

Peer Support in Perinatal Mental Health: Review of Evidence and Provision in Scotland (Internship Project Report)

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October 2020

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1. Introduction

This report provides information on research and evidence about perinatal peer support, existing practice in Scotland and potential areas for future development¹.

1.1 Background

Estimates suggest that around 20% of mothers (Prevatt et al., 2018; Geller et al., 2018) and up to 10% of fathers (Cameron et al., 2016) experience poor mental health in the perinatal period. This experience will range from mild to moderate mental health difficulties to more severe and enduring mental illness, and evidence suggests that vulnerable populations are disproportionately affected (Scottish Government, 2017b). Death by suicide remains the leading cause of maternal death in the year following the end of pregnancy (Knight et al., 2018).

The Scottish Government is aiming to improve the recognition and treatment of perinatal mental health difficulties, through commitments in both the Mental Health Strategy 2017-2027 (2017a) and the Programme for Government 2018-2019 and 2019-20 (2018; 2019b). In March 2019, the First Minister announced £50 million of investment for perinatal and infant mental health services over 4 years. The Perinatal and Infant Mental Health Programme Board is guiding the investment of this additional investment based on the recent perinatal and infant mental health Delivering Effective Services Report (Scottish Government, 2019a).

The Delivering Effective Services Report on perinatal and infant mental health services across Scotland made the recommendation to enhance access to peer support as part of a wider range of services for women, infants, partners and families in the perinatal period. Peer support ranges from support groups with other parents, to volunteer befriending and peer workers in inpatient settings. Ministers have accepted the recommendations from the Report and are working towards enhancing peer support for women and families during pregnancy and after birth.

1.2 Aims

The aim of this research is to review the evidence base for peer support in perinatal mental health by responding to the following questions:

- What evidence is there on the effectiveness of peer support in the perinatal period?
- In Scotland, what models of perinatal peer support can be identified using currently available evidence?
- What evaluation evidence exists on the effectiveness of current models of peer support in Scotland?

¹ This report reflects the pre-COVID situation. The project on which this report is based was undertaken in October – December 2019. Due to the COVID-19 pandemic the service landscape is likely to have changed in terms of both the availability and modes of delivery of peer support.

- Based on the above evidence, what may be the best ways to develop peer support models in perinatal mental health in Scotland?

1.3 Methodology

This research was based on two different methods: a rapid literature review and primary data collection on perinatal peer support services available in Scotland.

A range of search terms were developed for the literature review, covering the fields of peer support and perinatal mental health. Database and website searches were carried out for peer-reviewed academic literature, third sector and government literature.² Additional relevant evidence was collected through contact with stakeholders. Due to limited Scottish specific evidence the search was expanded to include the rest of the UK and international evidence. The specific focus was on Europe, North America and Australasia, as these were perceived to be more comparable with UK due to healthcare systems and income distribution. The report is based on a rapid review of the literature, rather than using systematic review methodologies. A total of 122 journal articles, evaluation reports and other resources inform this report.

To develop a picture of perinatal mental health peer support services in Scotland, a list of 112 relevant stakeholders was developed, with input from subject experts. Through desk based research and email contact, the researcher identified 53 organisations that offered peer support for parents in the perinatal period. Twenty-two organisations provided further information, either by responding to a short questionnaire about peer support provision (n=16) or providing free-text comments (n=6). Organisations who represent specialist services or marginalised groups (e.g. support for fathers, ethnic minority groups, school-age parents and bereaved parents) were among those contacted, to ensure that their perspectives were taken into account. This information was collated and synthesised with the literature on peer support to inform section 3 of this report.

1.4 Definitions

For the purposes of this report, the perinatal period is defined as the period from conception, through pregnancy and up to one year after birth.

Peer support has no fixed definition, but commonly has the following characteristics: people who have experienced adversity offering support, hope and encouragement to those in a similar situation (Jones et al., 2014). The activities of peer supporters vary widely, but the 'peer principle' (Mead and MacNeil, 2006) is that peer supporters have an equal relationship with the person they are supporting and an affiliation based on similar life experiences. Peer support can be paid or voluntary. The most significant aspects are that the support is delivered by a non-professional with a shared experience.

² For a full list of search terms, the databases searched and results, see Annex 1.

2. Literature on Peer Support in Perinatal Mental Health

2.1 Overview of the evidence base

Peer-reviewed literature examining the impact of peer support in the perinatal period is limited. The peer-reviewed evidence is mainly comprised of articles from England and North America. None of the peer reviewed literature returned in the search focused on Scotland.

The wider research evidence includes large scale quantitative studies of telephone based-peer support and generally smaller qualitative studies of face-to-face peer support. Third sector evaluations tend to focus on pilot projects or small numbers of clients. The research base in Scotland is comprised of third sector evaluations. A significant proportion of the evaluation literature of peer support in the perinatal period found in the search comes from rural Pakistan and India (Sikander et al., 2015; Atif et al., 2017). However, this evidence was not included in the literature review because the social, economic and health context is not comparable to the UK. Therefore.

The literature shows general positive effects, with some studies showing mixed outcomes. However, the particular mechanisms which effect the positive impact of peer support are not identified or tested robustly in the literature.

The evidence supports the effectiveness of peer support in reducing social isolation and improving self-esteem and parenting self-efficacy for new mothers. Many studies also demonstrate a reduction in depressive symptoms for mothers and an increase in social contact outside the home.

The literature makes only passing comment on the situation of women from marginalised groups. The distinct challenges for women from ethnic minority backgrounds, women with disabilities, women living in isolated geographical areas or those women whose religious or cultural beliefs may make it difficult for them to access support are not well represented. No studies were found that evaluated peer support for fathers or other caregivers. In addition, peer support for women who experience miscarriage or baby loss is not represented in the literature.

Overall, the literature review suggested that evaluation of perinatal peer support is at an early stage in Scotland. Third sector perinatal peer support services would benefit from integrating evaluation into their service to offer a robust evidence base for their work and to expand knowledge of what works and doesn't work in the sector.

The results of the literature search are presented thematically below, across six headings; (1) acceptability of peer support, (2) training and matching volunteers and clients, (3) social support and reducing social isolation, (4) improving self-esteem and self-efficacy, (5) reduction of depressive symptoms, (6) impact on peer supporters.

2.2 Acceptability of peer support

The acceptability of peer support to mothers is well evidenced across the literature base. Studies evaluating telephone based and face to face peer support found a high level of satisfaction and positive feeling toward peer support among mothers. In a pilot randomised controlled trial of telephone-based peer support in Canada, Dennis (2003) found a high level of maternal satisfaction with and acceptance of the service. In a later study examining the perceptions of mothers who received telephone-based peer support as a preventative strategy for postpartum depression Dennis (2010) found that the majority of the mothers viewed their experience as positive. A more recent small scale quasi-experimental study also in Canada (n=64) found that telephone-based peer support is acceptable to mothers and effective for both early postpartum depression and maternal depression up to two years after delivery (Letourneau et al., 2015).

While most studies demonstrated that women accept and feel positive about peer support, there are indications that peer support may be especially helpful to women who feel stigmatised, are socially isolated or in high-stress circumstances. In their study conducted in England, Fogarty and Kingswell (2002) found that telephone based and face to face peer support was most welcomed by women who were new to the area and especially valuable to women involved in or leaving, an abusive relationship.

Stigma was also a significant factor impacting on the acceptability of peer support services for women. Letourneau et al. (2007) conducted 52 semi-structured interviews with women in Canada who had experienced postnatal depression. Stigma surrounding postnatal depression, both self-stigma and feeling stigmatised by external experiences, was identified as the main barrier to seeking support. Women identified that a combination of one-to-one peer support in your home and the option of attending a peer support group would be the most effective way to support women to overcome the stigma surrounding postnatal mental illness and seek help. Participants also suggested that peer support could reduce stigma by increasing knowledge of the symptoms of postnatal depression for their families and friends. Peer support was particularly valuable for counteracting stigma, as the peer volunteers modelled openness and honesty about their experiences, demonstrating that poor perinatal mental health was nothing to be ashamed of.

