Exploring innovative strategies to improve perinatal mental health in Scotland

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DOI:
10.20933/100001293

Publication date:
2023

Document Version
Publisher's PDF, also known as Version of record

Institute for Social Sciences Research (ISSR)
University of Dundee

School of Health Sciences
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PND & me

HOME START Dundee

One Parent Families Scotland
changing lives, challenging poverty

Exploring innovative strategies to improve perinatal mental health in Scotland:

co-development of an action-research agenda with women, families and practitioners.

We acknowledge funding from the Institute of Social Sciences Research (ISSR) through the Interdisciplinary Incubator Grant (IIG)

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Contents

Introduction

Perinatal mental health (PNMH) is an ongoing concern for women and families, as well as for health and social care services. It is estimated that 10-20% of women will experience mental health issues [1-4] and up to 10% of fathers may also experience difficulties with their mental health [5]. This issue was recently highlighted by national media [6].

Our previous stakeholder consultation work identified service gaps for women in the mild-moderate category of PNMH [7]. This project aimed to explore this identified gap further by bringing together a diverse group of partners, including women/families, practitioners and researchers to co-develop a collaborative action-research agenda. Project design and delivery was developed in collaboration with an expert with lived experience to ensure all elements were relevant and relatable.

It is crucial to involve all stakeholders, including those with lived experience and practitioners, in discussions regarding successful interventions for perinatal mental health. This approach ensures that families receive better outcomes in a sustainable and scalable manner.

Project aim

The project aim was to further explore a previously identified gap in services for women experiencing mild-moderate perinatal mental health (PNMH) and consider both the evidence base of interventions and participants' views of these interventions. We developed three proposed activities, which included:

- Co-development workshops
- Animation-based report from the co-development process
- CSO grant writing (submitted to Chief Scientist Office (CSO) Research Grants on the 30th of June 2023)

Project development

The workshops were initially designed to involve three main groups of participants: researchers, women with lived experience of PNMH and PNMH stakeholders from NHS and Third Sector Organisations across Scotland. However, Workshops 2 and 3 were further split for reasons explained below, resulting in five overall workshops.

Workshop 1

In Workshop 1, we conducted a systematic review of reviews (ongoing, not yet submitted for publication) in line with Cochrane ‘overviews of reviews’ guidance. This provided an evidence-base (n=190 systematic reviews) on a broad range of effective interventions in

PNMH (Workshop 1, April 2023). Six members of the research team participated in Workshop 1 and are working towards publication of this review.

Workshop 2 & 3

Workshop 2 was a half-day workshop with young mothers with lived experience of PNMH, and based at Home Start Dundee where they were accessing services. During the workshop, six women worked collaboratively with artist Andrew Low, researchers and Home Start staff, to co-develop a stop motion animation video about their PNMH experiences and needs. This co-produced video is available at https://discovery.dundee.ac.uk/en/publications/what-works-for-me-an-exploration-of-perinatal-mental-health-inter

