year (Sanger, Haynes, Rayns, Galloway & Hogg, 2015). The societal cost of perinatal mental health problems is considerable, both financially and – perhaps more importantly – in terms of the child's development. It has been estimated that the average case of perinatal depression costs around £74,000, of which £23,000 relates to the mother and £51,000 relates to impacts on the child (Bauer, Parsonage, Knapp, Iemmi & Adelaja, 2014). Longitudinal research carried out between 2005 and 2010 also found that the perinatal mental health problems had a significant impact on the development of the child by the age of four, particularly with regards to their behaviour, emotional wellbeing, and relationships with their peers (Marryat & Martin, 2010). These negative impacts will likely shape their experiences in pre-school and primary school and the effects could be long-lasting.

For some women, the perinatal period may be the first time they have experienced mental health problems. However, women with pre-existing mental health conditions may experience deterioration or recurrence of symptoms during this time (Stein et al., 2014). Crucially, fathers and partners can also experience poor mental health during the perinatal period due to challenges of forming a fatherhood identity and coping with new financial pressures and lifestyle changes (Baldwin, Malone, Sandall & Debra, 2018). Mothers with prenatally depressed partners also demonstrate significant worsening of perinatal depression symptoms over the first six months postpartum (Paulson, Bazemore, Goodman & Leiferman, 2016). With suicide now the leading cause of maternal death in the first postnatal year (Orsolini et al., 2016), and poor maternal mental health associated with impairments to later infant neurobiological and socioemotional development (Hoffman, Dunn & Njoroge, 2017), maternal mental health poses a significant public health concern for the Scottish Government and the Scottish public.

However, a lack of statutory funding often means that women and their families face a 'postcode lottery' in accessing high quality maternal mental health services through the NHS (Bauer et al., 2014). As a result, there is an opportunity to look at different types of non-clinical support and what works under different circumstances as a potential means of addressing these gaps in maternal mental health service provision.

3 Definitions

Term	Definition
Maternal Mental Health	In this report, mother's mental health is viewed as influenced by psychological factors relating to the mother, psychological factors relating to the partner, and the presence/absence of wider social networks who provide informational and/or emotional support during pregnancy and the first year after birth. As such, this report is adopting a holistic definition of 'maternal mental health' to include mental health and wellbeing.
Perinatal Mental Health	Refers to specific mental health conditions (e.g. depression, anxiety, psychosis) experienced by the mother (or father) during pregnancy and the first year after birth. 'Perinatal mental health' is often used interchangeably with 'maternal mental health'.
Third Sector	In this report, 'third sector' refers to charities, organisations, and smaller community-based support systems which provide non-clinical interventions to mothers, fathers, and their families.
Non-Clinical Interventions	Interventions delivered in non-clinical settings (e.g. the mother's home, community centres, cafés) to support the wellbeing of the mother, infant, and the wider social network.

Maternal Mental Health

The World Health Organization (WHO) defines maternal mental health as "a state of well-being in which a mother realizes her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her community"[1]. 'Maternal mental health' may therefore be viewed as a mother's ability to respond adaptively and demonstrate resilience during a time of significant change[2]. However, 'maternal mental health' may also be used to refer to specific mental illnesses experienced during pregnancy and after birth. 'Maternal mental health' may therefore be defined in a *dimensional* manner which encompasses a mother's: strength, resilience, and tolerance to stress[3]. 'Maternal mental health' is a term used by many organisations and advocacy groups – both nationally and internationally - which aim to promote care and support for new and expectant mothers, such as: Maternal Mental Health Alliance, Maternal Mental Health Scotland, and Maternal Mental Health NOW.

The term 'perinatal mental health' is also used when discussing a mother's mental health. This term is often used when discussing specific mental health conditions (e.g. depression, anxiety, psychosis) experienced by mothers (and fathers) during pregnancy and the first year after

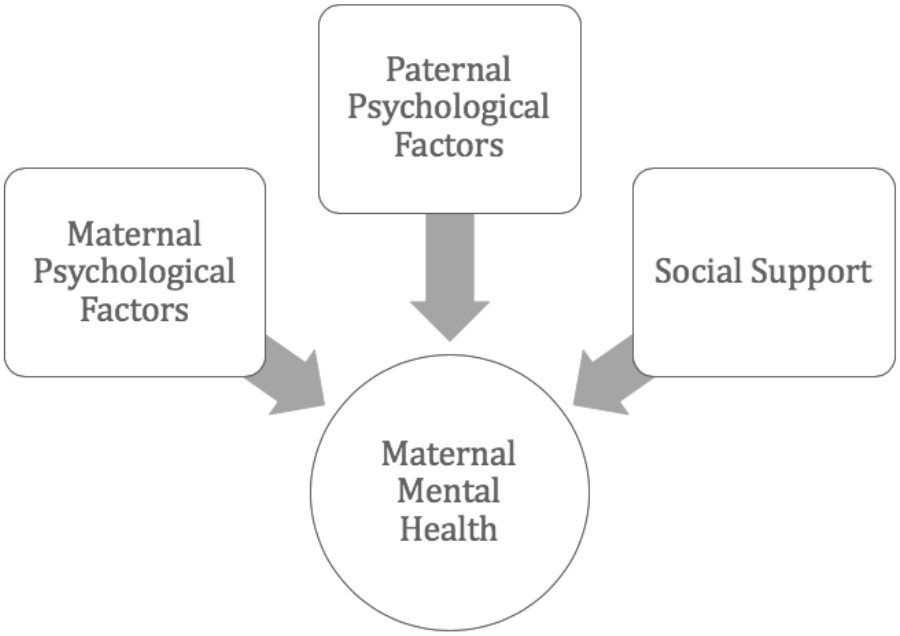
birth[4]. In contrast, 'maternal mental health' does not usually refer to the experience of mental ill health during a specific time period; instead it can continue beyond the first 12 months after birth. Despite this apparent distinction, the two terms are often used interchangeably within the public and third sector, particularly when referring to the experience of mental ill health during pregnancy and the first postnatal year [4].

A potential challenge of using the two terms interchangeably is that 'maternal mental health' is sometimes seen as being synonymous with specific mental health conditions, e.g. depression, anxiety and psychosis. One of the limitations of some definitions of 'maternal mental health' is that they do not explicitly include the wider social networks which may be present in the mother's life. These may be key to providing social support which in turn is linked to improved mental health. Low social support during pregnancy is associated with increased depression and anxiety symptoms at 4 months post birth, which in turn predicts increased risk of anxiety at 1-year post birth[5]. Partners and family members may be an important part of the network of support for new and expectant mothers, encouraging mothers to attend GP appointments, take medication, or simply talk about how they are feeling[6,7].

The term 'maternal mental health' may also be seen as excluding the father or partner's mental health; centring as it does on the mother. Importantly, however, those close to the mother are also at risk of mental health problems themselves. 13.3% of expectant fathers report depressive symptoms during their partner's third trimester with significant predictors including poor sleep quality, lower perceived social support, financial stress, and elevated maternal depressive symptoms[8]. Paternal depression is also associated with impaired parenting and bonding[9]. In addition, mothers with prenatally depressed partners demonstrate significant worsening of perinatal depression symptoms over the first six months postpartum[10]. Emphasis has therefore been placed on the need to address paternal mental health, as well as the relationship between the expectant mother and father, as a protective factor against maternal mental health difficulties[11, 12]. In addition, a number of previous briefings on maternal mental health have called for the development of 'wrap-around' approaches - interventions which support the mother, child, and wider family unit – as a protective and supportive factor against maternal mental health difficulties[12,13].