Deprived socioeconomic circumstances may challenge women's engagement with peer support. Murphy et al. (2008) conducted a qualitative interview study with peer supporters and women receiving face to face, home based support in Northern Ireland. While many women appreciated the support and sharing of experiences by peer supporters, relationships were difficult to initiate and maintain, which negatively affected the morale of peer supporters. The study was conducted in a highly deprived area, and it seems that the challenging circumstances of some women's lives led to them engaging inconsistently with the support or disengaging entirely. This result was echoed in a recent evaluation of the National Childbirth Trust's (NCT) *Parents in Mind* programme (MacLeish and Hann, 2019) *Parents in Mind* was trialled

over three sites in England, and the most highly deprived location experienced low referral numbers and inconsistent engagement, especially for support groups.

Another indicator of acceptability appears to be that an equal power balance is key to successful peer support. In Canada, a study evaluating home based peer support for mothers found no significant treatment effects after a 12-week support programme featuring maternal-infant interaction teaching by peer volunteers. The authors concluded that maternal–infant interaction teaching by peers is not well received by mothers with postnatal depression and that the service would be better delivered by professionals (Letourneau et al., 2011). It seems that while support and validation from a peer is beneficial, using peer volunteers to give advice or deliver training diminishes the benefits of the peer role.

2.3 Training and matching peer volunteers and clients

Adequate training for peer supporters is vital, whether employed as a peer worker or working as a volunteer. Several papers reference how the training process and careful matching of peers and clients contributes to the success and sustainability of peer support programmes. In their review of the perinatal peer support literature, Letourneau and Leger (2015) identified six studies, three conducted in Canada (Dennis, 2003; Dennis et al., 2009; Dennis, 2010), two in England (Fogarty and Kingswell, 2002; Barnes et al., 2009) and one on Ireland (Murphy et al., 2008). Overall, Letourneau and Leger found that adequate training of volunteers and matching of peer volunteers with mothers is important. They also emphasise ensuring that support is meeting the needs of mothers and families by seeking their input. Dennis (2010) also found that paying close attention to the matching of volunteers and mothers and training for volunteers would be likely to benefit the development of a supportive relationship.

The importance of training has also been highlighted by third sector reports. All of the volunteers taking part in NCT's *Parents in Mind* programme rated their 8 week training programme as good or excellent, however after starting to volunteer many peers expressed that they did not feel the training had prepared them sufficiently for the reality of the work (MacLeish and Hann, 2019). An evaluation of a Home Start project in North Glasgow providing perinatal peer support reported that after completing an 8 week training course and starting to work with clients, peer volunteers requested additional training on specialist areas, such working with refugees and asylum seekers (Heywood et al., 2016). Similarly, in their evaluation of the Family Action Perinatal Support Project, Barlow and Coe (2012) found that robust training was an essential part of establishing safe practice, and after the initial 6 week training volunteers also requested additional training on issues such as domestic violence. The Family Action model was adapted and expanded by Scottish charity Aberlour, in the development of their Perinatal Befriending Support Service.

Evidence from peer reviewed and third sector literature suggests that robust training which responds to the needs of peer volunteers is a key factor in the success and sustainability of peer support work. Appropriate and timely clinical supervision for peers is also essential to maintain safe and high quality support for mothers and

babies. This is also reflected later in Section 3 on current models of peer support in Scotland.

2.4 Improving self-esteem and self-efficacy

Peer support has been shown to enhance self-esteem and self-efficacy for mothers across a range of studies. Several dimensions of this effect are demonstrated, increased self-esteem, enhanced parenting self-efficacy and positivity toward their parenting role. A pilot study with mothers who took part in a six week programme of peer support with volunteer supporters reported increased self-esteem and positivity towards their parenting role (Cust, 2016). The most recent qualitative study based in England, Mugweni et al. (2019), interviewed 14 women and gathered pre-post outcomes data from 123 women. Mothers reported that the peer-befriending service enhanced their sense of self-efficacy as parents. Several further studies conducted in England and one in Northern Ireland offer the closest site for comparison with Scotland, and suggest that peer-support programmes have demonstrated an improvement in parenting self-efficacy for mothers (McLeish and Redshaw, 2015; Mugweni et al., 2019).

In addition to enhancing self-esteem, self-efficacy and parental warmth, research suggests that peer support may offer additional benefits to women who are from an ethnic minority background, recent migrants and women experiencing multiple disadvantages. McLeish and Redshaw (2017) conducted a qualitative study, using semi-structured interviews with 47 women to describe the experience of organised peer support in the perinatal period. This study recruited participants from 10 different perinatal peer-support projects across England, finding overall that peer support helped the women to feel less isolated and more empowered as parents, increasing their sense of self-esteem and self-efficacy. The authors found that peer support can be especially positive and impactful for women who are recent migrants without any social support network, women who have a cultural or religious background where mental health problems are taboo, or those who are very isolated for other reasons, for example by having controlling and critical partners.

2.5 Social support and reducing social isolation

One of the strongest themes in the literature was the impact of peer support in providing social support and reducing social isolation. Lack of social support is a major risk factor for perinatal mental health problems, and several studies report that women link the onset of their poor perinatal mental health with the loss of social support. Mauthner (1995) used semi-structured interviews with mothers in England who experienced postnatal depression and had accessed peer support, finding that the extent and nature of the mothers' relationships with other mothers are closely linked to mothers' own feelings of psychological and emotional well-being. The study suggests that social withdrawal from peers was associated with the onset of postnatal depression. Interviewees also linked their journeys out of postnatal depression with the renewal of contact with other mothers. Mauthner suggest that befriending approaches and support groups may harness the impact of this effect in a valuable way.

In another study, Montgomery et al. (2012) gathered data to describe Canadian women's experience of a peer support group. Women expressed that 'Peers validated that mothering in illness "is very difficult"' and described attending peer support groups as a safe environment, providing recognition and support for each other's growth as capable mothers in challenging circumstances. The authors identify this process of seeking support and sharing suffering and wisdom with peers as part of the women's path to recovery from their postnatal depression. Qualitative data from interviews and focus groups conducted by Cheyne et al (2016) reports that a Scottish befriending service was effective in helping mothers to gain confidence, both as parents and to take part in activities outside of the home. Increased social contact is a significant step towards recovery for many women experiencing perinatal mental health problems.

It seems that the impact of social isolation could be even more powerful than socioeconomic deprivation. Raymond (2009) conducted semi-structured interviews with women in England from highly disadvantaged backgrounds. While many experienced poverty, cramped living conditions and chronic unemployment, emotional isolation resulting from a lack of social support was the most problematic issue for the women. The women expressed that social support and contact with other women in their situation would have been hugely helpful for them, with several participants offering to provide peer support to other pregnant women as a result of their experience of feeling unsupported.

One of the major advantages of peer support is the bridge that it offers to social activities outside the home. McLeish and Redshaw (2017) reviewed 10 different perinatal peer-support projects across England and found that women were less socially isolated after receiving peer support and more likely to participate in activities outside the home. In a recent English study Mugweni et al (2019) found that mothers reported that peer support helped them to attend activities outside the home, for example a peer-support group which mothers described as 'invaluable'.

Peer support groups can be especially supportive as many women report that those close to them don't understand their situation. In Canada, Letourneau (2007) reported that many women are discouraged from seeking support from family and friends, who can be keen to normalise or minimise their difficulties. In their meta-ethnography, Jones et al. (2014) identify five qualitative studies examining the role of peer support in acting as a protective factor against mental ill health in the perinatal period. Women experienced peer support as particularly helpful as people close to them often had limited understanding of postnatal depression, and so their ability to offer effective support was also limited in the perception of the mothers.

The fact that peers are people who are not part of your existing social network is also significant. Tammentie et al. (2004) interviewed Finnish mothers and fathers experiencing postnatal mental health difficulties about social support. Mothers reported that peer support groups were an important source of support, especially if they were organised by a third sector organisation and with mothers they did not know before pregnancy. This was distinct from peer support from friends, as discussing their situation with friends who were mothers led to comparison and

inhibited mothers' ability to be open about their difficulties. One mother described the peer support group like this:

'You get to hear that everybody has the same problems, that we are not the only ones who have failed, mothers talk about their lives and it felt like they were talking about my life.'

