

Supporting women with perinatal mental health problems: the role of the voluntary sector

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Abstract

The prevalence of perinatal mental health problems is high with estimates suggesting that around a fifth of women experience anxiety and or depression during the ante- and post-natal period. Mental health problems in pregnancy and the postnatal period have an adverse impact on the development of the foetal and infant nervous system and the parent-infant relationship, with significant long-term consequences for the child. The charity Family Action established a Perinatal Support Project (PSP) underpinned by the Newpin model of working, at four sites across the UK. The service offered women experiencing perinatal anxiety and depression support from volunteer befrienders. The result of a service evaluation of PSP shows high levels of need, and promising results in terms of outcomes for parents. The stakeholder interview data found that front-line professionals such as midwives and health visitors highly valued the service being offered. The PSP appears to be filling a gap in service provision with women who have mild to moderate ante and post natal depression. There would appear to be scope for the PSP to work with service users earlier in the antenatal period where the impact may be even greater.

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Background

Prevalence rates of depression in the antenatal period are similar to postpartum levels and range from 12% to 20% (Marcus et al, 2003; Heron et al, 2004). The prevalence of postnatal depression (PND) is in the region of 13%, ranging from 7 to 19% of women (O'Hara, 2009).

Anxiety and depression in pregnancy are strongly associated with adverse outcomes for mothers and babies, including preterm delivery and low birth weight (Dunkel Schetter and Tanner, 2012; Dunkel Schetter, 2011). They are also associated with alterations to the neurobiological substrate of the affect regulation system of the foetus including for example, higher basal cortisol levels and reduced high-frequency heart-rate variability (HRV), low dopamine and serotonin levels (see Bergner et al, 2008). Longitudinal studies also show alterations in HPA axis (hypothalamic-pituitary-adrenal) functioning in 10-year-old children (Dunkel Schetter and Tanner, 2012; Dunkel Schetter, 2011).

Both anxiety (Beebe et al, 2011) and depression (Murray, 1996) in mothers during the postnatal period have been shown to have a deleterious effect on the parent–infant relationship which, in turn, has been identified as being an important predictor of insecure infant attachment (DeWoolf and Ijzendoorn, 1997), with insecure (eg, Berlin et al, 2008; Granot and Mayseless, 2001; Sroufe, 2005) and disorganised attachment (Green and Goldwyn, 2002) being associated with a range of compromised outcomes.

Recent evidence suggests that detection, referral and treatment of women with perinatal depression by obstetric providers is poor (Turner et al, 2008; Goodman and Tyer-Viola, 2010). A report by 4Children, *Suffering in Silence* (4Children, 2011), advocates a multifaceted approach, which includes raising awareness of the issue through national campaigns and promotes

a proactive approach to antenatal screening by health professionals such as midwives. It also endorses an antenatal role for health visitors in order to strengthen assessment and identification of anxiety and depression.

Supporting the mother and the developing infant through this period is recognised to be a key time for intervention in order to mitigate these negative outcomes. A number of psychological therapies have been found to improve maternal mood in both the pre (Vieten and Astin, 2008) and postnatal period (National Institute for Health and Clinical Excellence (NICE), 2006), with important components of both being the use of effective listening and the provision of techniques for regulating affect.

Evidence suggests that current needs in terms of women experiencing perinatal anxiety and depression exceeds statutory sector capacity and that many women are being prescribed drugs for such problems, particularly during the postnatal period (4Children, 2011).

The Perinatal Support Project

The Perinatal Support Project (PSP) was established in July 2010 for a period of three years and emerged from the earlier Newpin project, which found that women assessed as vulnerable to perinatal depression who received social support were half as likely as those in the control group to have experienced the onset of a depression sufficiently severe to warrant antidepressants, or to have remained without recovery from depression throughout the 12-month study period (Harris, 2008). It comprises a service for mothers who are either affected by, or at risk of, postnatal depression and other mental health problems.