In this briefing, 'maternal mental health' will therefore be viewed as being influenced by both maternal and paternal psychological factors (e.g. stress, resilience, emotional needs) as well as social support (e.g. presence of emotional and informational support from partner, friends, and family) throughout pregnancy and the first postnatal year (Figure 1). In contrast, 'perinatal mental health' will refer to specific mental health conditions (e.g. depression, anxiety or psychosis) that are experienced by the mother (or father) during pregnancy and for one year after birth,

Figure 1. Definition of Maternal Mental Health



Non-Clinical Interventions

In this briefing, 'non-clinical interventions' is used to refer to interventions which are delivered in non-clinical settings (e.g. within the mothers' home, community centres, or café). These interventions may elsewhere be referred to as 'community-based support'[4].

On 21 November 2018, The Robertson Trust and Maternal Mental Health Scotland co-convened a meeting with some key third sector organisations working within the field of maternal mental health in Scotland. From this meeting, three categories of non-clinical intervention were highlighted as important forms of support which warranted further investigation: **parenting support programmes**, **peer support**, and **psychological services** (e.g. counselling). This meeting also highlighted the importance of **community support**, which is provided by community members rather than specific charities or organisations, in supporting the mental health of new and expectant mothers and their families. However, the nuanced and varied support that is provided at a community level is outwith the broad nature of the current review. Therefore, this briefing will evaluate the effectiveness of the three forms of non-clinical intervention listed above in reference to our definition of maternal mental health (Figure 1).

4 National and International Context

Maternal mental health is widely viewed as both a mental health problem and a significant public health issue across the UK, Ireland, North America, New Zealand and Australia. Given that up to 20% of women are affected by mental health problems during the perinatal period[13], this poses significant risks to subsequent emotional, physical, and cognitive development of the infant[14]. In turn, maternal mental health problems are estimated to carry a significant economic and social cost to society of £8.1 billion per annum in the UK alone, with 72% of these costs related to the child and 28% related to the mother[13]. Yet, despite these significant costs, specialist perinatal mental health services often do not receive adequate political and economic attention[15].

'Specialist perinatal mental health services' refers to both specialist perinatal mental health community-based care teams (e.g. GPs, midwives, health visitors) and inpatient mother and baby units (MBUs) where both mother and baby are cared for together when hospitalisation is necessary. However, 'broken pathways' within maternal mental health care often mean that third sector organisations struggle to cope with high numbers of referrals for non-clinical interventions[13]. Due to the significant role that the third sector play in supporting mothers and their families during pregnancy and the first postnatal year, it is crucial to understand what works, what doesn't work, and why in non-clinical interventions across countries.

4.1 Scotland

4.1.1 Policy Approach

In 2012, the Scottish Intercollegiate Guideline Network (SIGN) made a commitment to implement the SIGN 127 Guideline on managing maternal mental health[16]. This guideline presents an outline of what world-class maternal mental health services would look like in regard to the efficient prediction, management, and provision of maternal mental health support. It asserts that effective detection and treatment is dependent on a number of individuals and organisations working together, including GPs, community mental health services, health visitors, social services, and third sector organisations.[17] In May 2017, the Perinatal Mental Health Managed Clinical Network (MCN) was established in order to bring together a range of health professionals who work in maternal mental health in order to identify gaps and pathways for change in specialist perinatal mental health services.

Due to a lack of appropriate funding and the rurality of parts of Scotland, women and their families often face a 'postcode lottery' in gaining access to support, with 40% of women in Scotland having no access to specialist perinatal mental health services[12]. As of 2017, NHS Greater Glasgow and Clyde is the only health board which provides access to a specialised perinatal community team that meets Perinatal Quality Network Standards Type 1.

Scotland has 2 specialist inpatient MBUs, each with 6 beds: St John's MBU (Livingston) and West of Scotland MBU (Glasgow). From 2016-2018, these MBUs had 115 admissions per year[17]. Access to these MBU is in high-demand, with St John's MBU at full occupancy for 49% of the time between January 2016 and November 2017[17]. In addition, West of Scotland MBU had 44 patients who could not be immediately admitted in 2018[17]. As a result, many women who require support during pregnancy and the first postnatal year may 'fall through the gaps' as specialist perinatal mental health services struggle to cope with demand. The Scottish

Government highlighted the need to address this in, 'Delivering for Today, Investing in Tomorrow: The Government's Programme for Scotland 2018-19.'

In March 2019 the Scottish Government announced a £50 million commitment to improve access to perinatal mental health services over the next five years. In relation to third sector support, a needs assessment by the MCN recommends that NHS boards should ensure that all new and expectant parents are made aware of third sector services available in their area[17]. In addition, the MCN recommends that third sector organisations should be actively included in regional networks in order to provide expertise in the provision of community-based counselling and peer support services[17]. Attention is also drawn to the need for the Scottish Government to work collaboratively with NHS boards and third sector funders in order to review community-based support and develop a clear evidence and evaluation base in order to support the development of a national delivery plan[17].

A number of third sector organisations in Scotland provide peer support, parenting education support, and psychological therapies within community settings (see Appendix 3). However, a meeting co-convened by The Robertson Trust and Maternal Mental Health Scotland in November 2018 revealed that third sector organisations often felt undervalued by the public sector and were facing significant challenges due to lack of sustained funding. As a result, third sector organisations expressed the need for the public sector, third sector, and funding bodies to work collaboratively in supporting mothers and their families.

4.1.2 Practice Approaches

The Robertson Trust's and Maternal Mental Health Scotland's conversations with some key third sector stakeholders (see Appendix 3) demonstrate that there is a wide range of charities and organisations working hard to address gaps in public sector mental health care in order to support new and expectant mothers and their families. Although no formal scoping exercise has been conducted to look at what practice and activities are currently taking place across Scotland, a handful of organisations were identified through this research process as having evidence that met the parameters of the study (see Section 1.1 and Appendix 1). These were:

- **Home-Start**, the national charity providing support to families with children under five who have provided a community-based peer support programme in Glasgow North
- **Aberlour**, Scotland's largest children's charity who have provided a community-based peer support programme in Falkirk
- **Mellow Parenting**, providers of parenting support programmes for mothers and fathers across Scotland

However, we recognise that there are a large number of other organisations and community groups that are providing maternal mental health support which have not been listed above. Some of these are referenced in a supplementary report which provides an analysis of relevant Open Awards grants. A more in-depth scoping exercise of the current third sector provision of maternal mental health care in Scotland has been recommended in section 8.

4.1.3 Evidence on Peer Support

Research commissioned by NHS Greater Glasgow and Clyde Anti-Stigma Partnership "From Bumps to Bundles" examined mental health in the perinatal period and highlighted social support as a key protective factor in supporting new and expectant mothers' mental health. As a result of this report, Home-Start Glasgow North was chosen to host a pilot peer-support project in 2014 for a period of 18 months.