Peer support reduces social isolation by providing direct social support, and by offering support with social activities outside the home. Social isolation is identified as the central difficulty for women even when they are experiencing other challenges, for example poverty and unemployment. Peer support is especially valued as peers are likely to validate and accept the experiences of the mother, not minimise them.

2.6 Reduction of depressive symptoms

Many studies use measures such as the Edinburgh Postnatal Depression Scale (EPDS) to record any measurable change in depressive symptoms after engagement with peer support. This offers a range of data demonstrating that peer support is linked to a reduction in depressive symptoms, including one large scale randomised controlled trial. A Canadian multisite randomised controlled trial (n=701) found that telephone based peer-support provided by trained volunteers soon after the birth was effective at preventing postnatal depression in women identified as high risk (Dennis et al., 2009). This study showed that women who had been supported had significantly lower scores on the EPDS than women in the control group who had not received support.

There is limited evidence of the reduction in depressive symptoms in Scottish research. An evaluation of the Aberlour Perinatal Befriending Service in the Forth Valley and East Lothian area was conducted with the University of Stirling (Cheyne et al., 2016). This was a mixed-method study using the Hospital Anxiety Depression Scale to measure depressive symptoms (n=14). The evaluation found that the outcome measures reflected a trend toward lower levels of anxiety and depression and increased warmth among the supported mothers, however the very low sample size means this data should be interpreted with caution.

Fogarty and Kingswell (2002) reviewed the effectiveness of a programme of telephone based and face to face support in England. The service, 'Pals in Pregnancy' supported vulnerable women via trained, paid peer workers. A significant reduction in EPDS scores was shown in 71% of women who took part, and women expressed that they found the listening skills of the peer workers beneficial. A pilot study in England with 30 mothers supported by untrained volunteer peer support volunteers found a six week programme of support delivered a significant reduction in EPDS scores over a 6 month period (Cust, 2016). In contrast, an evaluation of the impact of peer volunteers in England conducted by Barnes (2009) showed no link between peer support and a reduction in EPDS scores over the first year of the child's life.

Internationally, Prevatt et al. (2018) examined the impact of a peer-led support group in the US, finding that the support of other mothers could help women adapt to their new role and reduce the impact of stigma. The pre-post outcome measures in this study showed a significant reduction in EPDS scores, although participants who had experienced birth complications or an unplanned Caesarean-section showed less improvement than those who had not. In the only study identified looking at digital peer support, participants recruited from the US trialled the use of 7 Cups of Tea (7Cups), a digital platform that delivers self-help tools and 24/7 emotional support through trained volunteers (Baumel et al. 2018). 7Cups is an additional treatment for mothers diagnosed with postnatal depression and includes self-help tools and chats with trained volunteers who had experienced a perinatal mood disorder in their past. Participants experienced a significant decrease in scores on the EPDS. The authors suggest that access to a peer support service of this type may be beneficial in improving treatment outcomes for women with perinatal mental health problems and especially those who may find other forms of support inaccessible.

Overall evidence from studies in the UK and North America demonstrates a reduction in scores for women on the Edinburgh Postnatal Depression Scale when they engage with peer support in various forms, online (Baumel et al., 2018) telephone based (Dennis, 2003) peer support groups (Prevatt et al., 2018) or one-to-one peer support (Fogarty and Kingswell, 2002). This is one of the clearest themes of the literature review.

2.7 Impact of peer support on peer supporters

The NCT's review of the Parents in Mind programme, trialled across 3 sites in England, offers a well-developed logic model, theorising the positive and negative outcomes anticipated for peer volunteers. The model suggests that positive outcomes for peer supporters include increased knowledge, skills and confidence, satisfaction in helping others and increased recognition of their own continuing mental health challenges. Negative outcomes included feeling stress and sadness, feeling unprepared for the role, not feeling able to meet the level of need of the mother, worrying if mothers do not 'get better' and being emotionally triggered by their role to be affected by their own difficult perinatal experiences (MacLeish and Hann, 2019).

The peer reviewed literature reflects these themes, although there is limited literature looking at the experience of peer supporters. Overall evidence suggests that the impact on peer supporters is generally positive. In a Canadian study, Letourneau and Leger (2015) returned mixed results on the efficacy of peer volunteers, but overall suggested that peer support can be rewarding for both those providing support and those receiving support. Also looking at peer support, but in relation to breastfeeding, Ingram (2013) used an online survey, interviews and focus groups to explore mothers' and professionals' experiences in England. The study found that psycho-social benefits for mothers, peer supporters and health professionals were associated with the provision of the breastfeeding peer support service. Continuity of visits with the same peer supporter from the antenatal to postnatal period was also found to be beneficial.

The urge to help and support other women seems to be the primary motivator for peers. In a study looking at the impact on peer volunteers working on a perinatal mental health helpline in Australia, Biggs et al (2019) found that volunteers in general were very motivated to make a difference and felt a strong desire to help others experiencing emotional distress.

There is also evidence of attitudinal change among peer volunteers over the course of providing peer support. In their qualitative pilot study of a volunteer peer support programme for mothers in England, Carter et al. (2018) found that peer support workers rejected the use of formal counselling approaches in favour of using their own experience and empathy as the basis for their supportive relationship. They found a transformation in the perceptions of peer volunteers, who at the outset of the project expressed a desire to 'help fix' the problems of women they were working with, and by the end of the project had come to see their role as more aligned non-judgemental support, rather than advice.

In addition to these shifts in perspective, studies suggest that peer volunteering can be a pathway into paid work for some women, with paid peer work or therapeutic training being the most common pathways into employment (Barlow and Coe, 2012; MacLeish and Hann, 2019).

3. Current models of peer support in Scotland

The literature review identified a range of peer support models in use internationally, covering peer workers in perinatal services, peer volunteers and befrienders, peer groups and online and telephone support. To identify which of these models are active in Scotland, the researcher contacted (via email) a range of stakeholders known to provide perinatal services (n=88). The email included an information sheet about the research project and respondents were asked to complete a short questionnaire about their support provision. Where there was no response via email, the researcher carried out online searches to identify if the organisation provided perinatal peer support and the nature of this support.

While this report on peer support has aimed to be as robust as possible, time constraints restricted the scope of the exercise and so the findings should be viewed as indicative rather than comprehensive.

3.1 Paid peer support workers

Paid peer support work in perinatal mental health is at a very early stage in Scotland. In Scotland, paid peer support workers in mental health services are mainly employed in the third sector, with some NHS general mental health services initiating peer support work more recently. When looking at perinatal mental health specifically, this review found no evidence of paid peer support workers in the NHS in Scotland. In the third sector, one organisation (Nurture the Borders) was identified employing paid staff with lived experience to provide peer support in the perinatal period (see box below).

In England, paid peer workers are present in perinatal services, including Mother and Baby Units (MBU) (see Annex 3). The research evidence from England shows that paid peer support workers can be effective in supporting women and over time depressive symptoms can be reduced (Fogarty and Kingswell, 2002) however, no evidence has been identified which can help to define the distinct differences between paid peer support workers and volunteer peer support workers.

Service Model – Paid peer support workers

Location: Nurture the Borders, based in the Scottish Borders.

Provision: Provides a range of support services including one-to-one support by Perinatal Support Officers, who are employed on the basis of both their skills in supporting parents and their experience as parents. Through their Cherish Project, Nurture the Borders' Perinatal Support Officers support women experiencing emotional or mental health challenges during the perinatal period. This support is individualised and recovery focused, and includes providing emotional support, modelling and mentoring, signposting and information sharing. Perinatal Support Officers support mums directly and also train and supervise volunteer befrienders.

Eligibility: Perinatal Support Officers work with women from pregnancy until the child turns one.

