Briefing: Maternal mental health workshop April 2023

Background

This briefing gives an overview of conversations from a workshop on 26th April 2023 led by Ways to Wellness with support from colleagues at the NIHR Applied Research Collaboration (ARC) North East and North Cumbria (NENC) and the Perinatal Mental Health Clinical Network.

This was the second workshop Ways to Wellness have facilitated and there was healthy appetite for these sessions to carry forward quarterly. Chaired by Professor Chris Drinkwater the afternoon brought together colleagues to review the interim evaluation of the Ways to Wellness-hosted VCSE Maternal Mental Health Services project[i] and explore three themed areas as outlined below.

Ways to Wellness Interim Evaluation of VCSE Maternal Mental Health Services Project

Slides as presented by Ang Broadbridge, Project Manager for the VCSE MMHS project at Ways to Wellness are now available to read here.

Breakout group notes - key points from three breakout spaces

1) **Support for younger parents:**

- Becoming a parent as a significant transition – younger parents may want to come back into the process at a later stage: need to plan for a longer term *in/out* approach.
- All information provided must be understandable to the population base: noted that the average reading age in some areas is 11 years old.
- Be mindful of casual interactions, participants referenced cases where remarks about their age eroded trust with services – example of 'you're young!' being how one young parent was greeted. Some professionals' starting point is that being a young parent is a 'bad thing' and they are 'rubbish parents' – *stigma.* Important to acknowledge the efforts parents make and the barriers they face.
- Younger parents may not be used to speaking out, and support from the link worker might be well framed around building up their confidence. Younger parents may be particularly concerned about attracting the attention of the social services (linked to stigma ref. above).
- Participants who work regularly with younger parents said that group activities can be effective in smaller groups and where activities are selected according to the interests of young people – eg gaming. Face-to-face, across a table and making eye contact doesn't suit everyone: go for a drive or walk instead.
- Breastfeeding: this not a priority for some mums, even if there are financial benefits. Need to address the other issues which inform the choice whether or not to breastfeed. Influence of social media on the choice – eg Tik Tok – some mothers comparing themselves (negatively) with influencers.
- Noted that because it is usually a mother who registers the baby via the GP, young dads can be 'invisible' within the services. Feedback on support for Dads: Dads who only saw their children at weekends didn't want to give up that time to attend sessions: this didn't mean they weren't interested: different priorities, different service hours needed.

- Demand has increased post-Covid as other safety nets have been withdrawn: notion of people being *forced to engage*.
- Difficult to identify good sources of authoritative information on the Web: problem of information overload and misinformation.
- A question: What is the socially expected age at which to become a parent? Differs between groups – eg mothers in the Roma community tend to be younger.

2) Rural and remote experiences:

We have two prototypes working in rural communities: one in North Northumberland and one in North Cumbria. Our learning community have referenced a range of challenges for Mums experiencing rural isolation and associated challenges of remote living and access to support and services.

Key points from group discussions:

- Remote rural distinction – rural does not mean remote, not isolated, still connected – pubs, village shop. Remote – not connected, geographically isolated.
- A reminder to not forget coastal - rural, urban – all are v different. Value of place-based prototyping to explore needs.
- Multiple challenges related to living in remote settings some participants were surprised by - discussion surfaced challenges around it being time consuming to upkeep and live in an off grid home, and things that were previously more manageable become more challenging with a young family; the cost to run generators, cost to get connected to grid also raised.
- Resource and capacity needs to reflect area – satellite services operating with main hub. Challenge of scheduling / access to as many families/patients as possible in rural areas.
- Engagement methods need to reflect the community - requires collaboration and creativity. Links to other services; lone working potential issue in rural/remote areas; joint home visits – this could support practitioners. Several groups discussed transport as a way of delivering services i.e. library bus approach, outreach to access communities.
- Travel costs can impact on the social supports a family has in place – family may wish to offer support but travel can also be costly for them, friends and supports. Isolation - longer car/travel journey impacts on decisions about whether go out at all. Q. about whether funding/funders take account of rural need - is disadvantage understood, is it visible?
- People feeling they belong to specific local area – communication between all parties recognizing the individuality of areas.
- Home visiting post-covid had become much more of an issue. Getting clients to confirm they will be in before setting off for a distant visit and doing joint visits with Midwives/ Health Visitors probably needs to be explored.
- Diversity - Noted that in rural areas this concept ought to extend to include occupational groups – eg farmers and people working in fishing industries.

3) Learning community approaches and developing place-based evidence base:

- Prototypes have worked with fewer people than originally planned, partly due to time taken to introduce very new roles to the system, but that is also the nature of the levels of need and complexity we are encountering. So, for example, not sticking to allowing 6 sessions only, but offering ongoing support as needed.
- This project is universal and through outreach has supported people who are less likely to access other/clinical services, so it naturally addresses inequality.

- The trust between the person and the link worker is key.
- Link worker models have existed for some time, so are tried and tested. There are so many different social prescribing services – not necessarily duplication, as often targeting specific areas. Having 'generalist' link workers is good, but so is having specialists in the mix. Issue is that they keep being restarted and reinvented, this project needs to *build on previous.*
- We would expect this work to lead to reductions in 'use of' other services, but actually it can sometimes lead to increases in engagement with other services – this is a good outcome for families, but doesn't necessarily lead to savings in costs for health services.
- From the evaluation, the flexibility and badging of link worker role is important for women to engage and be honest about struggles without fear. The complexity of need this project is dealing with is like an iceberg! A person may get referred for one problem, but we soon uncover 15 problems. Mental/emotional health, housing & finances, relationships.
- 'Outcome Star' is quality control system which also supports the link workers.
- Health visitors have a good understanding of what the health inequalities are – this project could work in partnership with Health Visitors. But, health visitor services are being cut.
- What do we put forward as the strong argument about why we should keep this service and how it supports the services around the table? Does this go back to our original aims – what would the outcome for the family be without our intervention? Risk reduction? Long term tracking of family? Map out engagement increases in community and in other services. NECS can track service users after link worker support - other services have used this.
- To go forward, this project needs to be integrated and part of the 'whole system' – so it needs to demonstrate its impact across the whole system.
- Sunderland project has referrals that come in from S. Tyneside, which they can't take as not part of prototype – link workers see first-hand the impact between 2 comparable experiences.
- Could NHS be more innovative in their staffing/roles of staff. This could enable closer working with the VCSE, building trust - if women are struggling, they may need 'people' support, not 'service' involvement. Accessing this type of support can increase confidence to access clinical support effectively. Q - How do we support MWs to poverty proof?
- Discussion about prevention and early intervention, and agreement that we can pick up some need antenatally, but even in this group there can be individuals who surprise us – those for whom once the baby arrives their anxiety disappears and they seem to adjust well, and the other group are the individuals who 'seem to fall apart' once baby arrives. Suggestion about locating link workers in Family Hubs in 20% most disadvantaged areas.
- How do we report as a system, our impact and wider ramifications?

Next steps:

- We look forward to continuing these conversations throughout 2023 and we would like to invite you to join us for a follow up event in September (date TBA) - **if you haven't attended a previous event and would like to be sent information to sign up, please email ang.broadbridge@waystowellness.org.uk**

[i] The 'VCSE Maternal Mental Health Services Project' is led by Ways to Wellness, in partnership with the NHS, Voluntary Community and Social Enterprise sector (VCSE) organisations and Maternity Voices Partnerships. Funding is provided by the North East and North Cumbria Mental Health ICS and Perinatal Mental Health Clinical Network team, as part of the NHS England Maternal Mental Health Fast Follower programme.