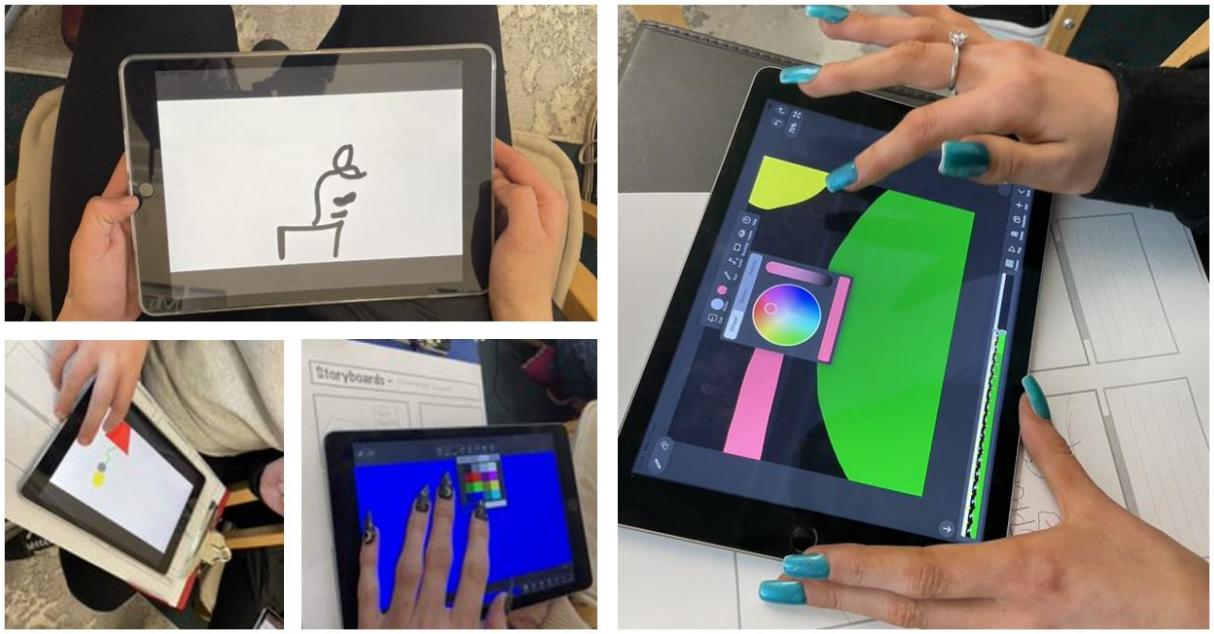
The researchers then facilitated group discussion around the interventions and focused on the key questions: What kinds of services should there be? How should they be delivered? Who should they be for? There was a clear preference for face-to-face services, peer support and Third Sector involvement in the delivery of these interventions (Workshop 2, 27th April 2023). The Workshop 2 agenda can be found in Appendix 1 and some main points of discussion can be found in Appendix 2.

To ensure an equity lens on our discussions, we also took the findings of the evidence base (Workshop 1), to a small group of women from disadvantaged backgrounds with lived experience in PNMH (Workshop 3). These five women were based in Edinburgh and supported through the One Parent Family Scotland charity. Some of the women had experienced living in temporary accommodation, history of substance misuse and social service involvement. A scenario-based board game was developed to ensure the discussion was interactive, accessible and inclusive. Women were given different antenatal and postnatal scenarios and a range of evidence-based interventions to choose from or adapt. Peer group support delivered face to face was chosen five times out of a possible seven times (Workshop 3, 10th May 2023). The game developed can be found in Appendix 3 and the workshop interventions comment summary can be found in Appendix 4.

Key findings between both groups of women with lived experience (Workshops 2 and 3) are summarised below:

1. There is a significant lack of care and support for women in the mild-moderate PNMH category;
2. Face to face peer support is the best option for PNMH interventions;
3. Third Sector delivery is preferable to NHS;
4. Partners need to be included in PNMH services;
5. Peer support is essential as the value of lived experience outweighs any professional training.

Figure 1 - Women developing the animated video during Workshop 2



Workshop 4 & 5

Originally, only one stakeholder workshop was planned, but the team decided to split this into a face to face and online option due to stakeholder availability. Workshop 4 was a face to face, full day workshop with 12 stakeholders and five staff attending (Workshop 4, 5th May 2023). Workshop 5 was conducted online with nine stakeholders and six staff attending (Workshop 5, 18th May 2023). These 21 participants were from a wide range of backgrounds including NHS PNMH services, Third Sector PNMH peer support services, social workers and GP's from across Scotland. The women's views and co-produced video were shown and discussed, alongside a world café activity exploring outcomes, who and how for service delivery as well as exploring the acceptability and feasibility of interventions. The Workshop 4 agenda can be found in Appendix 5, and the Workshop 5 agenda is available as Appendix 6.

