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'Out of the Blue'

A qualitative evaluation of the Home-Start Perinatal Mental Health Project

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Table of contents

Background to the project 4

The 'out of the blue' project 6

Evaluation of the project 7

Recruitment of participants 7

Methods 8

Focus group and interview 8

Topic guides 9

Volunteer diaries 9

Data analysis 9

Findings 10

Recruitment of families 10

Backgrounds of the women supported 11

Themes from qualitative data 13

Need for the PMH service 14

Benefits to the women supported 16

Benefits to volunteers 17

Benefits to Home-Start and the community 18

Challenges in the project 19

Report on the perinatal training course 21

Discussion and conclusion 24

Recommendations for 'Out of the Blue' 25

References 27

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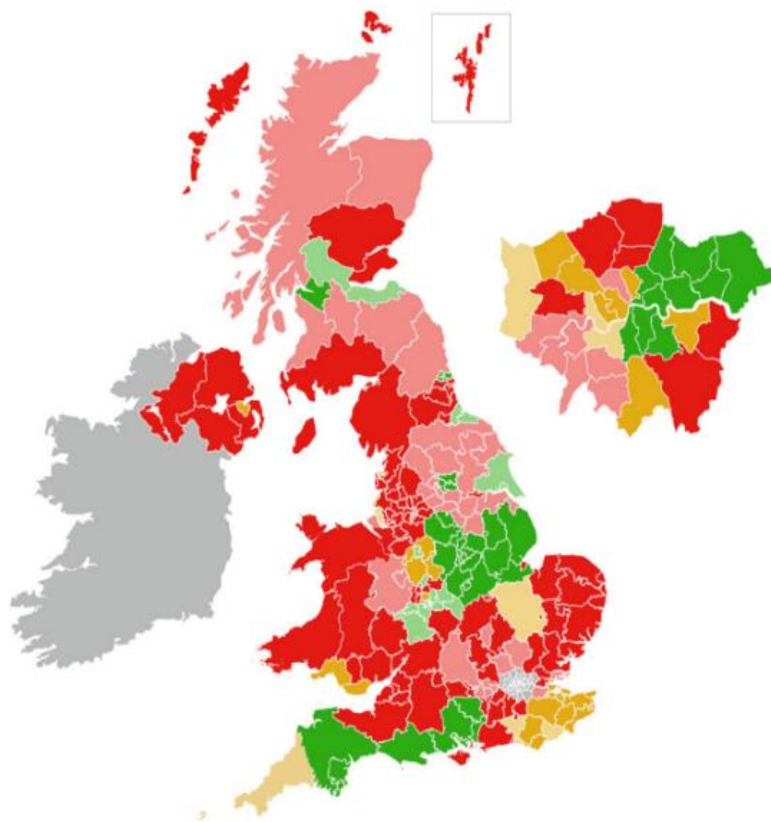
Background to the project

It is estimated that 15%-20% of women develop a mental health illness such as anxiety and depression, during pregnancy or within the first year after giving birth (NICE 2017) but to date more attention has been paid to post-natal rather than perinatal depression. Depression may coexist with one or more anxiety disorders such as obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and postpartum psychosis. This can have a variety of adverse outcomes for the mother, child and family (Ayers and Shakespeare 2015; Glasser et al. 2016; Glover 2014). A systematic review showed that anxiety during pregnancy was positively related to an increased risk of pre-term birth and low birth weight (Ding et al. 2014).

There has been little research on the diagnosis and treatment of perinatal mental health in primary care research and symptoms often go unnoticed or untreated by healthcare professionals. From evidence available, it is reported that GPs' lack the training and confidence to identify and treat perinatal mental health conditions (Khan 2015), and many midwives and public health nurses lack the knowledge or skills to provide the support women need (Bayrampour, Hapsari, and Pavlovic 2018; Higgins et al. 2017). This is compounded by the reluctance of women to seek help from health and social care professionals mainly due to the stigma around perinatal anxiety and depression, and the fears they have that their child may be taken away (Khan 2015).

Many areas in the UK (Fig.1) have less than adequate provision of perinatal support and Hertfordshire is a county that falls short of national standards[1]. It is estimated that each year, around 6000 women in Hertfordshire will experience mental health problems during pregnancy or in the first year following the birth of a child[2].

[1] http://everyonesbusiness.org.uk
[2] Public Health UK – Number based on averages estimated during 2014/2015 in Herts Valley CCG and East and North Herts CCG



Red areas - No specialist team exists.

Pink areas - Some extremely basic level of provision exists but currently falls short of national standards and needs expanding.

Amber areas - Some basic level of provision exists but currently falls short of national standards and needs expanding.

Green areas - Women and families can access treatment that meets nationally agreed standards.