In this intervention, support was provided by highly trained volunteer befrienders who delivered weekly home visits (2-3 hours long) to mothers during pregnancy and up to one year after birth with the aim of building a trusting, lasting relationship[18]. Befrienders supported women with practical (e.g. pre-birth support, help with baby and child routines, advocacy, and support with household management) and emotional (e.g. providing a listening ear, sharing parenting experience, building confidence and independence) needs, with support personalised to each individual[18].

A NHS Greater Glasgow and Clyde process evaluation of this intervention conducted qualitative interviews with mothers, volunteers, and other key stakeholders[18]. In addition, mothers were assessed in their improvement on the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) and Home-Start's own internal monitoring and evaluation system, MESH. The MESH forms are based on four headline categories and 13 identified needs. Women give a score between 0 and 5, where 0 is not coping at all and 5 is coping very well, for each of the four headline categories – A: parenting skills; B: parent wellbeing; C: children's wellbeing; D: family management.

Qualitative interviews highlighted that volunteer befrienders were key in increasing social support networks. As well as providing one to one support, befrienders encouraged mothers to access other groups and services (e.g. mother and baby groups, baby massage classes) through sign-posting which in turn lead to the establishment of friendships, support networks, and reduced feelings of isolation. Mothers reported feelings of empowerment and increased confidence in both themselves and their parenting ability. Mothers also noted that the supportive relationship that was developed with the befriender provided them with a safe space to discuss their feelings and concerns without fear of stigma. In addition, in some cases, children have been taken off the 'At Risk' register[18]. Importantly, two-thirds of the women supported by this intervention were asylum seeking women who had very little in the way of existing social support networks. As a result, peer support may be an effective way of reaching significantly marginalised mothers.

However, quantitative data is not provided for all mothers in this evaluation. In addition, quantitative data is not discussed in terms of statistical significance as questionnaire measures were used as a form of self-monitoring for mothers rather than an outcome measure. As a result, it is not possible to determine whether Home-Start Glasgow North's befriending intervention is associated with statistically significant improvements to wellbeing.

From 2015-2016, Aberlour rolled out a befriending support programme in Falkirk which aimed to improve maternal mental health, improve attachment, reduce social isolation, and improve self-confidence. Personalised support was provided by a trained befriender within the mother's home once a week for up to 3 hours. After the first year of the project, data from 14 participants demonstrated significant improvements in anxiety, depression, mother's relationship with the baby, and self-efficacy. However, as this study is based on a very small sample size these significant findings must be interpreted with caution. Statistically significant improvements were not seen in social support although mothers reported feeling more confident in their ability to go out socially and access other support services as a result of receiving befriending support. As a result, many mothers felt as if they had rediscovered their own sense of identity which not only benefited them personally but also improved their child's social development and strengthened overall family functioning[19].

Importantly, both Home-Start Glasgow North and Aberlour place emphasis on the importance of tailoring befriending support to the individual, matching mothers to appropriate volunteers (e.g. similar age and culture), and working collaboratively with primary and secondary maternal mental health care services in order to support referral into their befriending programmes.

4.1.4 Evidence on Parenting Support

Mellow Parenting is a Scotland-based charity which aims to research, develop, and implement evidence-based parenting programmes. Expectant and new mothers – as well as their partners and support networks – can gain access to these programmes via midwife, health visitor, social worker, or GP referral. Mellow Parenting provides a range of programmes, including: Mellow Bumps, Mellow Dads-to-be, and Mellow Dads.

Mellow Bumps (MB) is a group-based parenting programme, delivered by professionals trained in early childhood development, which supports pregnant women with additional health and social care needs. The intervention provides this support via encouraging the development of nurturing, engaging, and closely bonded relationships between mother and baby – as well as decreasing maternal stress and improving the mother's knowledge of her infant's ability to engage in social interaction. Therefore, MB aims to promote positive relationships within the family unit as a whole. MB is offered at between week 20-30 of pregnancy through delivery of six weekly sessions and a reunion session three months post-birth. Each 2hr session focuses on one subject related to maternal wellbeing (e.g. healthy eating, having fun, exploring barriers to good parenting) and one subject related to infant wellbeing (e.g. infant brain development and significance of early interactions for later psychosocial development). Within this intervention there is an emphasis on practical activities, viewing videos, and group discussion as well as guided relaxation sessions at the end of each week.

A peer-reviewed investigation of MB in comparison to care as usual demonstrates that, after six weeks of intervention, small improvements are seen in Adult Wellbeing Scale and Edinburgh Postnatal Depression Scale scores in both the MB and control group. However, no significant differences were found between groups[20]. Yet, post-intervention qualitative interviews highlight that MB was well-received by those who attended. Participants expressed that they felt very comfortable and relaxed and that MB provided a non-judgemental environment[20]. Other participants expressed that they felt more capable of bonding with their child and coping with stress after the intervention. Importantly, 48% of women who took part in Mellow Parenting programmes had a previous mental health diagnosis with 23% also facing child protection concerns. As a result, there is evidence to suggest that MB is effective in supporting mothers who are particularly at-risk. Yet, some participants did express frustration that the six-week intervention period was not long enough.

Mellow Dads-to-be aims to decrease isolation and stress experienced by dads and to help them understand and support their pregnant partner. This programme also helps dads understand their baby's ability to interact socially from birth and the importance of this interaction to social, emotional and cognitive development. A case study of Mellow Parenting interventions tailored towards fathers and partners highlights that the programmes are well received. Participants described feeling relaxed and happy, and also described forming bonds and friendships with other fathers which became an important source of social support[21]. Fathers also spoke openly about their ability to cope under pressure which they viewed as a sign of personal growth[21].

4.1.5 Evidence on Counselling/Psychological Support

One example of the community-based counselling services provided within Scotland is CrossReach. Through their Bluebell Perinatal Service, this charity provides individualised, tailored counselling support to mothers, infants, and partners through approaches such as: psychotherapy, relationship counselling, yoga groups, and baby massage.

This research did not return any publicly accessible evidence for community-based psychological support in Scotland. However, we are mindful that this may be a result of the search terms utilised in this research, which may have limited our access to this evidence, and is not a reflection of the quality of psychological support currently provided in Scotland by various charities and organisations.

4.2 England

4.2.1 Policy Approach

In 2014, it was estimated that only 3% of mothers in England had access to high quality perinatal mental health care[12]. By 2017, 50% of health boards continued to provide limited or no access to specialist perinatal mental health services[22]. However, as of 2019, new and expectant mothers in England have access to 20 mother and baby units, with four new units beginning operation since 2017[23].

Furthermore, as part of the Five Year Forward View for Mental Health, NHS England has announced £365 million in funding to build capacity and capability in specialist perinatal mental health services as a means of improving access to and experience of care, early diagnosis, and intervention. In addition, NHS England recently announced that expectant fathers and partners of pregnant women will be offered mental health screening. Importantly, NHS England also highlight the need to work closely with the third sector in order to provide care and support which is effective for the family as a whole.