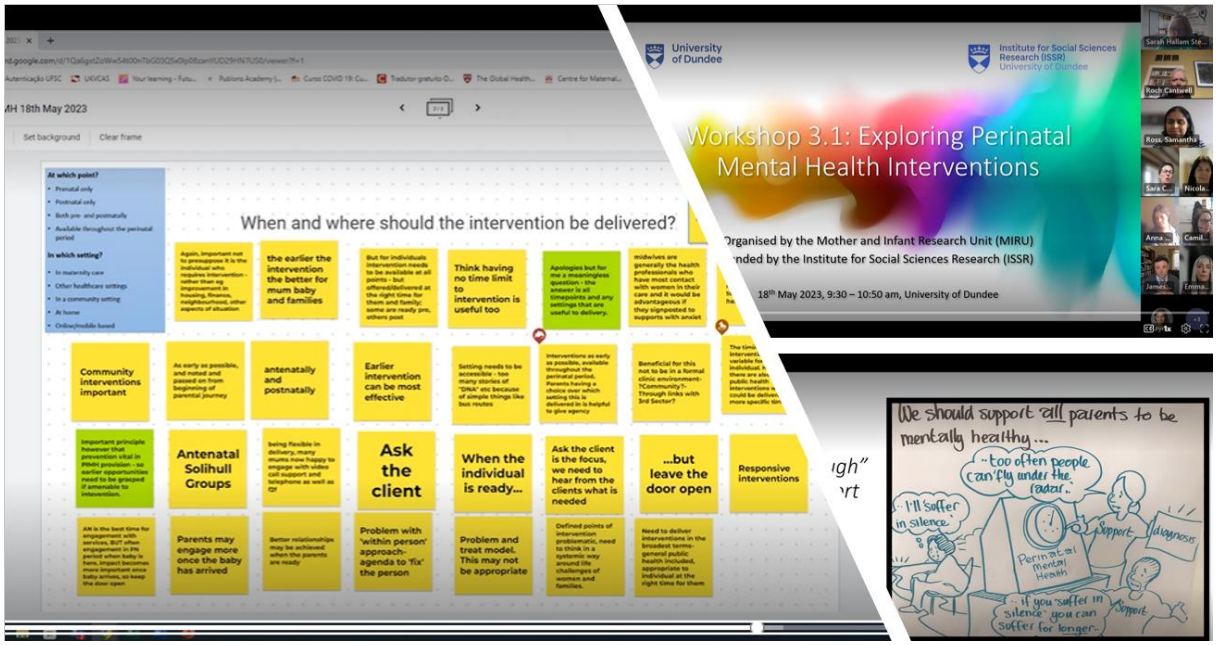
Our key findings from across all workshops were:

1. Individuals expressed feelings of fear of being judged, stigma, isolation, not meeting societal expectations, and peer pressure. For those in marginalised groups, there was fear associated with the potential of social services involvement and the implications of that for keeping the family unit together.
2. Women, their partners, and families did not feel well enough informed about what to expect in the perinatal period or where to find help and support. Earlier and more comprehensive information could have helped ameliorate feelings of fear and hopelessness.
3. Women and families felt that they were not ill enough to get support from services when they needed them.
4. Practitioners did not always feel well enough informed about what non-NHS help was available locally, nor the quality of the help being offered.

5. Some practitioners had felt compelled to refer women to secondary care, knowing that they did not meet the criteria, as they did not know what else to do.
6. There was little evaluation of existing NHS and third-sector services in terms of value and outcomes, with most evidence anecdotal.

Figure 2 - Activities with practitioners during Workshop 4

Figure 3 - Discussions with practitioners during Workshop 5



Participant feedback from all five workshops highlighted the importance of the topic of women with mild-moderate mental health needs in the perinatal period. Participants greatly valued the ability to come together from different backgrounds and relationship-building opportunities this facilitated.

One third sector worker reported that the workshop helped her establish a positive relationship with the social work team. This then led to social work attendance at the mothers' group she ran and facilitated positive conversations between the women and social workers.