3.2 Peer support volunteers

Evidence from this review suggests that peer support volunteers or befrienders in perinatal mental health are a much larger group in Scotland than paid peer workers. Volunteer peer supporters in perinatal mental health deliver the majority of one-to-one perinatal peer support in Scotland. This trend reflects the literature review, where the majority of studies evaluate telephone-based and face-to-face peer support delivered by trained volunteers. Peer support volunteers will:

- offer emotional and practical support for parents and families.
- offer a chance to talk about difficulties to a non-judgemental fellow parent.
- help with practical everyday tasks and advice on day-to-day challenges like housing, benefits and how to support parents' mental health and children's development.

Peer support volunteers work in a range of voluntary organisations, from small local charities to national organisations. The organisations listed in the box below provide peer support through volunteers and befrienders in Scotland.

Large organisations like Home-Start and Aberlour offer support across wider geographical areas, and have the capacity to evaluate their services using measures with a larger client base. Smaller local voluntary organisations are vulnerable to changes in funding and often function due to the commitment of a few individuals.

Service model – Peer support volunteers

Location: Home Start Scotland, while not a perinatal specific service, offer the widest geographical coverage, with 31 regional Home-Start branches covering 63% of local authority areas in Scotland (Home Start Scotland, 2019). Central Scotland has the most coverage, as Aberlour's Perinatal Befriending Support service supports mothers in Forth Valley and East Lothian, and Juno Perinatal Mental Health Support a befriending service for mothers in Edinburgh. Nurture the Borders operate a befriending service for mothers in the Scottish Borders.

Provision: Home-Start, Aberlour, Juno and Nurture the Borders all offer support to women who are experiencing poor mental health in the perinatal period. Home-Start offer support to the whole family and often work with parents during the perinatal period (although their support is not solely focused on this). Home-Start, Aberlour and Nurture the Borders all provide volunteer befriending services to support women experiencing emotional or mental health challenges during the perinatal period. Juno offer befriending for mothers. Nurture the Borders also provide a befriender as a birth partner for women who find themselves without someone to fulfil that role.

Eligibility: All organisations support women in the perinatal period, however there are varied definitions of this period. Home-Start offer peer support to families with children under 5 or expectant parents. Aberlour support women antenatally and postnatally, with specified end point for support. Nurture the Borders support women through pregnancy and till the child is one year old. Juno identify the perinatal period as through pregnancy up until the child is two years old.

3.3 Peer support groups

Peer support groups feature prominently in the literature on perinatal peer support. Some groups are organised as part of wider perinatal services and some are individual volunteer led groups. With some variation, peer support groups tend to be informal and led by volunteers with experience of perinatal mental health difficulties. Some groups are facilitated by professionals, and some introduce creative activities for parents. Many groups offer play facilities for babies and young children while parents take part in the group, and some groups offer a free crèche onsite. Some groups badge their service as for mothers only, while others are badged as accessible for mothers, fathers and other family members.

Service model – Peer support groups

Location: Home-Start branches serve a wide-geographical area in Scotland. Most other peer support groups identified are concentrated in central Scotland. Blank Canvas, Quarriers Maternal Mental Wellbeing Service, 3D Drumchapel and Paisley Abbey's Talk it Over Group operate peer support groups in the West of Scotland. PANDAs run peer support groups across central Scotland. Juno run peer support groups in Edinburgh. Nurture Parents run peer support groups in Dundee, however their service is coming to an end due to lack of funding. It is likely that other groups run in community settings across Scotland, that were not identified in this review.

Provision:

- Home-Start branches across Scotland offer weekly peer-support groups to pregnant parents/parents with a child under the age of 5, staffed by Home-Start staff and volunteers.
- Juno run peer support groups for mothers across Edinburgh, led by volunteers with experience of perinatal mental health difficulties. Women are free to attend antenatally, postnatally and drop in and out of the group to meet their own needs.
- Blank Canvas run creative workshop groups in Lanarkshire for mothers affected by perinatal mental illness during pregnancy and postnatally. Workshops are delivered by mums with lived experience of perinatal mental health difficulties.
- Nurture Parents run peer support groups with peer volunteers in Dundee, however their service is coming to an end due to unavailability of accommodation and lack of funding.
- PANDAs run peer support groups across central Scotland for parents suffering from perinatal mental health issues.
- Paisley Abbey's Talk it Over Group offers a weekly peer support group for mothers suffering from postnatal depression in Paisley. Groups are run by volunteer health professionals and children are looked after in the free crèche onsite.
- Quarriers Maternal Mental Wellbeing Service runs an antenatal and two postnatal peer support groups for mothers as a wider programme of parenting support in North East Glasgow. Both groups have an onsite crèche and transport facilities.

- 3D Drumchapel run a weekly postnatal support group for new parents called Tea & Tots in Drumchapel, Glasgow. This group offers new parents and carers the opportunity to come along and meet other families, improve their confidence as a parent, and find out about opportunities, support, information and resources available for them and their baby. The group helps to build community support by fostering social networks.

Eligibility: Many peer groups are badged as accessible to new parents and other carers, however it is likely that the majority of attendees are mothers. Some groups are for mothers only, for example Blank Canvas, Juno and Paisley Abbey's Talk it Over Group.

3.4 Informal peer support (including online)

A range of informal perinatal peer support was identified, from facilitated drop-ins to online support groups:

- Café Stork – drop in group for parents and carers
- Dads Rock – dad specific groups with creative, music based activities
- Aberdeenshire PND Peer support – online support group
- Birth Trauma Association – online support group
- Lanarkshire PND Support and Awareness – online support group
- Pandas Online support – online support group
- PND and Me – online support group

As these groups are informal and mainly facilitated by parents with experience of perinatal mental health difficulties, little evaluation evidence is available. However, Café Stork, a drop-in group facilitated by Greater Glasgow and Clyde (GGC) Health Improvement Staff, evaluated their service with a small study using interviews and questionnaires (Nihsen, 2019). This found that parents felt they benefited from attending Café Stork and that peer support occurred across different ages, cultures and socioeconomic positions, with many participants stating that Café Stork improved their mental health. However language barriers proved to be a challenge and attendance from fathers and male caregivers was very low. It is likely that support groups for new parents are attended primarily by mothers, with some father-specific parenting groups developing to address this issue (e.g. Dads Rock).

3.5 Peer support in specialist perinatal mental health services

In Scotland, there is currently no peer support work within specialist perinatal mental health services, as far as this report could identify through desk-based research and consulting with the Lead Nurse and Lead Clinician for the [Perinatal Mental Health Network Scotland](#).

For an example of the integration of peer work into a Mother and Baby Unit service in England, please see the case study below and Annex 3 (developed through interviews with staff and consultation of key documents). This is an innovative

approach which could act as a model for promoting peer support in perinatal mental health in Scotland. However it should be noted that the case study is descriptive and not evaluative, or an indication of the quality of the service or organisation.

Service model – Peer support workers in specialist perinatal mental health services

Location: Jasmine Lodge Mother and Baby Unit (MBU), Devon Partnership NHS Trust, Exeter

Provision: Jasmine Lodge Mother and Baby Unit (MBU) is a specialist inpatient perinatal mental health unit for mothers and babies from 32 weeks of pregnancy up to one year after birth. Jasmine Lodge is an example of several MBU services in England who have recently incorporated peer work in perinatal inpatient services. The community perinatal mental health service has been operational for the last 10 years, and since inception has incorporated the experience of mums who have used the service. The focus on the involvement of peer workers is based on the clinical experience of staff, who recognise the benefits of peer work for mothers using the service.

3.6 Peer support for more marginalised groups

Organisations that represent the perspectives of more marginalised groups were asked for their perspectives on the provision of perinatal mental health peer support, and provided some information about the ways they felt peer support could be helpful in their sector.

Black, Asian and Minority Ethnic women

There are very few ethnic minority women's organisations providing perinatal peer support and they are in mainly urban, central Scotland. The Council of Ethnic Minority Voluntary Organisations (CEMVO), told us that ethnic minority women experience general difficulties accessing mainstream services due to a lack of awareness; cultural and language barriers; and non-sensitive or inappropriate services. Terminology is also important due to the stigma of mental health difficulties which can be particularly widespread among ethnic minority communities. They suggested that research was needed to identify the peer support needs of ethnic minority women and the barriers that they experience in seeking support. Existing models of support may not be appropriate as they are based on Western cultural and social models.