4.2.2 Practice Approaches

Despite improvements in England's specialist perinatal mental health care, the English third sector still plays a key role in supporting mothers and their families within the community. Although no formal scoping exercise has been conducted to look at what practice and activities are currently taking place across England, a handful of organisations were identified through this research process as having evidence that met the parameters of the study (see Section 1.1 and Appendix 1). These were:

- **Family Action**, a befriending support service which aims to support mothers during pregnancy and the first post-natal year
- **Best Beginnings**, a charity which aims to address socioeconomic inequalities in the UK by supporting parents to give their child a strong start in life
- Parenting support programmes that are delivered within the community such as **Baby Triple P** which aim to improve communication, attachment, and parent self-efficacy
- **MumsAid**, a non-profit organisation which provides psychological support and counselling to new and expectant mothers

4.2.3 Evidence on Peer Support

Family Action's befriending support service has been shown to be effective in improving maternal mental health. This service provides personalised support through home visits by trained volunteer befrienders, parenting groups to increase understanding and knowledge of infant needs, and help in forming social support networks. An independent evaluation across four sites (Hackney, Mansfield, Oxford, and Swaffam) highlighted significant improvements in anxiety, depression, mother's warmth towards the infant, and social support[24]. Qualitative data from this investigation demonstrates that having the opportunity to socialise with other parents and babies was key in improving mothers' mental wellbeing. In addition, mothers reported that befrienders provided them with a safe, non-judgemental space to discuss their mental wellbeing which often eased anxieties. Importantly, women who took part in this intervention demonstrated high levels of unmet needs. Many women were single parents or had no waged adults in their household to provide financial support. Some participants also had children currently on the Child Protection Register. As a result, peer support programmes may be particularly effective in supporting mothers who face adverse socioeconomic difficulties.

A qualitative investigation of ten non-profit organisations in England which provide maternal mental health support during the perinatal period highlights that peer support can have a number of positive impacts on emotional wellbeing[25]. Mothers reported feeling empowered and valued through gaining access to peer support. In addition, mothers noted that peer support helped to reduce anxiety and depression through overcoming feelings of isolation and increasing self-efficacy and parenting competence.

4.2.4 Evidence on Parenting Support

Best Beginnings – an organisation which aims to help break cycles of inequality – has developed a parenting support app, Baby Buddy, which provides access to easy to understand information regarding the transition from the early stages of pregnancy to parenthood. Importantly, this app is endorsed by NHS England and is used as a tool to support communication between families and practitioners. Preliminary evaluations highlight that 87% of 2,507 users report that the app helps them look after their mental health, whilst 90% of 3,092 users report that the app makes them feel closer to their baby. In addition, 98% of 2,881 users report that the app has improved their confidence in caring for their baby. Interestingly, families at risk of poorer outcomes and young women were over-represented amongst Baby Buddy users. As a result, this suggests that Baby Buddy may be an effective way of reaching those at greatest risk of poor mental health and difficulties in parent-infant bonding.

Parenting support programmes have shown effectiveness in English mothers experiencing poor maternal mental health. A 2015 investigation evaluated the efficacy of the Baby Triple P programme – a seven session programme which aims to improve communication, attachment, and parental coping – in women with clinical levels of depression and demonstrated significant improvements in depressive symptoms, happiness scores, and parenting confidence[26]. The intervention was also found to be highly acceptable to participants, with many mothers expressing that they enjoyed the intervention and found the support helpful. However, no statistical differences were found between this treatment and treatment as usual[26].

4.2.5 Evidence on Counselling/Psychological Support

Non-profit organisation MumsAid provides support to new and expectant mothers through 12 sessions of counselling. The organisation aims to tailor support to the needs of the mother and infant, incorporating Cognitive Behavioural Therapy techniques as well as parent-infant psychotherapy. MumsAid services can be accessed in various Children's Centres in Greenwich and Lambeth. A Public Health England case study (2016) found that scores on the Edinburgh Postnatal Depression Scale improved for all mothers who had completed 12 sessions of counselling with mean scores decreasing from 18.02 to 9.05, with 85% of mothers now falling below the threshold for clinical diagnosis of depression. In addition, 61.5% of mothers reported that they no longer had difficulties bonding with their infant or had experienced considerable improvement in this area. Mothers also indicated increased confidence in their parenting ability.

4.3 Wales

4.3.1 Policy approach

In 2017, only Cardiff & Vale health board provided specialist perinatal mental health care in line with Perinatal Quality Network Standards Type 1, however, six out of seven health boards provided access to perinatal mental health services in some form. This improvement is a reflection of a per annum investment of £1.5 million by the Welsh Government into specialist perinatal mental health services[27]. However, Wales' only mother and baby unit closed in 2013. This means that mothers who require hospitalisation are unable to be treated with their baby and are instead admitted to adult psychiatric wards. Alternatively, mothers must travel as far as Derby, London, and Nottingham to access mother and baby units[27].

In addition, there is still considerable variation in the quality of specialist perinatal care which is provided across health boards. A NSPCC report highlights key differences in the referral criteria used and who can refer into specialist perinatal mental health services, as well as significant variations in the length of time that women were supported as well as the type of interventions made available[13].

A 2017 inquiry by the Children, Young People, and Education Committee highlights the key role that the Welsh third sector plays in providing support to mothers and their families. 43% of women who sought help for maternal mental health outside of specialist perinatal mental health services received help from charities or voluntary organisations[13]. These third sector organisations may be particularly important for women who express mild-to-moderate symptoms of perinatal anxiety, depression, and psychosis who often "fall through the gaps" in specialist perinatal mental health services[13].

However, the third sector in Wales faces considerable funding issues which means that projects often cannot start or are required to come to an end early than expected. The third sector also highlighted struggles in working collaboratively with the public sector as the public sector was often not aware of what support is available to mothers and their families via the third sector[13]. Many charities are also unable to access public funding despite high demand for their services[13].

4.3.2 Practice Approaches

A scoping exercise conducted by the NSPCC[13] highlights six third sector organisations in Wales who provide maternal mental health support in the areas of peer support, parenting support, and counselling (e.g. **Birth story listeners**, **Family Action**, **Mind Cymru. Pre and Post Natal Depression Advice and Support (PANDAS)**, **Serenity**, and Swansea Trauma Support). Yet, the

NSCPCC report did not discuss the effectiveness of the interventions delivered by these charities and organisations. As a result, this review attempted to gather this evidence. However, our search terms returned no publicly available research, either internal or external, for these organisations. Therefore, more general searches were conducted for third sector maternal mental health support in Wales in relation to our three non-clinical interventions of interest.

4.3.3 Evidence on Peer Support

Although a range of Welsh third sector organisations provide peer support to new and expectant mothers and their families, our search terms did not return any publicly accessible internal or external evidence on these interventions.

4.3.4 Evidence on Parenting Support

Parenting support interventions delivered within the community – such as Government funded programme Incredible Years Parent and Baby (IYPB) – have previously been shown to improve maternal mental health outcomes in Welsh mothers. IYPB aims to encourage physical, social, emotional, and language development in infants through promoting parent-infant attachment. An investigation of the efficacy of this intervention in 12 groups in Powys demonstrated significant improvements in parenting confidence, depression, and anxiety in at-risk mothers[28]. However, in a more recent study utilising a control group, significant differences were found only on sensitivity scores – with control mothers less sensitive than IYPB mothers[29].

4.3.5 Evidence on Counselling/Psychological Support

Although a range of Welsh third sector organisations provide counselling and psychological support to new and expectant mothers and their families, our search terms did not return any publicly accessible internal or external evidence on these interventions.