All participants and women received thank you vouchers and travel reimbursement, which was built into the proposal to honour and value the time given for research as part of NIHR recommended good practice. Women from workshop 2 were given the opportunity to comment and edit the video before the final edit, and the video is now available at https://discovery.dundee.ac.uk/en/publications/what-works-for-me-an-exploration-of-perinatal-mental-health-inter

Grant development

The final proposed activity was the development of a grant application for innovative strategies to improve perinatal mental health in Scotland. Findings from the workshops were collated to inform the grant application, and key participants from the workshops were invited to be co-applicants. A grant application was submitted to Chief Scientist Office (CSO) Research Grants on the 30th of June 2023.

Final remarks and reflections

We returned to Home Start Dundee to watch the fully edited video with the women and Home Start staff to celebrate their achievement. Women were given the chance to request any final edits or have their name removed if they no longer wanted it on there. All women were happy to keep their names there and reported feeling proud of what they had created. We discussed dissemination ideas for the video and all women were happy for this and some said they would possibly help present the video at a future event. The group discussed feeling empowered and proud to have been involved in the project. However, we also discussed the possibility of needing to change the word PNMH and consider a more positive label of mental health wellbeing. All women thought this could be an interesting further project.

We consider the project a success based on high levels of stakeholder and parent engagement from diverse backgrounds. This project has raised the profile of University of Dundee as key researchers of perinatal mental health in Scotland and built capacity for future collaborations both within and outside the NHS. We completed all the proposed activities and expected outcomes of the project within budget, including:

1. The development of a participatory animation video to raise awareness of perinatal mental health impact with the general population, giving visibility and encouraging conversations about the topic and looking at adaptable perinatal mental health interventions (the video is now available at https://discovery.dundee.ac.uk/en/publications/what-works-for-me-an-exploration-of-perinatal-mental-health-inter);
2. Submission of a grant application to Chief Scottish Officer (CSO) on the 30th June 2023.

We also had positive feedback from stakeholders:

"It was great to meet with all the different people and bring together so much experience, knowledge and skill and then work together to look for solutions."

Stakeholder, Workshop 4

Our final team reflections focused on doing collaborative research with vulnerable groups. Firstly, we feel it is important to consider budgeting for creche workers when grant costing work with women and families and we will continue to develop this cost in future research applications.

Secondly, thank you vouchers for vulnerable participants should ideally be delivered in physical format, not online, and available immediately as some participants may experience digital exclusion. This is important for maintaining relationships of trust needed for research with marginalised groups.

Finally, research work in Scotland should always be mindful of the needs of rural participants who are unable to attend events via public transport. When applying for future funding, we will ensure to cost for fuel for those who live rurally without public transport access.

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Appendices

Appendix 1 – Agenda Workshop 2

Agenda for Workshop Two: Home Start Dundee 27.04.2023

Arrival: from 08.45

Workshop times: 09.30-12.30

9-9.30 am

Set up whilst teas and coffees available.

9.30-9.40 am

- Introduce team
- Introduce workshop aims and show discovery from previous workshop of not enough care for mild-moderate category
- Brief introduction of interventions work
- Discuss ground rules of confidentiality, respect etc. Introduce idea that women will choose level of identifiability at the end of the workshop
- Recheck consent for audio recording for notes

9.40-10 am

- Introduce APP and video capabilities
- Demonstrate with brief test examples
- Discuss video question and introduce story board idea, including if they want any voice over elements or background text to be edited in
- Play around time for women to get comfy with the app and produce anything

Reminder to all: All videos in Landscape only mode!

10-11.30 am

- Commence video work and storyboard time

11.30 am-11.45am

- Storyboard check in. Everyone to remind women there is half an hour left, and to check in with where they are in their storyboard.
- Final edits and rediscuss if women want to write their names on the video etc.