The service has been established in four areas of the UK: Hackney; West Mansfield; Swaffham; and Oxford. The four areas are diverse and contrast strongly, particularly in terms of ethnicity and geography. The

Table 1. Mean scores for the key measures pre- and post-intervention

Measures	N	Baseline (standard deviation (SD))	Post-intervention (SD)	Sig
Parental mental health	33			
Anxiety		11.8 (4.1)	8.4 (3.8)	.000
Depression		10.1 (4.3)	6.1 (2.7)	.000
Mother's relationship with the baby	35			
Warmth		22.9 (7.8)	29.0 (4.4)	.000
Invasiveness		12.1 (6.3)	10.3 (5.3)	.109
Social support	42	18.7 (6.3)	20.6 (5.2)	.007
Self-esteem (Volunteer befrienders)	80	30.6 (4.8)	32.2 (4.4)	.000

PSP aims to:

- Improve the mental health of participants
- Improve attachment between mothers and infants
- Reduce social isolation
- Improve self-confidence of participants and volunteers.

Women with mild-to-moderate mental health issues who are pregnant or mothers with infants under one year of age are recruited to the project via a range of referral routes, including midwives, GPs and health visitors. Women may also self-refer. Women with severe mental illness are not offered the service.

The PSP provides intensive community-based support throughout the woman's pregnancy and during the first year of the child's life. Support ceases on the infant's first birthday. An initial assessment of need is made by a project co-ordinator and is followed by the provision of home visits by a trained volunteer befriender and or attendance at a targeted support group. Parents are encouraged to attend parenting groups to increase understanding and knowledge of the infant's needs and to help to develop informal support networks.

Volunteer befrienders receive an initial six days of training, covering a range of topics including child development, perinatal problems and roles and responsibilities. Ongoing supervision and support is provided by the project coordinator.

This paper describes an evaluation of the

pilot phase of the PSP.

Aim

This research aimed to measure outcomes for service participants and volunteer befrienders engaged in the PSP and to explore stakeholder perceptions and experiences of delivering and engaging with the PSP.

Method

Both qualitative and quantitative research methods were employed and comprised two components:

- Service evaluation addressing the impact of the PSP on the following key outcomes: anxiety and depression; social support; and self-esteem
- Interviews with a range of participants drawn from those providing the service, those receiving the service and referrers to the PSP in order to explore perceptions, views and experiences the PSP.

Service evaluation

All families involved in the PSP were required to complete a range of standardised measures on entry to the project (ie, at baseline) and following completion of service delivery (ie, post-intervention): Hospital Anxiety Depression scale (HADS) (Zigmond and Snaith, 1983); Mother Object Relationship scale (MORS) (Oates et al, 2005); Maternal Social Support Index (MSSI) (Pascoe et al, 1988). Volunteer befrienders completed the Rosenberg's Self-

Esteem scale (RSE) (Rosenberg, 1989).

Quantitative data were collected, entered into a database (Excel) by project co-ordinators at Family Action, and an anonymised dataset was then transferred to the University of Warwick for analysis. A range of descriptive statistics (means and chi-squared tests) was used to depict the demographic characteristics of participants, and a non-parametric test (Mann-Whitney U test) was used to identify statistically significant changes between baseline and post-intervention measures. Data were calculated for the following period: July 2010 to end May 2012.

Stakeholder interviews

Project co-ordinators were invited to take part in the research and identified other participants, including volunteer befrienders, service users and referring agencies. Informed consent was taken prior to conducting a semi-structured interview (face-to-face or telephone) at a time and place convenient to the participant. Interviews were conducted by the researcher and were then fully transcribed, returned to the interviewee for comment, and then entered into the qualitative database, NVivo 8 (2008).

Through a process of coding and analysis, common themes were identified. A narrative summary of the key themes that were identified is presented using quotations selected on the basis of their capacity to demonstrate some aspect of the theme.

The research was conducted in accordance with the Department of Health (DH) research governance procedures (DH, 2005) and ethics committee approval was granted by the University of Warwick Biomedical Research Ethics Committee.