4.4 Northern Ireland

4.4.1 Policy Approach

Despite committing to implementing NICE guidelines on Antenatal and Postnatal Mental Health, as well as developing an Integrated Perinatal Mental Health Care Pathway, Belfast was the only health board which provided access to some form of perinatal mental health service as of 2017. In addition, Northern Ireland does not have a mother and baby unit.

A NSPCC report highlights that concerns have been expressed by midwives and health visitors that underfunding, overworking, and growing demand for support means that the continuity of face-to-face contact with mothers and babies is strained despite a reported £390 million being pledged[30]. Education and support programmes by voluntary and community organisations are also limited with mothers often not made aware of the third sector services which are available to them[30,31].

The Public Health Agency made a positive step in March 2019 by publishing a comprehensive guide, The Pregnancy Book, which will be provided to all expectant and new mothers in Northern Ireland to support them through pregnancy, labour, and the first months of raising their baby. However, the Northern Irish Government is still facing criticisms of "political

stagnation" as the Government has yet to act on the recommendations outlined in the NSPCC report on maternal mental health in Northern Ireland.

4.4.2 Practice Approaches

The current lack of specialist perinatal mental health support in Northern Ireland is also somewhat reflected in the lack of accessible evidence in the Irish third sector. Our search terms did not return any publicly accessible internal or external evidence on the effectiveness of parenting support programmes, peer support, or psychological support in Northern Ireland. However, we are mindful that this may be a result of the search terms utilised in this research, which may have limited our access to this evidence and is not a reflection of the quality of the third sector support currently provided in Northern Ireland.

4.5 Republic of Ireland

4.5.1 Policy Approach

In 2017, the Republic of Ireland's Mental Health Division published A Model of Care for Ireland in relation to specialist perinatal mental health services. This model draws attention to the current lack of integrated maternal and psychiatric health services for new and expectant mothers in Ireland which means that women are not routinely screened for depression, anxiety, and other mental illnesses during their pregnancy. In addition, Ireland does not currently benefit from a mother and baby unit. As a result, the Model of Care for Ireland provides a number of recommendations to support the development of specialist perinatal hubs which work collaboratively with psychiatric services, with trained mental health midwives to raise awareness of mental health problems and increase early identification of mothers' mental health needs.

4.5.2 Practice Approaches

Within community settings, there are a considerable number of programmes which aim to provide prevention and early intervention to support the wellbeing of infants. A 2016 report draws attention to a number of initiatives such as Preparing for Life and Growing Child Parenting Programme which aim to educate parents on the social, emotional, and physical needs of infants in order to help young children reach school readiness. Findings from this report highlight that these programmes are effective in improving infant social and emotional wellbeing by 12 months. However, the mental wellbeing of mothers is not assessed as an outcome measure. As a result, no comment can be on the effectiveness of community-based, non-clinical interventions which support the wellbeing of the mother, infant, and wider family in the Republic of Ireland.

However, due to the Republic of Ireland's focus on infant development, it is possible that third sector mental health support for pregnant women and new mothers is delivered under a different term from 'perinatal' or 'maternal' mental health. As a result, the search terms used in the current research may have limited our access to this evidence and is not a reflection of the quality of the third sector support provided to mothers and their families in the Republic of Ireland.

4.6 United States of America

4.6.1 Policy Approach

Maternal mental health is considered a public health problem at both a federal and state level in the United States of America. Yet, new and expectant mothers in the USA often face difficulties in receiving mental health care and support due to a lack of specialist integrated care for women and children[32]. A 2013 pilot study by Maternal Mental Health NOW – an organisation which seeks to remove barriers to the prevention, screening, and treatment of perinatal mental health in Los Angeles – integrated maternal mental health care into a primary care family clinic. 33% of pregnant and postpartum women who were screened as part of the project were highlighted as being high risk and in need of follow-up care. As a result of this work, a Perinatal Mental Health Implementation Guide has been formulated.

In September 2018, the federal government's Health and Human Services Agency (HRSA) announced $4.5 million in grants would be issued in order to address maternal mental health over five years (2018-2023) in seven states, including: Florida, Kansas, Louisiana, Montana, North Carolina, Rhode Island, and Vermont. This funding aims to provide psychiatric consultation, care coordination, and in-depth training to ensure specialists are capable of screening, assessing, referring, and appropriately treating pregnant and postpartum women. Advocacy groups such as 2020 Mom aim to work collaboratively with these funded states in order to share best practice with states which remain underserved and underfunded.

4.6.2 Practice Approaches

As a result of the gaps in public sector maternal mental health support, the third sector plays a key role in supporting mothers, infants, and the wider family across the USA, including:

- **Postpartum Support International**, is a non-profit organization which aims to promote awareness, education, prevention, and treatment of maternal mental health across the USA – mainly through peer support groups. Chapters of this organisation are present in twelve states, including: Alabama, Arizona, Colorado, Connecticut, Delaware, Florida, Indiana, North Carolina, South Dakota, Tennessee, Vermont, and Wisconsin.
- Community-based parenting support programmes like **Mom Power**
- Community-based **couples relationship counselling**

4.6.3 Evidence on Peer Support

Community-based peer support programmes have shown to be effective for American mothers[33]. An independent evaluation examined the efficacy of a grassroots, weekly peer support group based in a local obstetrician/gynaecologist office where women were free to discuss whatever issues were currently relevant to them[33]. Attendants expressed high satisfaction with the programme as well as increased feelings of social support, acceptance, and reduced stigma. In addition, depressive symptoms were also found to decrease. However, some attendants did note that large-group sizes and secondary trauma were drawbacks of this intervention.

4.6.4 Evidence on Parenting Support

Mom Power (MP) – a ten-week psycho-educational parenting and self-care skills group intervention – has previously been shown to be effective in supporting the mental wellbeing of teenage American mothers. MP focuses on five key therapeutic "pillars": social support,

parenting education, self-care practice, guided parent-child interactions, and connection with care. The intervention is largely based on attachment theory and aims to personalise support to each mother-child pair. The intervention has been shown to reduce self-reported symptoms of depression and post-traumatic stress disorder[34]. In addition, MP was found to increase parenting competence, social support, and social connection[34]. Importantly, the majority of mothers who took part in this intervention were single and facing socioeconomic hardship[34]. As a result, this programme may be particularly effective in supporting those who are most vulnerable to poor mental health.

4.6.5 Evidence on Counselling/Psychological Support

There is also evidence to suggest that community-based relationship counselling can help improve the mental wellbeing of expectant American mothers. In an evaluation of a relationship education intervention – a psychoeducational intervention which aims to improve communication and support between partners – low income, ethnic minority pregnant women demonstrated increased relationship satisfaction, reduced parental distress, improvement social support, and improved family-based support after 12 hours of counselling[35]. Importantly, these effects varied depending on whether the mother already had children. Relationship education was shown to be effective in improving relationship distress and satisfaction in expectant mothers without children, and improved parental distress and social support in expectant mothers with children[35].