Figure 1: Maternal mental health support by county

Early intervention and parenting support such as home-visiting and planned perinatal support can help reduce mental illness in parents and children (Khan 2016). A US intervention[3] which provides home-visiting support for families at risk of perinatal mental health, was found to be cost effective and showed long term improvement and prevention (Sadler et al. 2013). Untreated perinatal mental health has high long-term costs to UK society. An economic analysis estimated that one case of perinatal depression costs society around £74,000 of which £23,000 relates to the mother and £51,000 relates to impacts on the child (Bauer et al. 2014). Evidence based treatments are available for the mother (NICE

[3] Minding the Baby, Yale University

2017) and investing in perinatal support has huge savings for society. Every £1 spent on perinatal support saves £28 per year in statutory support later in life (Khan 2016).

The 'out of the blue' project

In response to the lack of county service provision, Home-Start Hertfordshire (HS-H) developed a new service to support women at risk of perinatal anxiety and depression called 'Out of the Blue'[4]. The new perinatal service was piloted over an 18-month period across two areas of Hertfordshire, Dacorum and Stevenage. These areas were selected for the pilot because they are communities with high levels of disadvantage, high fertility rates and poor service provision[5] [6].

Experienced HS-H volunteers were approached to take part in the perinatal project. All volunteers had completed the 40-hour Home-Start preparation course and had previous experience of working with HS-H families. Each volunteer who wished to participate in the project was interviewed to ensure their own personal emotional safety before being given a place on the project.

A 2-day training course was developed to prepare the volunteers to work alongside families at risk of experiencing perinatal mental health issues. The course was created using evidence from key professionals and in conjunction with a perinatal mental health specialist and covered the following topics:

- The key psychological findings surrounding perinatal mental health
- The impact of maternal mental health on children and the effects on attachment relationships
- Early identification of mental illness
- How to support mental health
- What support is currently available and how to help a family access that support
- An introduction to mindfulness and wellbeing

[4] From here on the 'Out of the Blue' project is referred to as the perinatal project or service
[5] http://www.hertscf.org.uk/library/Final_The_Hidden_Need.pdf
[6] Office of National Statistics 2013

Three courses were held, one in Dacorum and two in Stevenage. Volunteers who attended the courses gave feedback via an evaluation questionnaire about their learning outcomes, the training environment, facilitator effectiveness and course content.

Simultaneously, outreach work was undertaken with key healthcare partners in Hertfordshire (e.g. community midwives and GPs) to raise awareness of the pilot project. Staff were provided with details of how to refer women who they identified as being at risk of perinatal mental health problems.

Trained volunteers were matched with mothers-to-be during the 3rd trimester of their pregnancy (24-35 weeks) so that home visits could begin in the weeks leading up to the birth of the baby and continue into the postnatal period. The volunteer's role was to provide focussed support that would improve the women's mental health particularly around their self-confidence in parenting, reducing isolation and improving attachment between the mother and her new born. The home visiting support continued for as long as necessary after which, families went on to the standard support.

Evaluation of the project

The University of Hertfordshire was commissioned to carry out an independent evaluation of the perinatal mental health project. The aim of this evaluation was to explore the coordinators' and volunteers' experiences of taking part in the project and their perceptions of the benefits and challenges to the women who were supported through the project. A qualitative approach helps to provide an in-depth understanding of participants' experiences and perspectives. Qualitative methods enable the collection of rich and detailed data that can be sensitive to the social context and allows for flexibility so that data collection can be adapted to the individual and their experiences and responses. Analysis of qualitative data can determine emergent and cross-cutting themes which provide detailed descriptions grounded in the perspectives of the participants (Ritchie et al. 2013).

Recruitment of participants

Two coordinators were invited to take part in an in-depth interview for the evaluation. They were selected for interview because of their key role in the formation of the perinatal service. We wanted to explore their experiences of setting up and coordinating the project,

particularly around the benefits and challenges of the training course, selection of volunteers, referrals from healthcare professionals and feedback from the women on the project.

Volunteers who had taken part in the pilot project were also invited to take part in a focus group. All volunteers had completed the 2-day perinatal mental health training and had supported a family during the pilot project. We were interested in their experiences of the training programme and whether it had prepared them well for working with the families. We wanted to know what their experiences were in taking part in the pilot, the benefits to the families who they supported and ways in which the service could be improved.

Methods

Focus group and interview

An in-depth face-to-face interview was carried out with the two coordinators who had been involved in setting up and running the pilot. It was felt that a dyad interview was appropriate since the two coordinators had worked closely together on the project and their interaction was important for discussing the project. Two researchers were present at the interview (AB, KA) which lasted about 90 minutes, and was held in an office at the University of Hertfordshire.

A focus group was carried out with seven volunteers who had taken part in the perinatal training and had worked with the families during the pilot project. A focus group approach enables the collection of multiple individual accounts and group interaction generates thought-provoking discussion when participants hear others' experiences and opinions. The focus group was facilitated by one researcher (AB) in a meeting room at the University of Hertfordshire and lasted 80 minutes.

All participants were informed about the purpose of the evaluation and with their consent, the interview / focus group was audio recorded and later transcribed. It was explained that the transcripts would be anonymised, and all participants were assured of confidentiality.