Refugee and asylum seeker women

The above issues are relevant in relation to the needs of refugee and asylum seeker women, who can often be isolated from family and experience language and cultural barriers in accessing perinatal support services. Based in Glasgow, Amma Birth Companions offer trauma-informed support to asylum-seeking and refugee women and those with insecure immigration status before, during and after the birth.

They also offer post-natal support and group activities that provide opportunities for friendships and integration for the women.

Drug and alcohol problems

Organisations such as Scottish Families Affected by Alcohol and Drugs and Addaction offer advice and support for women and their families affected by drug and alcohol problems, however the research did not identify any specific perinatal peer support services for women affected by alcohol and drug in the perinatal period.

Young parents

In Glasgow, based at Smithycroft Secondary School, the Young Parents Support Base offers a range of activities for school age parents that utilise a peer support approach. They offer antenatal work via Mellow Bumps' to support young parents to meet each other and share experiences. When the baby arrives, group work continues and the Young Parents Support Base offer support to young parents and families up to the age of 19 to give young parents opportunity to learn from their peers. This is designed to support young parents to re-engage with education, become successful learners and confident parents. This was the only example of a peer support approach for young parents identified in the research, however there may be other examples.

Baby loss and miscarriage

There are a range of specialist organisations working in Scotland who support parents experiencing baby loss and miscarriage³. Peer support from parents who have experienced baby loss and miscarriage is central to how many of these organisations work with parents.

Through engaging with stakeholders in this area, several significant issues were identified. Mothers who experience miscarriage or the death of a baby are often no longer meet eligibility requirements to be cared for within perinatal mental health services, but are experiencing poor mental health related to their pregnancy. Stakeholders also highlighted the importance of awareness around how baby loss and miscarriage can impact of further pregnancies, heightening the risk of poor mental health for mothers and families.

Fathers and partners

The review found no peer reviewed literature or third sector evaluations on perinatal peer support for fathers or other partners.

Research evidence suggests up to 10% of fathers experience depression during the perinatal period. Paternal depression is associated with lower satisfaction with parenting and poor emotional and behavioural outcomes for children (Cameron et

³ Through the course of this research we identified: Sands, Sands Lothian, Scottish Care & Information on Miscarriage (SCIM), Simba, Zaagi, Antenatal Results and Choices (ARC), Tommy's and Scottish Cot Death Trust.

al., 2016). Paternal depression is also closely associated with maternal depression, increasing the risks to children from exposure to two parents with depression (Foley et al., 2001).

To counter the negative outcomes associated with paternal perinatal depression, the provision of peer support could be beneficial for fathers in a similar way to mothers. Consultation with stakeholders who work to support the wellbeing of fathers (Fathers Network Scotland and Dads Rock) suggests that support for fathers in the perinatal period is desirable and would benefit fathers, mothers and infants.

4. Key findings

4.1 What evidence is there on the effectiveness of peer support in the perinatal period?

Evidence from the literature and responses from stakeholders demonstrate the benefits of a range of peer support models.

- Quantitative evidence shows that peer support can significantly reduce depressive symptoms for women experiencing postnatal depression.
- Qualitative evidence makes it clear that women experience improved self-efficacy, self-esteem and parenting confidence through peer support.
- Peer support directly reduces social isolation and can increase social activities outside the home for women experiencing perinatal mental health difficulties.
- There is also evidence that peer support can act as a bridge to build trust with clinical services.

A leading scholar in the field, Cindy-Lee Dennis (2009) summarises three ways peer support can be effective:

- a) Direct effect, where the peer support fulfils basic social needs or links clients with services that can meet those needs
- b) Buffering effect, where peer support helps protect clients from direct stress by bolstering coping mechanisms through additional resource
- c) Mediating effect, where peer support helps improve areas which have a protective effect for clients against direct stress.

To give an example of the mediating effect of perinatal peer support, Dennis suggests that support from peer volunteers may improve self-efficacy and social integration for women, enhancing their resilience to perinatal mental health difficulties (Dennis et al., 2009). Reviewing the evidence base on psychosocial interventions to treat perinatal depression, Dennis argues that there is the potential for peer support interventions to have beneficial effects for women with mild to moderate postnatal depression (Dennis, 2014). This is in the context of extensive research showing that 'a lack of social support is a significant predictor of postpartum depression.' (Dennis 2014).

What are the most effective forms of peer support?

It is clear that peer support in the form of peer workers, peer befrienders, peer groups or informal and online support, can be highly effective in supporting parents with perinatal mental health difficulties. Research evidence suggests that peer support:

- Builds parenting confidence and improves parenting self-efficacy for mothers/carers

- Reduces social isolation for mothers/carers and encourages them to form further social bonds
- Builds links between parent and other services, helping to develop trusting relationships
- Can reduce depressive symptoms as measured by the Edinburgh Postnatal Depression Scale
- Can be highly rewarding for both peer supporter and mother/carer when safe and appropriate

Research suggests that rather than one model of peer support being the most effective, different models of peer support serve different functions:

- **Individualised peer support** can be especially helpful for women who feel unable to take part in activities outside the home or who experience stigma or self-stigma, as they are not required to share with a group. It also seems to be helpful for women from disadvantaged backgrounds who are less likely to attend groups regularly.
- **Group support** is helpful in reducing isolation and forming more social bonds, for women who feel able to attend. Group support seems to help normalise the experience of mental health difficulties in the perinatal period and reduce stigma. Some studies suggest that women who are from less disadvantaged backgrounds are more likely to regularly attend peer support groups.
- **Telephone based or online support** seems to be especially useful for women who may find it hard to access other forms of peer support, due to geographical isolation, lack of other peer support options or other restrictions. The benefits of this kind of support seem to be flexibility, accessibility and autonomy for women with how they engage with support.

What does the evidence tell us about potential challenges and barriers?

The evidence indicates a number of potential challenges in the provision of perinatal peer support, which are summarised below.

Appropriate referrals

Peer support is suitable for women with mild to moderate mental health difficulties and can help prevent the worsening of their symptoms. Inappropriate referrals may occur due to a lack of other perinatal mental health support, leading to women being referred or self-referring into peer support services who require more intensive support.

Peer support is not a substitute for appropriate clinical treatment for severe perinatal mental illness, although it can provide complementary support. Severe perinatal mental illness requires more intensive, professional support or referral to formal counselling or psychological supports (). Ensuring clarity in service provision and

sharing referral criteria for peer support widely could help to ensure referrals are appropriate and safe (Heywood et al., 2016).

Preparation and supervision

Training and supervision for peer workers (whether paid or voluntary) is important. Insufficient training can mean that practice is variable in quality and may be ineffective or unhelpful. In rare cases this may lead to practice being harmful rather than helpful, for example, mothers feeling that their problems were being 'minimised' when the peer workers were simply trying to normalise the experiences the women were going through. Insufficient supervision can lead to similar issues with quality and reliability of support, and also may leave peer workers vulnerable to burnout or re-traumatisation.

Ensuring that the wider staff team are ready to work alongside peer support workers is also important. Conflict between the expectations of peer staff and non-peer staff can make it difficult for peer workers to integrate into the team. If existing staff do not have a recovery focus, or have not been trained and supported to embrace peer working, it is possible that peer workers might not be welcomed.

Clear role boundaries

Role conflicts and confusion about who is doing what and why can make it difficult for clinical staff and peers to work together. Clear job descriptions and proactive steps to integrate peers into the wider staff team can help to mitigate this difficulty.

Evidence suggests that women prefer to receive advice or training from professional clinical staff, and that when peers are asked to provide training to mothers this can be less effective. Letourneau et al (2011) found that when peer volunteers delivered a maternal–infant interaction intervention, this was not well received by the mothers and would have been better delivered by clinical staff. This is reflected in the Perinatal Peer Support Principles, suggesting that peer work is highly valued as distinct from the work of clinical staff.