4.7 Canada

4.7.1 Policy Approach

In 2018, the Canadian Government was criticised by maternal mental health experts for avoiding discussions of the current state of maternal mental health services in the country. During an eight-year period (2008-15) the Canadian Institute of Health Research (CIHR) invested approximately $44.7 million a year in mental-health-related research, compared with $133.8 million a year for cancer-related research. Although approximately 15-20% of women experience a maternal mental health condition in Canada, broken referral pathways, distant service locations, and a lack of specialised services are significant barriers to accessing services[36]. In addition, a lack of integrated psychiatric and maternal health services means that mothers and babies are often separated if the mother requires psychiatric admission. Canadian Perinatal Mental Health Collaborative (CPMHC) – a group of parents and maternal mental health experts – are currently campaigning for the federal government to develop a national strategy for maternal mental health.

4.7.2 Practice Approaches

A lack of integrated specialist maternal mental health services in Canada also means that mothers and their families are largely unaware of third sector sources of support[36]. Although our search terms did not provide evidence for specific third sector charities and organisations in Canada, there is peer-reviewed evidence to suggest the success of peer support and parenting education in Canada more generally.

4.7.3 Evidence on Peer Support

Telephone-based peer support from women with lived experience has previously been found to be effective in Canadian mothers[37]. Modest reductions in anxiety were found, however this was

non-significant. Yet, 80% of women who received telephone peer support were satisfied with intervention and would recommend this form of support to a friend. Previous research with Canadian mothers experiencing perinatal mental health needs highlights that many women would prefer one-to-one support from women with lived experience and also through face-to-face peer support groups[38]. Furthermore, Canadian mothers report using social media as a way to foster in-person social connections as finding mother-infant support groups in their area was often a difficult task[39].

4.7.4 Evidence on Parenting Support

Community-based parenting education programmes have previously shown success in Ontario. An evaluation of a 12-week intervention structured around mindfulness principles, psychotherapy, and infant-led play in mothers with clinically low levels of parenting confidence was associated with significant improvements in maternal depression and parenting stress[40]. Improvements were also found in mothers' abilities to manage their emotions as well as mother-infant interaction but these improvements were non-significant. Mothers expressed high satisfaction with this intervention, but commented that travel was a significant barrier to access with mothers stating they would prefer that the intervention was available through public health. Therefore, there is great potential for the public and third sector to collaborate in order to support holistic, integrated maternal mental health care in Canada.

4.7.5 Evidence on Counselling/Psychological Support

Our search terms did not return any publicly accessible evidence for the effectiveness of community-based counselling for Canadian mothers and their families. However, this should be understood as a limitation of the search terms used and should not be seen as a limitation of the community-based psychological support currently provided in Canada to pregnant women, new mothers, and their families.

4.8 New Zealand

4.8.1 Policy Approach

In 2012, the Ministry of Health published a Healthy Beginnings briefing which called for the development of a perinatal and infant mental health forum to encourage stakeholders within primary care, mental health, and child health to work together to support new and expectant mothers in New Zealand. However, as recent as 2017, the New Zealand Government continued to face criticism for failing to allocate sufficient funding to support maternal mental health services – with two-thirds of women experiencing delays in diagnosis and treatment as well as a lack of treatment options beyond prescription medication. In one health board alone, only 132 new mothers – out of 2198 live births - were treated for maternity related depression through the board's limited budget of $947,500 despite $97 million being reprioritised for wider health services in New Zealand.

Qualitative work with young mothers in New Zealand highlights that women do not feel well-informed about services that are available to them outside of their midwife and GP[41] which may be reflective of the restricted funding that maternal mental health services receive in New Zealand. This is problematic, as many young mothers report feeling unable to confide in these specialists about their mental wellbeing and instead would prefer to access services that are welcoming, non-clinical and present an opportunity to meet other people going through a

similar situation[41] . Therefore, there is strong potential for community-based third sector efforts to provide support to new and expectant mothers in New Zealand.

Importantly, organisations such as Mothers Helpers are actively working to bridge the gap between the public and third sector by forming GP and Midwife Partnership Programmes to increase referrals to community-based support.

4.8.2 Practice Approaches

A number of third sector organisations are attempting to address these gaps in public service provision in New Zealand by providing counselling, peer support, and practical help with referral procedures, such as:

- **Plunket**, who provide community based parenting education classes and peer support

4.8.3 Evidence on Parenting and Peer Support

Qualitative research of parenting education programmes provided by Plunket services demonstrates that mothers find mother-baby playgroups – where they can interact with other mothers and encourage their baby to develop socially and emotionally through interactive play and song – a helpful way of reducing isolation, sharing parenting knowledge, and gaining an understanding of the social abilities of their infant[42]. In addition, parenting programmes targeted towards fathers with personal experience of difficult childhoods also showed effectiveness[42]. These programmes aimed to help fathers identify negative patterns of parenting they had learned from their own upbringing, and worked actively with them to establish healthy new patterns that they could apply in raising their own children. Fathers noted that it was comforting to know that other fathers faced the same struggles as themselves when raising a newborn which created a safe environment to discuss anxieties and worries[42]. As a result, parenting education groups can also be a valuable means of peer support.

4.8.4 Evidence on Counselling/Psychological Support

Our search terms did not return any publicly accessible evidence for the effectiveness of community-based counselling for mothers and their families in New Zealand. However, this should be understood as a limitation of the search terms used and should not be seen as a limitation of the community-based psychological support currently provided in New Zealand to pregnant women, new mothers, and their families.

4.9 Australia

In 2008, Beyond Blue National Action Plan for Perinatal Mental Health recommended universal psychosocial assessment of all women during the perinatal period in Australia. In turn, this resulted in the Australian Commonwealth Government Department of Health's National Perinatal Depression Initiative (NPDI) which ran from 2008-2013. This involved developing clinical practice guidelines which recommended routine antenatal and postnatal screening for depression, access to allied psychological services, training of primary health care professionals and increased awareness and education within the community. In total, $85 million AUD were invested during 2008-2013 to support the initiative[43]. Increased funding to detect mental health problems early has been found to be significantly effective in reducing admissions of mothers to inpatient care during the first postnatal year[43]. As a result, Australia has become a world leader in specialist perinatal mental health care.

4.9.1 Practice Approaches

Despite significant improvements in specialist perinatal mental health care in Australia, the third sector still plays a fundamental role in providing support to mothers and their families during pregnancy and the first postnatal year including organisations such as:

- **Perinatal Anxiety & Depression Australia (PANDA),** Australia's only national helpline to support mothers and their families with maternal mental health problems. Support is provided by trained counsellors who can help individuals over the phone and also connect individuals with other services. Peer support is also offered by volunteers.

4.9.2 Evidence on Peer Support and Counselling

An evaluation of characteristics of Australian PANDA callers highlighted that the majority of callers – based on 365 calls – are pregnant women or mothers with a child under 1 year of age who are mainly seeking support for depression and anxiety[43]. Almost a third of callers were identified as 'at-risk', with some mothers experiencing thoughts of suicide and self-harm. Social isolation, stresses of pregnancy/birthing/parenting, and a history of mental ill health were all contributing factors which lead individuals to make contact with PANDA[44]. Importantly, a separate evaluation highlights that PANDA callers view the service as an accessible and supportive safe space where they can discuss private and complex emotions without fear of judgement[45]. Callers also noted that being able to speak to volunteers who also have lived experience of maternal mental health problems made them feel heard and understood, whilst also helping them to gain a new perspective and reframe their difficult emotional experiences[45].

Face to face support groups have also been shown to be beneficial for Australian mothers as maternal engagement in community-based peer support groups has previously been associated with significantly increased social capital, social support, and mental wellbeing in comparison to mothers who did not engage in support groups[46].