Topic guides

An interview schedule was developed for the interview with the two HS-H coordinators. This addressed a number of issues relating to the pilot:

- Process of developing and delivering the training module
- Networking with key healthcare partners
- Challenges and benefits of coordinating the project
- How to improve the reach and effectiveness of the project
- Feedback to coordinators from the families on the project

A focus group schedule was developed for the volunteer focus group which addressed:

- How well the project has gone
- Challenges and learning points
- How well the training course prepared them for the pilot
- Additional training and support they would have liked
- Whether the level of supervision was adequate
- How the project was received by the mothers-to-be
- Volunteers perceived benefits of the project to the mothers-to-be
- Benefits of the project to the volunteers
- Whether experience of home visiting support is important for volunteer backgrounds
- Suggestions for improving reach and effectiveness of the project

Volunteer diaries

Volunteer diaries documented each of the volunteer's visits with the perinatal families throughout the home visitation period and were additional material that we could draw on for the evaluation. The volunteer diaries detailed the range of backgrounds and circumstances of the women who took part in the pilot and provided a narrative of how the women's needs change over time and how the volunteer adapts their support accordingly.

Data analysis

The focus group and interview transcripts were analysed using thematic analysis (Braun and Clarke 2006). This involves systematically working through the transcripts and identifying

emerging themes in the text. Initially, the transcripts were coded by one researcher and progressively the codes were integrated into overall themes. A second researcher verified the themes.

Findings

Recruitment of families

In total, 22 women were referred to HS-H perinatal pilot project. Four of these were self-referrals and 18 were referred by health and social care partners who had identified the women as being at risk of perinatal mental health (PMH) problems (details in Table 1). For this project, HS-H coordinators contacted local healthcare professionals, including those who did not typically refer to the standard HS-H service. The coordinators informed the partner referrers of the new HS-H perinatal service and as a result, a broad range of service providers referred to the project. These included new referral partners such as the community perinatal team and the midwives' team.

Table 1: Source of referrals to the pilot

	Referrer	**Frequency**
1	Children's Centre	2
2	Community Perinatal Team	2
3	Community Psychiatric Nurse	1
4	Health Visitor	4
5	Housing	2
6	Intensive Family Support Team	1
7	Midwives' Team	2
8	School Family Worker	1
9	Self-referral	4
10	Social Worker	2
11	Wellbeing Team	1
	Total	22

** Data obtained from Home-Start outcomes measure (MESH)*

Out of the 22 women referred to the project, 9 women did not continue with the volunteer home visits for several reasons. In some cases, women who had expressed an interest in the project could no longer be reached by letter or phone. Some women decided not to continue with the project because they no longer felt they needed support. In one case, it was decided that it was unsafe for a volunteer to go into one family who were being assessed for safeguarding issues by Social Workers. In total, 13 families were supported over the life of the project.

Backgrounds of the women supported

The volunteer diaries provided detailed information about the backgrounds and individual circumstances of the perinatal families. The women who were supported for the duration of the project all had perinatal mental health problems, as well as a range of complex health needs. This included health problems that resulted in hospitalisation. Many had housing and financial difficulties and were struggling to make ends meet. Two of the women were homeless during the project and were living in hostels or temporary accommodation. There were multiple agencies involved in their lives including social workers, child protection and care coordinators. Several were too anxious to leave their home which created a cycle of isolation and loneliness. The diaries also detailed that some of the women would hide their mental health problems from health care professionals.

Further details of the women's backgrounds are given in Table 2.

Table 2: Women's backgrounds (from diary data)

	Mental or physical health problems	Other problems
1	Previous suicide attempt, panic attacks, poor physical health (chronic pain)	Cannot cope with everyday tasks such as cleaning, housebound. Has had confrontations with neighbours involving police. Unreliable partner. Often in pyjamas. Domestic violence
2	History of postnatal depression (PND), previous late miscarriages, poor physical health (in hospital)	C1* is 'at risk'. Partner has drink and drug dependency
3	History of PND and psychosis, physical health problems, fatigue	Partner has panic attacks and OCD
4	History of depression and anxiety, recurring physical health problem, emotional and irrational behaviour, social anxiety	Homeless – lives in hostel. Runs out of medication regularly. Baby's father no longer around. Difficult relationship with parents, baby has health problems (in hospital). Avoids people
5	Chronic anxiety, previous late miscarriage, eating and sleeping problems	Baby has health problems. Difficulty coping with older child
6	Mental and physical health problems, OCD	Homeless – lives in hostel. Partner leaves during project. Baby goes into hospital
7	Various mental health issues including previous PND, hypermobility problems	Ex-partner (father of other child) has drinking dependency
8	Low mood and anxiety. Isolated	Rarely goes out
9	Anxiety and depression, traumatic childhood, physical health problems	Does not have a safe or protective relationship, social services involved. Father has left/strained relationship
10	Previous PND history of anxiety and depression. Lonely	5 other children (one has gone to live with dad elsewhere). Relationship breaking up. Struggles to go out, bereavement. 2 children with SENs
11	Chronic anxiety and experiences panic attacks	Partner has left, finds it hard to leave the house
12	Anxiety, 2 previous miscarriages	Domestic abuse from father – children on child protection plan. Unborn baby has kidney problem
13	Poor mental health, feeling very low during current pregnancy	Difficulty getting washed and dressed, difficulty going out

*C1 = older 1st child

The case study below is an example of one of the women (using the pseudonym, Sally) who took part in the project. Her story shows that her history of PMH had reached a critical level. Over time, she and her volunteer built a trusting relationship which crucially gave Sally someone to confide in.