Accessibility of services

In the course of researching this report, several barriers to accessing peer support were identified which may prevent parents from getting the help they need:

- Minority ethnic groups experience additional difficulties in accessing peer support, including language difficulties, and cultural and religious beliefs which may stigmatise seeking support for mental health difficulties. A Home-Start evaluation in north Glasgow identified language and cultural barriers as a key difficulty in supporting mothers (Heywood et al., 2016).
- Rural isolation, transport difficulties and a lack of local infrastructure can make it difficult for some women to access peer support, especially outside of the central belt of Scotland.
- Disabilities or health problems may make accessing peer support difficult, either through lack of accessible peer support or through stigma or discrimination.

- Fathers or partners are likely to experience the absence of peer support, with many perinatal peer support services only available for mothers. It is also likely that fathers and partners may experience additional stigmatisation in relation to perinatal mental health difficulties and this may mean they are less likely to seek support.
- Socioeconomic disadvantage is likely to prevent families from accessing peer support services which require any additional cost, such as the cost of transport to attend support groups, or paying for childcare to attend a group.

4.2 What models of perinatal peer support can be identified in Scotland?

This report identified 53 organisations in Scotland who provide peer support for parents in the perinatal period. These included paid peer workers (the smallest number), volunteer befrienders, peer support groups, and online and email peer support. These organisations are overwhelmingly based in the central belt of Scotland, suggesting less provision for women living in rural or remote areas.

4.3 What evaluation evidence exists on the effectiveness of current models of peer support in Scotland?

Very limited evidence exists to evaluate the efficacy of perinatal peer support models in Scotland. Nurture the Borders use pre and post measures to evaluate their service, which includes paid peer work, however current numbers are still quite low (Nurture the Borders 2019). Aberlour, Home-Start and Nurture the Borders have conducted their own evaluations of their volunteer perinatal peer support. These evaluations have returned positive feedback on the services, however the sample sizes are too low in these studies to offer robust evidence on the efficacy of the support services. Quarriers evaluated their perinatal peer-support groups, however experienced very low response rates. Several of these evaluations were conducted with external academic partners, and show strong commitment to robust evaluation by the services involved. However, limited numbers, limited resources and low response rates among clients are currently curtailing the extent of evaluation activity in perinatal peer support in Scotland.

Cost effectiveness

Overall, there is a lack of data to evaluate if peer support offers a cost saving overall by supporting women and families and diverting them from requiring more intensive support later. This review found two examples from Scotland of economic evaluations of perinatal peer support. An evaluation of a Home-Start trial, providing specialist perinatal support in North East Glasgow found that: “The peer support model is a cost effective way of supporting vulnerable and marginalised mothers and their families in the perinatal period” (Heywood et al., 2016). A realist evaluation of Aberlour’s Perinatal Befriending Service in Forth Valley and East Lothian suggested that the service could have economic benefits by preventing the need for more intensive support at a later point, but that the data gathered was not sufficient to provide evidence of potential cost-savings.

4.4 Potential resources for developing perinatal peer support in Scotland.

This review has identified a number of resources that could be useful when developing perinatal mental health peer support in Scotland.

Case study examples

- The Greater Glasgow and Clyde Perinatal Mental Health Network (PMHN) is an informal network of NHS, Local Authority and Third-Sector organisations supporting parents' and infants' mental health in the perinatal period. It is an innovative approach to promoting awareness and access to perinatal mental health services, and an example of facilitating good relationships between clinical services and the third sector. Further information is given in Annex 2.
- The Mother and Baby Unit at Devon Partnership NHS Trust is another innovative approach that could act as a model for promoting peer support in perinatal mental health in Scotland. Further information is available at Annex 3.
- The case studies were developed through interviews with staff and reviewing key documents (e.g. job descriptions). It should be noted the case studies are descriptive but not evaluative, so they do not provide any indication of the quality of the service.

Job roles and descriptions

- Exemplars from peer support services in the rest of the UK – for instance, the perinatal peer support worker job description from the Mother and Baby Unit at Devon Partnership NHS Trust – could be a helpful resource for developing job descriptions for NHS Scotland.
- ImROC Guides to Peer Recruitment and working with/supporting peer workers (Repper et al., 2013) have already been used with success in introducing peer work in adult acute mental health wards in the West of Scotland. Job descriptions for these peer workers in a general acute mental health setting are helpful in defining the peer worker role.

Evaluation

- The validated Peer Support Evaluation Inventory (Dennis, 2003) is a custom tool to evaluate participants' experience of peer support. Evidence suggests this could be a useful data collection tool in evaluation of peer support, alongside pre and post measures such as the Edinburgh Postnatal Depression Scale.

Change model

- The change model developed by Gillard (2014) offers an excellent overview of the processes and outcomes when incorporating peer work into existing NHS or third sector services. Figure 1 below illustrates the resources, mechanisms of change and process outcomes making up peer work interventions. The model reflects the evidence base detailed in the literature review and is a useful distillation of a complex intervention.

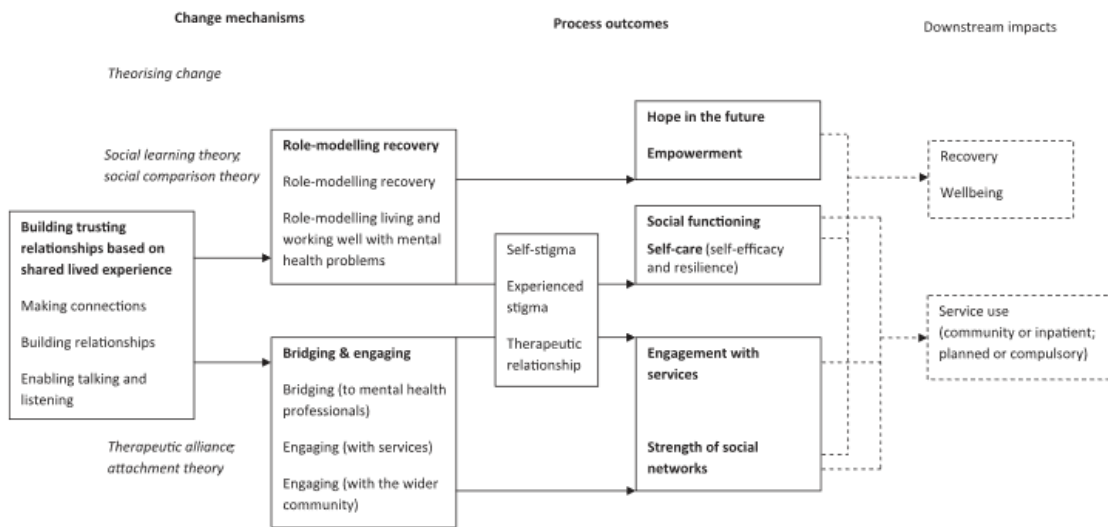


Fig. 1. Change model underpinning peer worker interventions.

5. Conclusions and recommendations

Peer support is a flexible and accessible form of support for women experiencing mental health challenges in the perinatal period. Evidence from the UK and from international studies suggests that peer support can be an effective way to improve the mental health and wellbeing of women during the perinatal period. The main conclusions and linked recommendations are listed below under five main headings.

5.1 Identify and support existing good practice

Conclusions:

A wide range of perinatal peer support services exist in Scotland, however, the vast majority are voluntary and group based. Geographical coverage is limited outside the central belt of Scotland. Continuity of provision is inconsistent, with some valued and well-attended groups forced to close due to lack of funding or accommodation.

Perinatal mental health networks such as the Greater Glasgow and Clyde Perinatal Mental Health Network (PMHN) can aid shared knowledge of local services, helping NHS staff to direct people to appropriate third sector services based on clinical need. Networks also provide a forum for creating and sharing standardised 'peer principles' and a hub for expertise and continuing professional development.

Recommendations:

- Where there are examples of good practice, with evidence of appropriate training and support for peer volunteers, these should be championed, supported and built upon.
- A range of peer support models should be available, with improved access to services across geographical areas throughout Scotland.
- Regional perinatal mental health networks with statutory and third sector services should be facilitated to share best practice and aid appropriate referrals.