12-12.30

- Lunch
- Facilitated group discussion of the how, who, what, where of PNMH interventions

Appendix 2 – Workshops 2 &3 Intervention Comments Summary

What kind of services should there be?		How should it be done?	Who should it be for?
Online	Online- you can't tell if people are really listening to you and giving their attention	Staffed by people with lived experience	Mums
	Online- you can hide your emotions	TSO's recruit with lived experience not CVs- women want lived experience	Mums and Dads
	Online- you can't lip read so excludes deaf community	Better coming from TSO sector as less judgemental, more consistent relationship and LONG-TERM support (not discharged at specific time from NHS pathway)	Dads need a separate group
Telephone	Telephone services- not out of the blue calls. Need an arranged time to call so can plan your day. Risk of staying inside all day if you don't know when you are being called. Or risk being called when out in public and can't share personal information in that public space.	Mode of delivery- a safe space where we are comfortable	Involve wider family (kinship carers, foster carers, grandparents etc)
Professional Services (NHS)	Professional services need to develop a relationship with clients- it's only as good as the relationship with HCP	Utilise NHS students	
	EPND scales problematic- can feel different the next day	NHS specialists should come to groups to talk about the services available, put a face to the name etc.	
	Risk of power imbalance in services led by HCPs	AN and PN input important	
	Linked up services- giving the same guidance, not conflicting advice	Creche facilities need to be built into design of all PNMH services, can't expect single mums with several children to have access to childcare for appointments or interventions	
	Need to have exemptions to NHS catchment area of services- if you move you should be allowed to keep the same GP, HV, Midwife etc	Training for dealing with suicidal thoughts needs to be built into even mild-moderate services	
Face to Face	Face to face helps get you out of the house	No agenda-not appointments "for" something, just a space to be together with others in similar position.	

What kind of services should there be?		How should it be done?	Who should it be for?
	Face to face allows for spaces of silent communication and touch (hand holding etc)	No agenda- not trying to 'fix' you, just listen	
	Need face to face for human connection and relationship building		
	Face to face is best option		
Peer Support	Peer Support works		
	Groups coming together- just other people to talk to		
	Need to connect with others in the same position (groups, face to face, peer support)		
	PNMH groups=shared experience as equals		
Third Sector used to deliver interventions	Interventions to be delivered THROUGH the TSO who already run the groups and have the relationships (so yoga, art therapy, mindfulness work better if delivered through the TSO)		
	More services like Home Start		
	Bring the services to US, in our safe space		
	Therapeutic groups run by voluntary sector- wouldn't do it on an app but would do it with a trusted group		
	Home visits first- "I won't go if I don't know"; need for home visits from service supplier (TSO) to help encourage mums to go to the service, can then arrange to meet at service etc		

Appendix 3 – PNMH Game

PNMH Game developed by Sara Cumming

PNMH Game

Aim: introduces services from evidence base and encourages discussion around pros and cons without having to share personally as the focus is on the imaginary scenario.

i. Take card scenarios in turns
ii. Participant selects from multiple choice solutions and give reasons why
iii. Monitor number of times each solution is chosen, note reasons why chosen and note any 'other' suggestions for solutions

Antenatal	**SOLUTIONS**
[Name] has been medicated for depression since she was a teenager. She stopped taking her medications as soon as she found out she was pregnant but this was without GP guidance. She had bad morning sickness at the start of the pregnancy and found it difficult to get out of bed some days. Now the sickness is easing but she still finds it difficult to get out of bed- she is worried she is not coping with her mood and her depression is increasing.	• Talking therapies with specialist psychologist through the NHS • Befriending service run by local charity, home visits offered at the start. • Online Counselling from NHS • Peer group support-face to face • Online peer support (e.g. Facebook group) • Request referral for general counselling via midwife or GP
[Name] has always felt anxious but it is much worse in pregnancy. She now worries everyday that something bad is going to happen to the pregnancy. Recently she has been pretending to be sick so she doesn't have to go to work as she finds it too stressful travelling by public transport to get to work and worries the bus will crash.	• Telephone support from trained support services • Online self-directed course in mood management • Wellbeing services- yoga, mindfulness (online or face to face) • Other (make your own!)
[Name]'s partner suffers with severe mental health challenges. She is finding it harder to support him as the pregnancy advances. She feels tired a lot and is beginning to feel resentful towards caring for her partner. She wants someone to look after her.	At each choice, these further questions to be discussed: - is the focus prevention or treatment? - Who should receive the service-the woman? The partner? The wider family? - Where should it be done? (e.g. at hospital, home or online) - Delivered by trained professionals or trained peers with lived experience?
[Name] had a really traumatic birth with her first baby and suffered postnatal depression but never sought treatment for this. She is now becoming increasingly anxious about the birth and even regrets becoming pregnant, which makes her feel even worse. She hasn't told	