Box 1: Case study

Sally was referred to the HS-H perinatal project by a Tenancy Support Officer. She already has two children and in both these pregnancies suffered from postnatal depression. She experienced domestic abuse in a previous relationship but is now in a relationship with a supportive partner. Last year she attempted suicide and is now under the supervision of a mental health nurse. During this pregnancy, she has had physical health problems and panic attacks. Sally avoids going out because she has problems with her neighbour and this makes the school run particularly stressful for her.

Sally was matched with a HS-H volunteer who visited her three times during the third trimester. The volunteer noticed that Sally would often not be dressed when she arrived and the house would be messy and dirty. The volunteer suggested they do the household chores together e.g. doing the washing/drying up, pegging out the washing or sorting clothes for the new baby. Sharing the chores meant that they could talk to each other about Sally's mental health and on the visit, Sally expressed her concerns that the suicidal thoughts might return once the baby was born. She confided in her volunteer that her suicide attempt was because she believed her children would be better off without her. Sally said she has no time for herself. The volunteer knew Sally was artistic so she suggested that Sally get some pencils and draw each day. Sally liked this idea and began drawing for pleasure and relaxation.

The volunteer continued to visit Sally at home once her baby was born. Sally's mental health fluctuated over these visits and the volunteer provided a range of support during this time. The volunteer accompanied Sally on the school run, helped with household chores which gave Sally some quality time.

Themes from qualitative data

Two coordinators took part in an in-depth interview about their role in the setup and management of the project. Both coordinators had been in this role for the past 8 years. However, one coordinator had previously worked as a HS volunteer (3 years) and the other coordinator had worked in mental health before her role in HS.

Seven volunteers took part in a focus group to discuss their role and experience of the perinatal project. Their volunteering experience at Home-Start ranged between 10 months and 13 years; the average was 5 years. Most of the volunteers wanted to participate in the project because they had an interest in mental health. Two volunteers had professional healthcare backgrounds (nursing, midwifery and health visiting), and one volunteer had a psychology background and had worked in mental health, and another had previously

worked in children's services. Three volunteers spoke about relatives' or own experiences of postnatal depression (PND).

This section reports the main themes that emerged from participants' accounts which are illustrated with examples of quotes from the data (given in italics). Quotes are anonymised with a code to show if the comment was made by a volunteer e.g. V1, V2 etc. or a coordinator (C1, C2).

Need for the PMH service

The coordinators and volunteers reported that there is a genuine need for the Home-Start perinatal service. This view is based on their experience of working in partnership with health and social care services and their experience of working with families. They reported that there is a lack of specialist support for women with PMH problems and that levels of service provision e.g. health visiting and midwifery can vary across the county. Both co-ordinators and volunteers identified how the women referred to the perinatal project were often in desperate need of support; many had faced multiple disadvantages, including homelessness and domestic abuse, and had complex physical and mental health needs. Volunteers said that the women reported not having sought help because they are afraid that their child may be taken away from them. Additionally, the stigmatisation of mental health means women tended to hide the extent of their mental health problems from others.

Coordinators and volunteers perceived that the HS-H perinatal service addressed a gap in service provision for women with PMH. A unique aspect of the project was that it provided one-to-one home visiting support and there were clear examples that the women they supported benefited from this. A key aspect of the perinatal project which is unique from other services, is that the support could begin prior to the birth of the child. This was an important period during which the women and volunteers could build rapport and a trusting relationship. The coordinators reported the need for careful and sensitive matching of the volunteer to the family; the success of matching was evidently crucial to the success of developing a supportive relationship. Volunteers said the value of this project is that it is

"preventative" and that Home-start has some capacity to be proactive rather than reactive in their support for women with perinatal mental health problems.