Results

Service evaluation

A total of 86 volunteer befrienders were recruited and trained, and the service was provided to around 189 women during the study period. Each of the four PSPs received a significant number of referrals over the study period ranging from 42–52 and waiting lists were implemented when demand outstripped capacity.

The demographic data suggest that the PSP was serving a high-risk group of women, with over two-thirds living in no-wage households, a third being single parent families and between 2% and 11% having

child protection issues in addition to the presenting problems (eg, perinatal anxiety and/or depression). Around 20% of women did not take up the offer of the service, with some being non-contactable.

Pre- and post-intervention data were available for one-third of the women who received the service, and Table 1 shows the mean scores pre- and post-intervention for the three outcomes. The results show significant improvements in anxiety and depression, social support and in the mother's relationship with the baby in terms of warmth and invasiveness. There was also a significant improvement in the self-esteem of the volunteer befrienders.

Stakeholder interviews

Face-to-face and telephone interviews were conducted with a total of 41 individuals from the following groups: co-ordinators (5); volunteer befrienders (14); service users (13); and referrers to the service (9).

Service users

Service users who took part in an interview were aged between 20 and 45, the majority being in their 20s. They were all in relationships and cohabiting, except one mother who had separated from her partner. All women classed themselves as 'white British'. Numbers of children ranged from 1–5. One father took part in the research.

The quantitative data highlighted the high level of need in the population being served by the PSP and this was confirmed by the interviews, which indicated a range of problems such as social isolation and relationship difficulties. One lone mother described the impact of her depression on her young daughter:

'Because she used to like to sit in one corner and stay there. Because sometimes I thought one day she was even sick but she wasn't. But I think it was the situation and the place where we were staying it was small. And myself I was depressed ...so I didn't have time for her' (Service user #12)

A number of women highlighted the importance of being supported and given the opportunity to socialise with other mothers and babies:

'So we've been to a baby centre like she has suggested ... So we do do that. So she has

helped us with the sort of socialising. Because obviously I was frightened to take her to baby centres and stuff. Especially on my own' (Service user #17)

Some interviewees highlighted the benefits of the additional support:

'To have somewhere to go once a week and meet other people and sort of somewhere, if you like, to offload a few of your problems and somebody just to get you to understand that it's not you that's a bad person that ... do you know what I mean? Oh I can't explain it. It's support. Because you've got your partner, you've got your immediate family, but ... my mum's fantastic and we're really close, I don't know ... So I think without having the co-ordinator and the other girls there to understand it's not just me and there's somebody else there, I don't know where I'd be now to be fair' (Service user #9)

The acceptance and non-judgemental approach of the volunteers appeared to be important to many women:

'It sounded good, yeah. Um. I was a bit sceptical about admitting that I might have needed some help because I thought people might judge me. But no X [project co-ordinator] made me feel at ease and everything so it was OK' (Service user #9)

The overwhelming message from the interviews with the service recipients was that of relief and gratitude:

'Just to thank [co-ordinator] because she really, really changed my life. I didn't know that one time I could be somewhere happy. That's the only thing I can say ... Really, really did a good job in my life' (Service user #12)

Referrers to the PSP

Referrers were unanimous that the PSP filled a gap left by other services. Frontline practitioners, such as midwives, health visitors, family workers and social workers, embraced the project wholeheartedly and were pleased to have a service such as the PSP to which to refer women:

'But I thought, that sounds really good, because we deal with um lots of mums who are socially isolated or culturally isolated, who have difficulties getting out, who suffer with

a bit of depression, but not serious enough to bring in the services of sort of mental health or anything' (Referrer #20)

Agencies referring to the project were very appreciative of the PSP, alongside the potential support available to clients who had previously been unable to access suitable services. One health visitor referred to the level of need in her area as follows:

'Yeah, very high need. I'd say probably 25% of my adults that I continue to visit is because of emotional health problems, including post-natal illness. So there's a very high need in this area' (Referrer #10)

The use of joint assessments was highlighted, and the feedback provided by PSP co-ordinators was highly rated by referrers:

'Very good feedback I have to say. So written updates. Letters. Emails. Verbal updates. We do joint visits. Joint assessments. Initial visits' (Referrer #23)

The following case study (names have been altered) illustrates the benefits of the PSP for one couple.