anyone about all these things she is feeling and is beginning to avoid people so she doesn't have to talk about the pregnancy.	
[Name] is pregnant with her 2nd child and has been on medication for anxiety since she was 11. She is a single parent and depends on her mum for child care support. Her mum also suffers with poor mental health and [name] feels like she can't talk to her about her own mental health because of this. She is beginning to feel the medications aren't working and her anxiety is increasing. She doesn't know where or how to get help.	
[Name] had a previously unwell baby who spent over 6 weeks in NICU when they were born. This pregnancy the baby is growing well and doing fine but [name] finds her anxiety that something will go wrong is increasing by the day. She feels scared there is something 'wrong' with this baby and finds herself calling triage every few days to seek reassurance.	
[Name] has recently fled a violent relationship and moved to a new town with her two other children under 5. They are living in a one bedroom flat until more permanent accommodation can be found. [Name] doesn't know anyone in this new town and feels isolated. She feels her mood is low and cries a lot. She doesn't want to tell the midwife what's going on because she is afraid she will tell social services.	
Postnatal	
[Name] had hoped for a waterbirth but was advised to have an induction for being postdates. It was 4 days from the start of the induction until baby was born, and she didn't sleep much. When baby was born she didn't feel the big rush of emotion and love that she had expected (and been told) she would feel. She didn't manage to breastfeed baby as she had hoped and now feels like she hasn't bonded well with baby. She feels like she is 'failing' at being a 'good' mother but can't tell anyone this.	
[Name]'s baby was unexpectedly admitted to NICU after birth for a few weeks. She is now home with baby but feels she is struggling to cope with the 3 hourly feeds through the night plus looking after her toddler in the day whilst her partner works. She went to see the GP about her low mood but was told it was to do	

with sleep deprivation. She feels things are getting worse and she isn't coping.	
[Name]'s partners mental health has deteriorated significantly since the birth of the baby. The baby has reflux and cries a lot and is unsettled at night. [Name] feels she is at breaking point trying to care for the baby and her partner. She feels very isolated and doesn't know where to get help from.	
[Name] was moved just before baby was born to more permanent accommodation in a different part of town. She has changed midwives and GPs again and has seen a different midwife each time postnatally. She hasn't talked to them about her previous violent relationship or having to move and feeling isolated. Her low mood has increased significantly since moving again and birth, she is finding it hard to get out to take her toddler to any groups and is exhausted with the baby.	
[Name] has found the PN period much harder than she thought it would be and is worried she hasn't bonded with the baby. She finds herself avoiding mother and baby groups and meeting up with other mums because she just doesn't want to 'put on a happy face' and pretend everything is ok and she is loving it. She keeps hoping it will get better once the baby sleeps better.	
[Name] felt anxious through the whole pregnancy but put it down to pregnancy hormones and didn't seek any help. She is now finding her anxiety has escalated since the birth and finds herself worrying about the baby a lot. She is finding it hard to leave the house because she worries about freak accidents that might happen to baby. She tries to spend most of the day downstairs with the baby now her partner is back to work because she feels too anxious to carry baby down the stairs on her own.	