Box 2: Comments about the need for a perinatal service

Historically there hasn't been much support in general for perinatal support – C2

I know that this project would be such a fantastic thing to keep up because ***there is a need*** *for it – C1*

at one of the events was that the midwives actually stood up at their community perinatal launch and said we don't always know about spotting the signs of mental health C2

The health professionals don't have the time, I know mine is quite keen to ring whoever often, and they don't get back to her and she leaves a message for the health visitor and the health visitor doesn't ring her back. Because ***they are stretched*** *and busy – V6*

There's always that anxiety that they are watching you or they're going ***to take my child away****… whereas they are more trusting of us as volunteers – V1*

There are other services like in the community, mental health that were supposed to be…but they are all swamped… there is very little ***preventative work*** *available now in the community - V4*

…the referral of my family was more pre-emptive, to try and ***prevent*** *something happening V6*

…we need more funding so it can continue really I suppose, because now is the ideal time for it to progress V2

We just used to go and have coffee because she was homeless as well, so she was in quite a dire situation, so I think she just…she really appreciated having ***someone … to talk to*** *- V7*

…getting to know her beforehand and establishing that kind of comfort and sort of her ***trusting me*** *and being able to open up, but me also just being able to see how as a family how they live – V1*

…because you're spending a lot of time ***one-to-one*** *with the mum you do build up more of a* ***relationship*** *with them -V7*

…it's what Home-Start's always done, ***it's the matching that's really important****, we don't just say here's a volunteer and here's a family, we need to make sure that that family and that volunteer are going to be matched up as well as we possibly can – C2*

V= volunteer, C= coordinator

Benefits to the women supported

Volunteers and coordinators reported numerous benefits to the women they supported through the project. Volunteer feedback and coordinator reviews indicated that women found the service provided them with a constant, reliable and unconditional source of support. This contrasted to the relationships some women had with their extended families which were unsupportive, chaotic, and based on meeting certain expectations and conditions. Volunteers said these women found it easier to speak to someone outside the family. Volunteer support was very much focused on talking to and listening to the mother-to-be. The women confided in their volunteer, for example about feeling isolated or experiencing emotional difficulties. In many cases, the volunteer was their only confidant and as such, provided an important mechanism of support. Many women told their volunteer how much they valued their support and looked forward to their visits.

Volunteers also provided much needed practical support not available from other service provision. This could include accompanying the women to healthcare appointments or to a HS-H group. Input from the volunteers helped some women maintain medication regimes and to sustain engagement with appropriate health services. The qualitative data also suggests that some families would have been at risk of social service intervention had they not been part of the project (although establishing the reliability of this finding requires further investigation in future evaluations).

Box 3: Comments about the benefits to the women who were supported

*she said to me is 'You're the only **consistent** person in my life.' - V7*

*it's very different from having somebody who's **neutral** to the family – C2*

*[mother to volunteer] 'Oh I don't know what I'm going to do, you're the only one who is **consistent'** - V7*

*I think the **consistency** has been important for my family as well in terms of nobody else is really that reliable – V6*

*she said to me that **she feels she can talk to me more because she knows I'm not actually a social worker or a health visitor** or a doctor, she knows I'm a volunteer – V7*

*it's just having someone to sort of **hold your hand** to know you can do these things and feel confident, to **build her confidence**…helping her know how to interact with her children and engage with them – V5*

Benefits to volunteers

Volunteers reported that taking part in the perinatal project had positive benefits for their own personal development. Volunteers enjoyed the opportunity of acquiring specialist knowledge and skills from the training programme which positively impacted on their engagement with the project. Volunteers had previous experience of working with Home-Start families and they felt this experience was valuable and necessary for the perinatal project. Previous experience gave them the confidence of knowing how different families function and helped them to understand their own boundaries and self-care. The coordinators said that HS-H volunteers were able to provide valuable feedback about the perinatal families because they were experienced.

Volunteers appreciated the higher level of supervision and support they received from the coordinators on the perinatal project. Some volunteers said the supervision from the two coordinators running the project was better than they had received for the standard Home-Start service. The supervision was more frequent e.g. there were regular phone calls with the coordinators and supervision was more detailed. The coordinators made extra visits to the perinatal families and this was helpful to the volunteers to have this support.

Another positive aspect of the perinatal project was that it brought together volunteers from different areas of Hertfordshire. Volunteers suggested it would be beneficial for them to meet occasionally to discuss their experiences of working with perinatal families and provide peer-to-peer support.

Box 4: Comments about the benefits to the volunteers

So it's brought Home-Start together and it's ***united some of the volunteers*** *who haven't met before I also thought after the training the support from…like I was under [name of coordinator], was really good – V2*

Yeah, exactly the same with…I hadn't been under [name of coordinator] before but I've had much more – V4

I could always ring and get hold of her [the coordinator] if there was a problem – V7

It's good to be part of a ***worthy project*** *– V5*

It's what it gives you *as a volunteer, you know. – V4*

we did it in a very Home-Start way - C1 ***(Interviewer: What's the Home-Start way?)…***
It's quite a nurturing way, I think, we, I think ***Home-Start as whole organisation is a very nurturing organisation****, so it's always thinking about everybody's wellbeing as well – C2*

Benefits to Home-Start and the community

Through the perinatal project, HS-H has expanded its partner networks through its outreach work to new referrers e.g. midwives, GPs and community teams. Health and social care partners were enthusiastic about the perinatal service as it filled a gap in service provision for women with perinatal mental health problems. The new Home-Start perinatal service has raised awareness of perinatal mental health issues with local health and social care partners and there was a notable associated increase in referrals to the standard Home-Start service. The coordinators could see the potential to expand these networks further and to develop new working partnerships with existing services which are currently overstretched. HS-H can complement existing services and there is great potential for partnerships with key referrers.