4.9.3 Evidence on Parenting Support

Parenting education programmes which focus on both the mother and father – through discussing communication, conflict management, parenting, infant care, mutual partner support, and intimacy – have been shown to improve communication, parenting stress, and relationship satisfaction in Australian couples at risk of difficulties in adjusting to parenthood[47].

5 Summary of what works

5.1 What works and for whom?

It is important to note that no previously discussed investigations have explicitly highlighted which aspects of the intervention are most crucial for improvements in mental wellbeing. This means that it is not possible to determine which components of specific interventions are most important in future replications. However - in line with previous research of the mediators of maternal mental health[5,47] - interventions which foster mother-infant attachment[20,25,27,28,33], improve parenting confidence[18,19,33] and increase social support[18,19,20,21,23,24,32,34, 36, 41, 43,44,45] are associated with improvements in maternal mental health. Therefore, aspects of interventions which aim to address these elements (e.g. mother-infant play, supporting mothers to attend mother-baby groups, and providing a listening ear) may be key to improvement. In addition, there is some evidence to suggest that fostering strong collaborations between the public sector and third sector is beneficial as this collaboration increases mothers' options for support[18,19]. Third sector non-clinical interventions appear to support a wide variety of pregnant women and mothers from diverse socioeconomic backgrounds. Yet, strong generalisations of the effectiveness of these treatments cannot be made due to small sample sizes.

Whilst there is considerable supporting evidence for parenting support programmes and peer support, both nationally within Scotland and internationally, the picture is less clear for community-based counselling support.

Peer Support										
		Scotland	**England**	**Wales**	**N. Ireland**	**Republic of Ireland**	**USA**	**Canada**	**New Zealand**	**Australia**
	Evidence	**X**	**X**				**X**	**X**	**X**	**X**
	What works?	• Delivered by professionals or trained volunteer befrienders • Delivered in mother's home, in the community (e.g. community centres or local doctor's office), or over the phone • Practical support (e.g. help with household chores and caring for other children to allow the mother to focus on the baby) • Emotional support (e.g. sharing parenting experience, helping to build confidence) • Personalised support tailored to the individual • Establishing a relationship of trust • Working collaboratively with public sector boards								
	How does it help?	• Reduces anxiety • Reduces depression • Reduces social isolation • Reduces stigma • Increases confidence • Increases parenting confidence and self-efficacy • Increases social support								
	Who has it helped?	• Young, socially disadvantaged single mothers • Older, educated mothers in relationships • Refugee and asylum-seeking mothers • Mothers at-risk of struggling to adapt to parenthood • Pregnant women and new mothers								

Parenting support										
		Scotland	**England**	**Wales**	**N. Ireland**	**Republic of Ireland**	**USA**	**Canada**	**New Zealand**	**Australia**
	Evidence	**X**	**X**	**X**			**X**	**X**	**X**	**X**
	What works?	• Delivered by professionals trained in early childhood development • Delivered in group settings • Educating mothers and/or fathers/partners on how to develop nurturing, engaging, and closely bonded attachments with their baby • Educating mothers and/or fathers/partners on their baby's ability to engage socially • Educating mothers and/or fathers/partners on the importance of healthy interactions and bonds to their baby's social, emotional, and cognitive development • Working with both the mother and father to strengthen their relationship to support effective co-parenting								
	How does it help?	• Reduces depression • Reduces anxiety • Increases parenting confidence • Increases social support • Increased relationship satisfaction • Improves communication								
	Who has it helped?	• Mothers with previous mental health diagnosis • Mothers facing child protection concerns • Pregnant women and new mothers • Fathers with personal experience of difficult upbringings								

Counselling/psychological support										
		Scotland	**England**	**Wales**	**N. Ireland**	**Republic of Ireland**	**USA**	**Canada**	**New Zealand**	**Australia**
	Evidence		**X**				**X**			**X**
	What works?	• Delivered by trained counsellors in person or over the phone • Tailored support to meet the individual's needs (e.g. combination of Cognitive Behavioural Therapy techniques, Parent-Infant psychotherapy) • Active listening • Working with the mother and father to improve support within the relationship to reduce maternal stress								
	How does it help?	• Reduces depression • Reduces stigma • Reduces social isolation • Improves bonding • Improves communication within relationships • Improves relationship satisfaction • Increases confidence in parenting ability								
	Who has it helped?	• Pregnant women and mothers at risk of suicide and self-harm • Pregnant women and mothers meeting clinical diagnostic criteria for depression								

5.2 What doesn't work?

Due to publication bias – a tendency for journals to selectively publish research which provides significant results – there is little evidence which highlights interventions that are less effective in supporting the mental health of new and expectant mothers.

However, whilst women with lived experience have been shown to be effective in providing emotional, informational, and practical support to expectant and new mothers[18,19,24,37,44,45,] previous research suggests that volunteers may not be effective in delivering maternal-infant interaction training. An examination of the effectiveness of 12 weeks of peer support combined with maternal-infant interaction training - delivered by peer volunteers who had received 8 hours of training in providing informational, emotional, affirmational, and practical support, as well as teaching mothers about optimal mother-infant interaction – demonstrated that intervention mothers did not improve in maternal-infant interactions and continued to demonstrate clinical levels of depression[49]. Information from activity logs and field notes demonstrates that some mothers reported feeling uncomfortable when receiving mother-infant interaction training from peers. It is a possibility that mothers may feel that they are being judged on their parenting ability when this support is delivered by peers – rather than professionals – which may heighten mothers' feelings of guilt and distress[49].

6 Quality of the evidence

The quality of existing evidence can be understood both quantitatively, in relation to the methodological rigour of investigations, and qualitatively, in relation to the lived experience of participants.

Whilst the majority of investigations report *improvements* in maternal mental health on measures such as the Edinburgh Postnatal Depression Scale, these improvements were not statistically significant in a number of investigations[20,26,37]. Caution must also be exerted when interpreting statistically significant findings[19, 28, 34,35] as many investigations were based on small sample sizes. As a result, it is unclear whether these investigations present true positive effects of the interventions they examine or whether these findings reflect random variation in the data[50]. In addition, some evaluations do not discuss statistical significance of improvement as questionnaire measures were used as a form of self-monitoring for mothers rather than an outcome measure[18].

Furthermore, many investigations do not compare the intervention of interest to a control group[34, 40] meaning it is not possible to determine whether the intervention provided is more effective in addressing maternal mental health than receiving another form of support, or no support at all. Importantly, no investigation has examined the potential drivers of improvement in successful interventions, the components of the intervention which are key to promoting mental wellbeing, which means it is not possible to explicitly determine the fidelity elements required for replication. Yet, given the personalised approach to support adopted by many interventions[18,19,34] , attempting to determine drivers of change may be extremely challenging.