In answer to the question 'What difference has this project made to you?' Tracy hesitated and, in a voice filled with emotion, said:

'To be quite honest I think when we first had Tom he might have ended up in care.'

Both Shaun and Tracy are in their late 20s, both have learning difficulties and Tracy is physically disabled and a wheelchair user. Shaun is Tracy's full-time carer. Both parents report unhappy childhoods and difficult relationships with their families and for Tracy, difficulties making and sustaining friendships.

The couple were stable and self-sufficient until their situation changed swiftly with an unplanned pregnancy and the birth of a pre-term infant at 28 weeks. Bringing home baby Tom was daunting and both parents reported feeling depressed and overwhelmed. For Shaun it represented an overload in terms of caring responsibilities:

'I'll put my hand up. I said to Tracy I don't want him. I actually said that to her twice, didn't I?'



THE RESULTS OF THE QUANTITATIVE DATA FROM AROUND A THIRD OF PARTICIPANTS WERE SUGGESTIVE OF SIGNIFICANT IMPROVEMENTS IN ANXIETY



Tracy’s depression stemmed, in part, from her knowledge about Shaun’s feelings and her own feelings about being unprepared. The hospital care appeared to do little to prepare her for the practicalities of caring for Tom at home:

‘So we was in severe-shock [laugh] stage. And then, when he was born it was even worse because he wasn’t supposed to be born until March. So then when he did come home Shaun’s sort of like ... because I’m ... because of my disability I’m not allowed to pick Tom up or walk around with him. Because with Tom being premature, um we ... I didn’t really get a hands-on with him in the hospital either. And they didn’t know how to treat me because I was in a wheelchair at the time because of my C-section. So the thing ... it was sort of like kid gloves for Tom and for me, and they didn’t quite know how to treat us’.

The midwife working with the family referred them to the PSP soon after Tom was born and while he was still in hospital. At this point there were a number of services involved in the family’s care but it soon became apparent that the PSP was the key resource. Through the PSP both Shaun and Tracy were offered a volunteer befriender. This offer was immediately accepted by Tracy but declined by Shaun who felt that as long as Tracy was being helped, he could cope:

‘Because when Tracy’s on a “downer” it affects me and it affects Tom. So of course when it’s helping Tracy it helps me, it helps Tom’.

A number of other services were put in place via the PSP co-ordinator, including baby massage and respite care for the parents when Tom was six months old. The latter was highly valued by both parents

because it provided time for themselves but also an opportunity for Tom to mix with other infants, something they felt unable to provide for him themselves. Tracy was also referred for counselling, which she has found very helpful. Shaun describes the project as follows:

‘Basically, in one word, supportive. That’s how we found it. I mean, they’ve been brilliant. I mean, we come here ... all the staff are brilliant. Can’t fault one of them. I mean, counsellor’s helping Tracy. Co-ordinator ... without her getting everyone together and everything ... getting Tracy that befriender ... I would say they’ve really helped. But in one word, supportive I would say’.

A planned withdrawal of support was in progress, as their independence and support from other services has increased.

Service providers

Characteristics of the volunteers in this sample were as follows:

- Ages ranged from 20–60 years, with over half in their 40s
- All but one had children and most were either married or in stable relationships
- The majority described themselves as ‘white British’
- Motivation to volunteer stemmed from either having suffered from PND (half the sample claimed to have had PND) and others who wanted to get involved with the community.

The training and guidance they received, coupled with ongoing support from the project co-ordinator, was valued and praised by the volunteer befrienders. They acknowledged the need for the PSP and referred to the way in which they felt the visits increased women’s self-esteem and empowered them.