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Appendix 4 – Workshop 3 Interventions Comments Summary

Scenario	Strategy Choice	Comments
AN: [Name] has always felt anxious but it is much worse in pregnancy. She now worries everyday that something bad is going to happen to the pregnancy. Recently she has been pretending to be sick so she doesn't have to go to work as she finds it too stressful travelling by public transport to get to work and worries the bus will crash.	Befriending service run by local charity, home visits offered at the start.	• Home visits offer practical support to help get out the house if that is the challenge. • Pregnancy complications can trigger and escalate underlying mental health challenges.
AN: [Name] has been medicated for depression since she was a teenager. She stopped taking her medications as soon as she found out she was pregnant but this was without GP guidance. She had bad morning sickness at the start of the pregnancy and found it difficult to get out of bed some days. Now the sickness is easing but she still finds it difficult to get out of bed- she is worried she is not coping with her mood and her depression is increasing	Peer group support (face-to-face) As well as talking therapies with specialist psychologist (changed so NOT from the NHS)	• Peer support offers boost to go and do things but also to realise you are not alone. • Talking therapies should be offered by TSO as more informal relationship, less waiting list times than NHS. • But talking therapies would not be enough on their own, would need peer to peer support to help with the everyday challenges of getting out.
AN: [Name] is pregnant with her 2nd child and has been on medication for anxiety since she was 11. She is a single parent and depends on her mum for child care support. Her mum also suffers with poor mental health and [name] feels like she can't talk to her about her own mental health because of this. She is beginning to feel the	Telephone support (but for start only and then peer support once able to get out the house) Peer support, face to face	• Telephone support as a 'way in' to building relationship and then stepping onto other services. Telephone support would not be enough on its own. • Further conversation that texts would be better than telephone calls- risk of not being somewhere private when phone call is made, or something happening with children and not being able to answer call. Risk of

medications aren't working and her anxiety is increasing. She doesn't know where or how to get help.		being 'caught off guard' by a phone call. • Texts discussed as preferable as you take your time to consider your reply, express yourself more freely and answer in your own time. • Need for dealing with family mental health as well, but not in replacement of woman's MH needs. • Who? Trained person with lived experience, not professional because lived experience is "raw and real" and can't be learned in books. • Discussion around NHS being 'just their job' not their lives; 'they've just learned it from a book'. Too much emphasis on taking medications from NHS for mental health- they are just 'licensed to give a prescription'. • NHS is too stretched to deal with mild-moderate group, people disclosed experiences of being told to go to A+E if it gets serious, but not getting help before it gets serious. • Need for continuity in the service, otherwise it wouldn't work- need to have a trusted relationship, not a different person at each call/text. All women agreed they would NOT like a different person each time.
AN: [Name]'s partner suffers with severe mental health challenges. She is finding it harder to support him as the pregnancy advances. She feels tired a lot and is beginning to feel resentful towards caring for her partner. She wants someone to look after her.	Peer support (but for partner) choice of online AND face to face (online can be helpful for those with anxiety about leaving the house)	• Need for friends and family to step in with support. • Need for partner to understand and be aware of the impact of pregnancy and support needs. • Peer support for partners as often partners may not want to access NHS as seen as having a 'problem' in need of support. Peer support less intimidating to access. • Stay and play for men/partners, buggy walks for Dad/partner. • BUT mustn't lose sight of mum at the centre, so must offer a