The project has extended the services offered by Home-Start and the organisation now reaches out to families who may not have otherwise been referred to standard Home-Start services. The organisation is now supporting families earlier and now includes women

before they have had their first child. This change in HS-H's role was seen as a positive transition because the perinatal project is about preventative work.

HS-H now has an upskilled volunteer workforce who have enhanced their specialist knowledge and skills which has increased volunteer engagement. The volunteer network has strengthened across the county and there is potential for volunteers to provide each other with valuable peer support. Volunteers and coordinators said that other Home-Start schemes around the country have heard about the perinatal project and are very interested in running the project in their areas. The 2-day training course which was developed for the project can be transferred to other Home-Start schemes across the country.

Box 5: Comments about the benefits to HS

We did a stand at the launch of the community perinatal team again to ***raise awareness*** *- C1*

it's a new form of support and I think there needs to be a lot more work done with different organisations to ***raise awareness of perinatal mental health*** *- C2*

I think that's what Home-Start does very well actually, ***supervision*** *with, everyone gets supervised, everyone's wellbeing is checked all the time and it's more like a family isn't it, so this was an impact actually of us going out talking to people,* ***we saw our standard referrals going up*** *– C1*

So we're very privileged with the volunteers that we have, they are fantastic.
It is that relationship, ***it's the relationship between the volunteer and the family that creates the help*** *and then it's the relationship between us and the volunteer that enables them to do that so it is all about those relationships all the time – C2*

when it first was beginning that it was a project to go out and we couldn't believe how exciting that would be. It would be brilliant. From a preventative point of view, for child and parents - V4

Challenges in the project

A number of challenges in the project emerged from the qualitative data. Even though the perinatal service was well received by key healthcare partners, the number of referrals remained lower than expected and it was difficult to reach more families for the project. In a bid to improve referral rates, the coordinators developed a shorter referral form to speed

up the process for GPs and midwives who are short of time. This indicates that it can take significant resources in terms of time and effort to establish links with new referral agencies and raise awareness about the new service. Even after receiving referrals, retaining families was another challenge. In part, this speaks to the chaotic nature of some of the women's lives. Some mothers or mothers-to-be who were referred to the project were difficult to contact at a later point and were therefore unable to receive further support from the project.

A challenge for some volunteers was that they did not have many visits with the mother-to-be in the weeks leading up to the birth of her baby. Several visits were cancelled by the women for health reasons and in one situation the baby was born early. Having less visits in the 3rd trimester meant that it was more challenging for the volunteer and mother-to-be to build a trusting relationship and for the volunteer to understand how the family functioned prior to the arrival of the baby. This period of relationship building in the 3rd trimester was important for both mother and volunteer. It was suggested that some women may need support before the 3rd trimester of their pregnancy.

Volunteers sometimes found it difficult to provide adequate support to the mother-to-be if there were other children present at the home visits. The presence of other children made it difficult to speak with mother about her mental health since some of those conversations were not appropriate to have in front of a child. In some situations, the child would constantly look for their mother's attention so it would be difficult to have a meaningful, uninterrupted conversation. One of the subthemes that emerged was that there was a change of role for the volunteer on the perinatal project. Volunteers described their previous role as being a practical one, usually interacting with the children and which focused on the family 'as a whole'. The perinatal project meant that their role was more about being there for the mother-to-be before she had her child. This change of role took some adjusting to and volunteers would need to be prepared for that.

A main concern for the volunteers was how the women would cope once their home visiting support had ended. Volunteers said that their support could not continue forever but they felt it was particularly difficult to end the support for perinatal families.

Box 6: Comments about the challenges on the project

[GPs] …they'd be a really good point … of access to be able to support with Home-Start because they see from the front line that it's just, it just doesn't seem to happen …. ***the referrals didn't happen*** *– C2*

…although we haven't had much success with a lot of the referrers I think the work we've done there, the ground work we've done there, will ***continue to grow*** *– C1*

…this mum was referred but it was later on in her pregnancy and there wasn't necessarily the time and then she's other health conditions, physical health conditions and so that ***prevented me visiting*** *– V1*

So it's what's age-appropriate and I don't know how that could be navigated through, because the mum certainly gains from the emotional support, but when you do have another child in the mix. – V5

I've been there for quite a long time, where can the cut-off point be? I can see that as an issue, because you do need to have quite a clear sort of… ***it can't go on forever****. – V4*

I can't stay forever*, but I can't…it is hard, how do you end it really – V7*

It was very odd in the beginning *to be sitting having coffee for an hour, an hour and a half, and then doing exactly the same the same week – V4*

I think there was some anxiety around that at the start as well because volunteers were like – ***well if there's no child, what are we going to be doing?*** *What do we do? Where in reality they've tended to do slightly shorter visits and it's been chatting over a cup of coffee or maybe going to some appointments – C1*

Report on the perinatal training course

One of the outputs of the PMH project has been the development of a 2-day training course. The course was developed by two area coordinators with up-to-date evidence from key healthcare professionals and a perinatal mental health specialist. It is intended that the course will be rolled out to other Home-Start schemes. Volunteers who were selected for the training course had already completed the 40-hour Home-Start preparation course and previous experience of volunteering with Home-Start families. Their suitability for the pilot was assessed in a screening interview with the coordinators. Many of the volunteers had healthcare backgrounds and had an interest in mental health issues.