5.2 Ensure safety and quality

Conclusions:

For peer support services to be effective and safe for clients and peer supporters, robust and comprehensive training and regular supervision is essential. From recruitment, through training, supervision and supporting ongoing practice, processes should be tailored to the needs of peer supporters. This creates a safe working environment for peer supporters and ensures safety for clients, adequate care and due diligence.

Peer support work can be extremely rewarding for volunteers with peer experience. To be nurturing rather than draining for peer supporters, peers should be well prepared for their role and not be expected to achieve unrealistic outcomes. Peers should be supported and supervised, as they may experience guilt or worry

associated with being unable to help or support clients, or anxiety when unsure of how to manage a situation.

Specialised resources are available to support organisations who introduce peer support. Resources already exist to support all stages of peer support, from recruitment to ongoing training. These and are included in the existing resources section of this report(section 4.4).

Recommendations:

- Specialised approaches to recruitment, robust and ongoing training, appropriate and timely clinical supervision and support for ongoing good practice are essential elements in ensuring quality and safety.
- Peer supporters need robust support systems and additional flexibility in their roles to enable them to maintain their own recovery and wellbeing.
- Existing evidence based and quality assured resources should be utilised when creating peer support services to ensure high quality practice from the start.
- All peer support services should have their own policy around safe-guarding peer support workers, volunteers and service users.

5.3 Prioritise accessibility and inclusivity

Conclusions:

The design and delivery of peer support services should respond to the needs of particular communities. Socioeconomic background, family situation, geographical location, culture, religion, ethnic background, disability, health problems and other factors will influence a person's ability to access services. Peer support services are effective at reducing isolation for those groups at risk of being isolated, for example, asylum seekers and refugees. These isolated groups may benefit greatly from peer support but need a tailored approach or targeted support to ensure support is accessible.

Different models of peer support will be more accessible to some groups than others. It can be challenging to engage women living in deprived communities or marginalised groups who can be the most in need of support. Recent evidence suggests that one-to-one support in the home is more likely to consistently engage women from the most deprived backgrounds (Hann and Macleish, 2019). Women from more middle class backgrounds seem to more consistently attend support groups, meaning that a range of delivery modes is essential to ensure access to support across socio-economic demographics. For certain groups, for example those living in deprived areas, sustaining engagement is difficult, so facilitating access and engagement may help. This could mean offering support for travel, text or email reminders and more frequent individualised contact to encourage continued engagement. This is also true for groups who may be hard to engage due to rural isolation.

Peer support is not restricted to one-to-one support or formal groups. Organised social activities, for example, baby massage, walks or cooking lessons can provide

women with a safe space to discuss problems at an individual pace. One model will not be the most effective at supporting all women, and so a variety of support models is required.

Stigma, both self-stigma and feeling stigmatised by others, is a significant barrier to seeking support for women experiencing poor perinatal mental health. Flexibility in provision enables peer support to tackle stigma surrounding perinatal mental health difficulties using a range of approaches. One-to-one support at home can be effective at supporting women who experience self-stigma and do not feel comfortable attending support groups. Women who feel comfortable attending groups can benefit from the acceptance of others in the group who share their experiences, reducing the external stigma by normalising the experience of perinatal mental health problems. Peer support also challenges stigma through the example of peer supporters, who model recovery and living well with the challenges of perinatal mental health problems.

Social support is a key protective factor against perinatal mental ill health and in recovery from poor perinatal mental health. Increased social contact is an important step in recovery for many women experiencing perinatal mental health difficulties. In many cases this will need to be outside current social networks for women to feel comfortable sharing their experiences.

Recommendations:

- Peer support should be available in a variety of formats, for example, one-to-one, in-person, telephone and group support. This will ensure that the support meets the needs of a wide range of mothers/carers.
- Targeted peer support services should be designed to meet the particular needs of groups who are currently underserved by services, for example: Mothers/carers living in poverty, ethnic minority groups, geographically isolated communities, families affected by domestic abuse or substance abuse, parents who experience the loss of a baby, in addition to considering the impact of religious and cultural beliefs, disability, health problems and any other pertinent factors.
- Specific peer support for men should be widely supported and become more widely available. This will help to ensure this underserved group have a range of peer support services in place to support them

5.4 Respect the unique value of peer work

Conclusions:

The recently developed Principles of Perinatal Peer Support (Maternal Mental Health Alliance et al., 2019) advocate that the unique contribution of peer support is maintained as distinct from other therapeutic or clinical roles. Research evidence also suggests that peer support is most effective when peers use their uniquely valuable experience in a way which does not try to replicate the role of clinical staff by offering advice, training or therapeutic treatment.

Peer support is most effective when clear role boundaries are put in place for peers and those people they support. Clearly defined role boundaries allow the peer supporter to feel secure in what is expected of them and enable other staff and clients to know what to expect, reducing uncertainty. For example, the case study example in Annex 3 addresses the role of peer workers in an MBU setting, identifying that clear job roles in an NHS setting help other staff recognise the distinct role of a peer support worker and their value as a member of the staff team.

Sole working peer supporters can feel isolated, so job sharing or being part of a network for peer supporters could benefit morale, staff or volunteer retention and job satisfaction. Peer workers may need to access additional flexibility in work schedules to allow them to maintain their own wellbeing and recovery.

Recommendations:

- Peer support services should recognise and celebrate the benefits of peer experience and peer workers or peer volunteers should not replace clinical staff or be asked to do their work.
- Peer support worker and volunteer roles should provide clear boundaries of the role for peers, the people they support and the wider team.

5.5 Integrate robust evaluation

Conclusions:

International evidence from large scale studies suggests that perinatal peer support can reduce symptoms recorded by the Edinburgh Postnatal Depression Scale. This is the most commonly used measure of postnatal mental health problems

Research evidence on the efficacy of perinatal peer support in Scotland is extremely scarce. This is partly because peer support is a relatively new approach and not yet embedded in statutory services, offering limited opportunity for research studies. In addition, third sector organisations who organise peer support have limited resources for research and evaluation as they direct their resource primarily toward service provision.

Recommendations:

- Evaluation should be built into peer support services to ensure they are meeting needs of clients and peer supporters and providing safe, appropriate and effective services.
- To build the evidence base for peer support, new services should measure their effectiveness using validated measures, to reinforce a commitment to a robust evaluation.

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7. Annexes

Annex 1: Search Strategy

Primary searches were undertaken through University of Glasgow Library Databases, covering Science Direct, PubMed, Scopus, Medline, National Institute for Clinical Excellence, PsycINFO and other databases accessible through Web of Science and EBSCO Host. Grey literature searches were undertaken on OpenGrey and ISI Web of Knowledge.

Keyword Table for Literature Search

Peer support	Perinatal	Evaluation	Mental Health
Peer* Peer support* Peer work* Lived experience Befriender	Perinatal Peri-natal Maternal Maternity Antenatal Ante-natal Postnatal Post-natal Parental Very early years Pre-birth Post-partum New parent	Evaluation Evidence Measurement Report Briefing Summary Statement	Mental health Mental wellbeing Recovery Mental illness Mental ill-health

Level 1 Search Results

No.	Search terms	Level 1 results
1	(perinatal) AND (peer*) AND (mental health)	14,418
2	(perinatal) AND (peer*) AND (mental health) AND (evaluation)	8,740
3	(perinatal) AND (peer support*) AND (mental health) AND (evaluation)	8,116
4	(perinatal) AND (peer support*) AND (mental health) AND (evaluation) AND (UK)	3,453
5	(perinatal) AND (peer support*) AND (mental health) AND (evaluation) AND (Scotland)	1,261

Annex 2: Case study: Connecting peer support to wider services – The Perinatal Mental Health Network, Greater Glasgow and Clyde

Introduction

Greater Glasgow and Clyde Perinatal Mental Health Network (PMHN) is an informal network of NHS, Local Authority and Third-Sector organisations supporting parents' and infants' mental health in the perinatal period. The network meets quarterly and communicates via a monthly email to all members.