All evidence discussed in this report is cross-sectional meaning that improvements in mental wellbeing were not assessed over an extended period of time. As a result, it is not possible to determine whether support provided during the perinatal period is associated with long-lasting benefits to maternal mental wellbeing. There is also a paucity of research which considers the influence of third-sector interventions on the mother, father/partner, wider family, and the infant. Therefore, it is not possible to determine whether these interventions benefit solely those who receive them, or whether these interventions are associated with a positive 'ripple effect' throughout the full social network. Furthermore, this research area tends to largely focus on white, educated, middle-class women. Whilst some investigations have examined the effectiveness of parenting support in young socially disadvantaged mothers and ethnic minority women[34], peer support in asylum-seeking women[18], and counselling in ethnic-minority couple[35] – small sample sizes in these investigations make it difficult to generalise the success of these interventions to all mothers facing socioeconomic difficulties and mothers from various ethnic backgrounds.

Yet, despite these limitations, many investigations which did not find significant improvements in maternal mental wellbeing received positive feedback from the women who received support. For example, whilst improvements in maternal mental wellbeing were not significant, women who received support through Mellow Parenting reported positive improvements in confidence, coping, and social support[20]. Similarly, whilst significant improvements were not found in depression and anxiety in women who received telephone peer support – 80% of participants stated that they found this support helpful and would recommend the service to a friend[37]. This is echoed by qualitative investigations which report mothers lived experience of the benefits of social support to not only the mother but also to the partner, infant, and wider family[18,19,21,24, 33,42].

As a result, when determining the quality of evidence to support the implementation of a maternal mental health interventions, it is insufficient to focus solely on statistical significance and methodological rigour. Instead, the importance of the lived experience of the mother, partner, infant, and wider social network must be examined in order to understand the practical and emotional significance of these interventions to service users.

7 Conclusions

Mental ill health during the perinatal period has implications for the wellbeing of the mother, father, and infant. As 20% of mothers experience mental health problems during pregnancy and within the first postnatal year, maternal mental health is a public health problem which presents significant costs to society, both financially and in terms of the broader impact on the mothers' emotional wellbeing and the development of their infants. This briefing highlights that – at both a national and international level - inadequate referral pathways, restricted funding, and geographical limitations prevent access to specialist perinatal mental health services with many women and their families facing a 'postcode lottery' when attempting to access support. As a result, the third sector plays a valuable role in addressing gaps in service provision for new and expectant mothers and their families.

Both nationally within Scotland and internationally there is evidence to support the effectiveness of third sector non-clinical interventions, particularly in parenting support and peer support. These interventions were found to be well-tolerated by a wide range of mothers from different socioeconomic backgrounds both during pregnancy and after birth. Peer support networks are vital in forming relationships of trust which can help to reduce the stigma surrounding maternal mental health, improve self-identity, and decrease social isolation. Parenting education programmes are valuable in increasing mothers' understanding of their infants' capabilities, improving parenting confidence, and increasing resilience. These interventions appear to be particularly effective when delivered in close collaboration with the public sector. Some evidence was also found for the effectiveness of community-based counselling in reducing depression and anxiety, increasing social support, and improving communication between parents. However, there appears to be a limited amount of publicly available evidence for community-based counselling in comparison to peer support and parenting support.

It is important to exert caution when interpreting these findings. As many investigations are based on small sample sizes, it is a possibility that these investigations are underpowered[1] which could mean that significant results are due to random variation in the data rather than an actual positive effect of the intervention. There is also a paucity of randomised controlled trials in this area of research, as well as a lack of longitudinal investigations. As a result, it is difficult to determine whether third sector support is better than treatment as usual and whether benefits of these interventions persist over time. Despite these limitations, qualitative work demonstrates that pregnant women and mothers find non-clinical interventions positive and helpful. Thus, the quality of the evidence base should not be evaluated solely on statistical significance and methodological rigour but should also be evaluated based on the lived experience of mothers and their families.

Future research is needed in order to determine key drivers of therapeutic change associated with success in non-clinical third sector interventions. Furthermore, there is a need for research into third sector 'wrap-around' approaches which help support the family unit as a whole and the implications this may have for maternal mental wellbeing.

[1] The statistical *power* of a study is the probability that it will generate a statistically significant outcome. Studies or investigations that are 'underpowered' aren't big (or powerful) enough to detect the effects or changes that they are looking for.

8 Recommendations

The briefing aims to inform future decision-making by The Robertson Trust and the Scottish Government. Below are three recommendations which are drawn from the conclusions of the research above:

1. **Continue to support cross-sector learning and partnerships.** In line with the Perinatal Mental Health Managed Clinical Network's recommendations, there should be continued opportunities for public sector and third sector organisations, the Scottish Government, and independent funders, to collaborate. This could lead to improved cross-sector learning and effective partnership working.

2. **Consider a scoping exercise to determine what activities are happening across Scotland at a local, regional, and national level.** This research has focused on what evidence there is to show what types of activities work, when and for whom; it does not show the breadth and scale of non-clinical interventions which are currently taking place across Scotland. Before policy makers or funders develop new work in this area, it is recommended that a scoping exercise is completed to see what is currently happening and where. This will highlight any gaps in service provision, help to avoid duplication, and identify potential partners.

3. **Consider whether there is a need to address gaps in the evidence.** This study has shown there is a gap in rigorous evaluations of parenting support, peer support, and counselling programmes to identify which components of interventions are key to improving mental wellbeing for mothers and their families. As a result, there might be opportunities for organisations to work together to fill some of these gaps and to share the findings to inform policy and practice as relevant.

Appendix 1 - Methodologies

In order to determine the current state of the evidence for third sector delivered community-based interventions an in-depth literature review was conducted. This was carried out through desk-based research and liaison with some third sector stakeholders (see Appendix 3). In order to be included in this briefing, evidence was required to meet the following inclusion criteria:

1. Research must either be: 1) published in a peer-reviewed academic journal, OR 2) an internal/external process evaluation, OR 3) a PhD thesis freely available online
2. Research must have been conducted in Scotland, England, Wales, Northern Ireland, Republic of Ireland, United States of America, Canada, Australia or New Zealand
3. Participants must be pregnant women or new mothers/fathers of an infant one year of age or less
4. The intervention delivered must be non-clinical (e.g. not a recognised psychological therapy such as cognitive behavioural therapy) and delivered within a community setting (e.g. the home, community centres, cafes) by non-clinical practitioners

Literature was sourced by running searches on Google Scholar and databases (e.g. Web of Science) for a range of terms, including:

- Perinatal Mental Health Third Sector Support in [Scotland/England/Wales/Northern Ireland/Republic of Ireland/USA/Canada/Australia/New Zealand]
- Maternal Mental Health Third Sector Support in [Country]
- Parenting Education Programmes in Perinatal Period
- Parenting Education Programmes Maternal Mental Health
- Peer Support Programmes in Perinatal Period
- Peer Support Programmes Maternal Mental Health
- Community Based Counselling Perinatal Period
- Community Based Counselling Maternal Mental Health
- Paternal Mental Health in [Country]
- Paternal Mental Health Community Support

Literature provided directly through liaison with third sector organisations (see Appendix 3) was also included provided that it met the inclusion criteria.

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Appendix 3 – Maternal Mental Health Scotland attendees

The following organisations attended a meeting convened by The Robertson Trust and Maternal Mental Health Scotland (MMHS) in November 2018 and were later contacted to see if they had relevant literature that could contribute to this study.

- Aberlour
- CrossReach
- Dads Rock
- Fathers Network
- HomeStart Glasgow North
- Juno Perinatal Service
- Mellow Parenting
- Nurture the Borders
- Outside the Box
- PANDAs
- Quarriers