The training course gave an introduction to perinatal mental health, explaining the differences between anxiety, depression, obsessive compulsive disorder (OCD), post-

traumatic stress disorder (PTSD) and psychosis. The main focus of the training was around postnatal depression (PND) and anxiety and included active learning, video media, group working and role play. On day one of the course, a safe and confidential space was created so that volunteers could discuss their own personal issues of they wished to. Group work involved determining risk factors for PND and the importance of early identification of PND and the volunteers' role in this. The distinction between PND and anxiety was discussed. The training course also highlighted the impact of PND on the baby's development, on mother and baby attachment and wider impacts on other children, the partner and family members.

Day two of the course focused on why women with PND do not seek help e.g. stigma around mental health and many women fear their child may be taken away. The training course focused on how the volunteer can help the woman with PND through listening, reassurance, and support and where to signpost for further specialist help. The practical ways to help include helping with other children and accompanying the woman to health appointments. Research was presented about how to improve wellbeing and boost mental health. To complete the course, there was a focus on the volunteers' self-care and this included a meditation session to ensure that the volunteers protect their own mental health.

In total, 24 volunteers attended the training courses. Two courses were held in Stevenage; one attended by eight volunteers and the other attended by five volunteers. Eleven volunteers attended a course in Dacorum. Volunteers gave feedback via an HS-H evaluation questionnaire. This was carried out by HS-H and was not part of this evaluation *per se*. The training course evaluation questionnaire addressed the:

- **Learner's experience:** increased knowledge and understanding of perinatal mental health, knowing how to support
- **Training environment:** materials and resources provided
- **Facilitator effectiveness:** created an effective learning environment, had appropriate level of expertise, could impart knowledge effectively
- **Course content:** was relevant, met the objectives and expectations

Volunteers gave a rating of 1 to 5 for the different elements of the course, where 1 = low and 5 = high. Figure 2 gives the combined ratings for the volunteers who attended one of the training courses. Volunteers gave high ratings for their knowledge and understanding of PND including having "an understanding of the different types of perinatal mental health issues, risk factors and importance of early identification". They gave quite high ratings to "how to support the family with PND" and learning "the 5 ways to well-being" but there may be room for improvement in these areas. The training facilitators received very high scores as they managed to create an effective learning environment, were knowledgeable of the area and communicated this expertise in a way that enabled volunteers to learn. Volunteers rated the course content highly for meeting its objectives and said the training was relevant to the volunteers' role. Volunteers reported that the course was pitched at an appropriate level and met the learners' expectations. The video clips were helpful in the course and the workbooks were rated highly. Participants provided additional comments about the course on the evaluation sheets.