		service to the mum alongside partner services. The same TSO could offer mum and partner groups. • NHS support is seen as 'too close to the other services' (e.g. social services) so fear of judgement. Third sector is seen as more neutral and can offer longer term continuity. In a crises, would rather speak to support worker from TSO because feel unjudged as not 'part of the services'. • NHS waiting list is too long to receive support from. • More continuity with TSO- more long-term relationship. • NHS is so busy, even if you get the same GP or psychiatrist, then don't always remember you exactly and your story. More impersonal.
AN: [Name] had a really traumatic birth with her first baby and suffered post natal depression but never sought treatment for this. She is now becoming increasingly anxious about the birth and even regrets becoming pregnant, which makes her feel even worse. She hasn't told anyone about all these things she is feeling and is beginning to avoid people so she doesn't have to talk about the pregnancy	Peer support group, face to face	• Needs someone to talk to in her own space. • Needs peer support to understand she is not alone. • Needs that human face to face connection to overcome the guilt of lack of bonding or resenting baby etc. • Birth trauma can influence bonding, and lead to depression but more difficult to diagnose as hidden behind birth trauma. • A lot of untreated life trauma can surface after birth.
PN: [Name] had hoped for a waterbirth but was advised to have an induction for being late. It was 4 days from the start of the induction until baby was born, and she didn't sleep much. When baby was born she didn't feel the big rush of emotion and love that she had expected (and been told) she would feel. She didn't	Peer support face to face Talking therapies via TSO	• TSO has more time to dedicate to relationship building over the phone before even coming out, adaptable and flexible service. • Risk of NHS groups run as a formal 'service' and therefore risk being removed 'out the group' if miss a few sessions, but TSO offers more open service, with no official agenda etc. • From the women's perspective, feel pressure to attend NHS run groups as a 'formal service' which

manage to breastfeed baby as she had hoped and now feels like she hasn't bonded well with baby. She feels like she is 'failing' at being a 'good' mother but can't tell anyone this.		can put you off returning if you miss a few. Less pressure and more flexibility with TSO or peer support group.
PN: [Name] has found the PN period much harder than she thought it would be and is worried she hasn't bonded with the baby. She finds herself avoiding mother and baby groups and meeting up with other mums because she just doesn't want to 'put on a happy face' and pretend everything is ok and she is loving it. She keeps hoping it will get better once the baby sleeps better.	(Same as above in general discussion for both PN scenarios)	

Appendix 5 – Agenda Workshop 4

University of Dundee

Institute for Social Sciences Research (ISSR) University of Dundee

Workshop 4: Exploring Perinatal Mental Health Interventions

Organised by the Mother and Infant Research Unit (MIRU)

Funded by the Institute for Social Sciences Research (ISSR)

Friday 5th May 2023, 10am-1pm

Agenda

Welcome	10.00-10.10
Team introductions	10.10-10.20
Round table introductions	10.20-10.40
Summary of previous work on PNMH	10.40-10.45
PNMH Evidence	10.45-11.00
Activity 1: World Café	11.00-11.30
Lunch break	
Feedback from women's workshop	12.00-12.10
Activity 2: How can we work together?	12.10-12.45
Final thoughts and next steps	12.45- 13.00

"Coming together is a beginning, staying together is progress, and working together is success."

Henry Ford

THANK YOU FOR ALL THE WORK YOU DO TO IMPROVE PERINATAL MENTAL HEALTH IN SCOTLAND!

Appendix 6 – Agenda Workshop 5

University of Dundee

Institute for Social Sciences Research (ISSR) University of Dundee

Workshop 5 Agenda Thursday 18th May 9.30am-11am Teams

Aim: the feasibility of implementing the interventions identified from workshops 1 and 2 will be explored with those who have experience of supporting women and their families and who are accustomed to working with or within the NHS, Third Sector and social care context.

Attendees: 9 participants and 7 staff

1. **Welcome and House rules**- recording, respect and confidentiality, consent for follow up (Team)	9.30-9.35
2. **Team introductions**	9.35-9.40
3. **Round table introductions**: Name, organisation, brief outline of organisations PNMH work	9.40-9.50
4. **June overview**	9.50-9.55
5. **PNMH Evidence**: Introduction and overview	9.55-10.00
6. **Jamboard activity (10 mins per question)** i. what (outcomes) who (women, families etc) and how (delivery) is needed from services. Group discussion and jamboard	10.00-10.30
7. **Video and women's feedback**	10.30-10.35
8. **Group discussion** i. Group discussion about women's feedback and PNMH services. Focus discussion on what is **acceptable, appropriate, and feasible**.	10.35-10.50
9. **Conclusion and next steps**	10.50-11.00