They described various ways in which they

felt the support that they provided had benefited the families:

‘But I remember this particular girl the first time I met her she just ... I could tell by her eyes what pain she was in. She just had ... she sort of glared at me. And now she does actually look happy again and there is that sparkle in her eyes’ (Volunteer befriender #11)

Volunteer befrienders also described a range of personal benefits for themselves and for their families, noting increasing confidence. One volunteer referred to an increased sense of acceptance:

‘It’s just really ... I just found it really rewarding. I wanted to give something back to the community really and I feel that I have done that. Um. It’s kind of made me feel accepted in a way’ (Volunteer befriender #11)

Discussion

The findings of this research suggest that the PSP was serving a population of women with complex needs (ie, no-wage households, single parents and child protection issues, in addition to the presenting problems of perinatal anxiety and/or depression). In addition, it is filling a significant gap in existing provision for women experiencing perinatal mental health problems.

A wide range of practitioners referred women to the PSP, including social workers, midwives, health visitors and a perinatal mental health service seeking input for women discharged from the service but still in need of further, less intensive support. Referrers to the service identified high levels of unmet need in their local populations and were appreciative of the opportunity to refer women to a service such as the PSP. Evidence of effective partnership working between the voluntary and statutory sectors emerged, including effective information sharing and

Key points

- The impact of perinatal mental health problems are well documented in terms of the long-term consequences for the infant
- The Family Action Perinatal Support Project (PSP) provides a volunteer befriending service which shows promising results in improving outcomes for infants and their parents
- The PSP appears to fill a gap in service provision for women with mild to moderate ante and post natal depression
- The PSP was welcomed by health visitors, midwives and other referrers to the service
- Service users, referrers and providers rated the PSP highly and identified a range of benefits for service recipients and for volunteer befrienders

the conduct of joint assessments.

The results of the quantitative data from around a third of participating women were suggestive of significant improvements in anxiety and depression, self-esteem and warm feelings towards the baby. These results were reflected in the users' reports of the service, which were unreservedly unanimous in their praise of the PSP, described by some as being 'life-changing'.

The holistic and flexible nature of the support on offer was highly valued and the data suggest that following involvement with the PSP, service users were able to access a variety of services, including opportunities for socialising with other mothers and infants (parent support), in addition to opportunities for learning ways of promoting their infants wellbeing (parenting support).

All stakeholders who were interviewed rated the PSP very highly and identified a range of benefits for both service recipients and volunteer providers. However, few midwives referred women during the antenatal period and, given the evidence about the impact of chronic anxiety and depression during pregnancy, there would appear to be scope for greater use of such services by midwives who identify women in need of additional support during pregnancy.

The PSP was intended to support women during the perinatal period but most referrals were of women experiencing postnatal problems. Research shows that antenatal anxiety and depression are common and have a significant deleterious impact on the infant (see background for further detail), and there would, as such, appear to be further scope for the PSP to engage in more preventive work by offering support to more women during the antenatal period.

This would require the PSP to target midwives and health visitors who are now conducting the antenatal promotional interview at 28 weeks of pregnancy as part of the Healthy Child Programme. Intervention during this period would enable the PSP to offer opportunities for more sustained support (ie, over a longer period) that would not only be aimed at addressing the women's mental state, but could also focus on promoting the relationship with the baby.

Limitations

The PSP was piloted in a number of areas and this service evaluation was the first step in the evaluation process. As such, there was

no control group and we cannot be sure that the changes that were identified would have occurred without the benefit of the intervention (ie, regression to the mean).

In addition, it was only possible to collect data from one-third of the women who received the service. This occurred because many volunteers only managed to collect data at one time-point (ie, baseline or post-intervention). However, we cannot be confident that the women for whom there was no data available at both time-points were not in some way still anxious or depressed. Consequently, these findings should be treated with caution.

Conclusion

The qualitative data suggest that the women accessing this service had complex needs, in addition to the presenting problems of anxiety and depression. Outcome data for a third of the women who received the service showed promising results, with improvements across all measures. There would appear to be further scope for the PSP to work with service users in the antenatal period where the impact may be even greater. This would involve a shift in emphasis in terms of referring agencies, particularly midwives and health visitors.

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