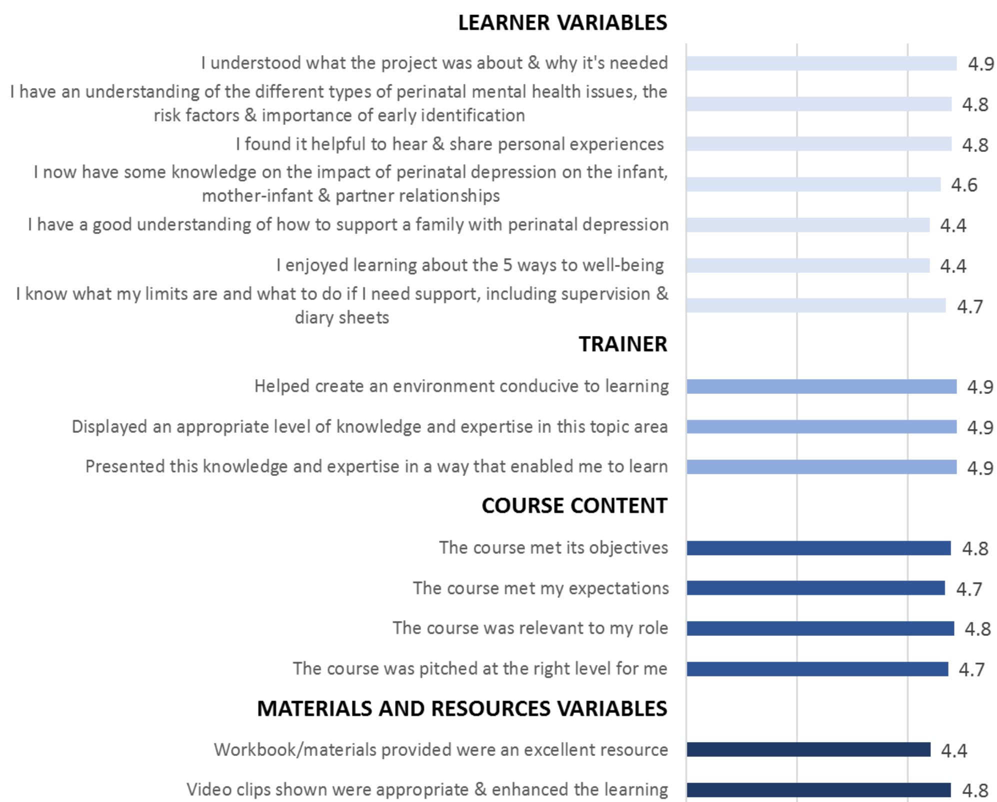


Figure 2: Average scores evaluation of the PMH training course (average scores out of 5, Dacorum and Stevenage combined data)

In the interview and focus group, coordinators and volunteers were asked about their views and experiences of the training course. They spoke at length and enthusiastically about the course (see Box 7).

Box 7: Comments from volunteers about the training course

*I really **enjoyed it** – V1*

Very thorough – V4

*We did a good exercise with anxiety and depression didn't we and different symptoms? I thought that was quite **helpful** – V5*

*I think that is a strength of Home-Start, for me personally the initial training that we had and this training both were really **high quality** – V5*

The role-plays are very helpful – V7

*we're split into groups and then we work something out and then present back and it's the whole sort of day goes like that. It's a **good format** – V1*

I just love and adore any of the courses they do because it brings back things that you might have thought about or heard of and worked with years before – V4

Discussion and conclusion

The perinatal service developed by HS-H is unique in that it provides consistent one-to-one support to women with PMH problems beginning in the third trimester of their pregnancy and continuing into the postnatal period. This evaluation explored the views and experiences of HS-H volunteers and coordinators and to establish the impact of the project on the women who participated in the project. The findings showed that the pilot project has had a positive impact on the volunteers, coordinators, and the women who participated and wider benefits to Home-Start which has developed new contacts with agencies and new routes for standard referrals. The period leading up to the birth proved to be a vital time for the women and their volunteers to establish a trusting relationship and it enabled the volunteers to adapt their support depending on the women's mental health. The training programme was well received and prepared the volunteers for working with women at risk of perinatal mental health problems. There were some challenges for the project such as

lower than expected referral rates, but these connections will take time to establish and overall healthcare professionals were encouraging of the project.

Recommendations for 'Out of the Blue'

The 'Out of the Blue' perinatal project was delivered by an experienced, skilled and knowledgeable volunteer and coordinator workforce and this has been the key strength to the success of the project. We recommend that HS-H should continue to invest in the training and supervision of its volunteers and coordinators as the benefits of this will filter through to the families that HS-H support. The perinatal training programme was well-received by volunteers who said they felt prepared for their role on the project. We suggest that the training programme could highlight the changing role of the volunteer when moving to perinatal support and could provide practical tips for volunteers in how to support the mother when other children are present at home visits.

A successful aspect of the project was that volunteers could work with the women in the 3rd trimester of pregnancy but we recommend that HS-H consider that some women may benefit from volunteer home visits before the 3rd trimester and some may need extended volunteer visits. The volunteer diaries provided valuable information about the women's backgrounds, ongoing living circumstances and mental health. We recommend that the volunteer diary template may need further evaluation and development to ensure consistency of diary entries across volunteers, especially as the diaries provide valuable context to the quantitative data collected at home visits. The strong relationship between the volunteers and women was the key to success for the perinatal project but these strong bonds may also make it more difficult for volunteers and families to part ways when the support ends. Some volunteers may need the supervision and support from their coordinators at the point of closing perinatal family support.

Referral rates were lower than expected but the publicity of the project will take time to reach new referrers and we recommend that the coordinators continue with their outreach work. The strategy to promote the service should use HS-H's community networks, social media channels and use more formal healthcare networks to raise awareness of the project.

In order to show how the women have improved over time, quantitative data would need to be collected using validated measures to establish a baseline so that an accurate

measurement of change could be established. However, it is important that this information is collected accurately and that there are no gaps in the data. Collecting this evidence would clearly show the long-term benefits of the perinatal project.

We suggest the dissemination of the findings could include a seminar about the perinatal project to midwifery and nursing students at the University of Hertfordshire. This will not only highlight the issues around PMH to the next generation of healthcare professionals, but it will also promote HS-H services.

In conclusion, the evaluation has shown that there is a real need for the HS-H perinatal service and that there are huge benefits to the women supported and to the volunteers who gave their time each week to the project. Further funding would enable the perinatal project to continue and provide parents with long-term specialist support from HS-H and would allow for wider dissemination of the project to other schemes and organisations. The perinatal mental health project has shown that HS-H can offer a high level of one-to-one support through its volunteer programme and work in partnership with other services.

it's about getting that right person supporting the right family -C2

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