The PMHN was initiated in 2016, after colleagues shared the benefits of a similar network focusing on Child and Adolescent Mental Health. The network began as a mapping exercise to find out what provision existed in perinatal mental health services in Glasgow, and was initially focused on Glasgow city, before word of mouth helped the network expand to cover Greater Glasgow and Clyde. There were many local organisations working in perinatal mental health but often organisations were unsure of what other support was out there, leading to a disparate way of working. The network was set up to support connectedness and joined-up working in the sector.

Management

The network is managed by the Mental Health Improvement Team at NHS Greater Glasgow and Clyde. There is a quarterly face-to-face meeting in Glasgow for network members to share updates, news, ask questions of the wider network or discuss issues which affect the sector, such as funding opportunities. The network manager also co-ordinates a monthly perinatal mental health 'snippet' via email, covering relevant research, training and funding opportunities with a rolling spotlight to highlight existing services. The terms of reference and purpose of the network are regularly reviewed to ensure things stay on track.

Members

Organisations in the Perinatal Mental Health Network are:

Aberlour; 3D Drumchapel; Addaction; Amma Birth companions; Barnardo's Nurture; Barnardo's Threads; Café Stork; Children 1st; Crossreach Bluebell; Early Years Scotland; Family Nurse Partnership; Fathers Network Scotland; Homestarts (Glasgow North, South, Renfrewshire/Inverclyde); West of Scotland Mother and Baby Unit (Leverndale); Lifelink; Mellow Parenting; Mental Health Network (GGC); Mind Mosaic; Maternal Mental Health Change Agents; NSPCC; One Parent Families Scotland; Pandas South Glasgow; Quarriers; Robertson Trust; Rosemount; Ruchazie Family Resource Centre; Safe Harbour; SAMH; See Me; SNIPS (Special Needs in Pregnancy); NHS Health Improvement (across GGC); Talk it Over; Young Parent Support Base.

Benefits and Challenges

Benefits	Challenges
The PMHN helps statutory and non-statutory services to develop knowledge of what other services are doing.	The network has members from a wide variety of services, and one way of working won't work for everyone.
Services are able to link-up to work more effectively, and avoid duplicating efforts.	Building trust in partnership working takes time.
When services are communicating regularly, current strengths and service gaps perinatal mental health become clearly visible and can be addressed.	Organisations who are used to operating independently may have reservations about sharing details of funding bids or service development.
Knowledge of how other services are working helps organisations to take a collaborative approach to funding, demonstrating their unique offering within the sector.	The network shares information and links up services, but it cannot endorse organisations or act as a regulatory body.
The network enables 'big picture' thinking, helping organisations to be strategic in developing their services.	The network is inclusive, but membership of the group can't be a guarantee of quality or an endorsement. The approach of the PMHN is 'curious but critical'.

Future plans

- Promoting the network to make sure it reaches the wider perinatal health agenda.
- Working with the Special Needs in Pregnancy service (SNIPS) and Family Nurse Partnership (FNP) to strengthen connections with maternity services.

Working more closely with health visitors and sharing information with them to facilitate referrals.

Advice and lessons so far

- The network needs a figurehead, a central person to co-ordinate the activities.
- Small staff time commitment can produce big results.
- Glasgow is an area with a concentration of services, but more rural areas with less infrastructure, fewer resources, isolation and a lack of provision could also benefit from a similar network to identify gaps in provision.
- Organisation of the network should adapt to local geography - a series of smaller local networks with an umbrella groups may be more appropriate in some areas.

Annex 3: Case Study: Peer support workers in a Mother and Baby Unit MBU – Jasmine Lodge MBU, Devon Partnership NHS Trust

Introduction

Jasmine Lodge Mother and Baby Unit (MBU) is a specialist inpatient perinatal mental health unit for mothers and babies from 32 weeks of pregnancy up to one year after birth. It is a brand new purpose-built unit which opened in May 2019 and has capacity for eight mums and their babies. The unit is part of Devon Partnership NHS Trust and is based in Exeter.

Jasmine Lodge includes an open-plan living/kitchen/dining area, activity rooms, baby-centred spaces, en-suite bedrooms, a purpose built office space, landscaped gardens and extra facilities for supporting families including two apartments for visiting family members.

The team consists of a perinatal psychiatric consultant, occupational therapist, clinical psychologists, a ward manager, deputy managers and a team of experienced mental health nurses, social workers, support workers, peer support workers and nursery nurses who care for the mums and their babies during their recovery. The team is supported by an experienced admin team. A full-time Band 4 Peer Worker role is split as a job share between 2 peer workers.

History of peer workers in the service

The community perinatal mental health service has been operational for the last 10 years, and since inception has incorporated the experience of mums. The focus on the involvement of peer workers is based on the clinical experience of staff in recognition of the benefits of peer work for mothers using the service.

When the process of making a bid to operate the Mother and Baby unit began around 3 years ago, the Consultant Perinatal Psychiatrist and Perinatal Service Manager ensured that a full time Band 4 Peer Worker role was costed into the proposal. When presenting the bid, a mother who had been supported by the service shared her experience, which was instrumental in the successful bid.

Recruiting, training and integrating peer workers

- Through consultation with other MBUs who had peer workers in place, a job description was developed and the job was advertised on NHS Jobs England.
- As part of the recruitment process, people who had used the service were contacted to let them know about the opportunity.
- As part of the feedback process on their experience in the MBU, people who have used the service are asked if they would like to be kept up to date with any future opportunities to be involved in the service in a voluntary capacity. This information is retained to aid recruitment to peer roles of people with experience of the service.

- After the recruitment process, Peer Workers took part in a two-day training course based on the principles of Intentional Peer Support, facilitated by Recovery Devon, a local Community Interest Company focused on recovery in mental health.

Managing and supervising peer workers

- Peer workers have both line management supervision and clinical supervision in their role.
- Peer workers access supervision with a clinical psychologist on a monthly basis, and also have access to clinical supervision as and when required.
- Formal line management is provided by an operational manager, for example, the ward manager. This helps to support the role of the peer worker as the ward manager has an overview of all the specialist staff on the ward.
- Peer workers also have links to informal support from more senior members of staff with peer experience, in a mentoring approach.
- Line management and support for peer staff is really important, as peer workers can feel isolated, especially when they are the only peer worker in their team.
- As peer work is highly autonomous and to counteract this isolation, it's important that managers and senior staff are proactively inclusive of peer workers and communicate the purpose and boundaries of the peer role to the wider team as peer work is often not well understood.

Benefits and challenges

Benefits	Challenges
Mums will talk to peer workers about things that they won't talk to anyone else about.	A lack of clear shared understanding of the peer worker role for both peer workers and the staff team they work within.
Through sharing their own experiences, peer workers support patients to feel they are not alone in their mental health difficulties.	Acceptance of the value of peer work in the wider staff team.
Peer workers can offer mums hope for the future through modelling recovery.	Many peer workers are highly educated women changing careers, which can leave other staff feeling threatened by their skills and ability.
Peer workers help to tackle stigma by saying 'I've been there'.	The psychological impact of working in an MBU can be challenging for peer workers.

Peer workers don't wear uniforms, so they are more approachable	Peer workers cannot thrive unless well supported by their line manager and adequately supervised by clinical supervisor.
Peer workers have the time to just 'be' with patients, when often no one else in the team has time to do this.	Peer workers may require additional flexibility, for example breaks or days of unpaid leave, to manage their own mental health and wellbeing.
Peer workers advocate for mums and ensure that the experience of the patient is represented in multidisciplinary meetings.	Peer workers can be so passionate about helping families that it may be hard for them to know when they are working too hard and giving too much.
Peer workers also lead activities like exercise or cooking, based on what mothers would find helpful.	These challenges do not diminish the value peer work, but they do need to be managed by supporting peer workers to maintain their own wellbeing in their work.

Advice and lessons so far

- Ensure that the peer worker and the wider team share a clear vision of the job role and purpose.
- Line managers should structure the first few weeks to ensure a smooth start and transition for peer workers and avoid role conflict.
- There should be a proactive approach to integration of peer workers into the team. This is especially important if the peer worker will be working alone.

While flexibility and autonomy are key in peer work, some ongoing structure is useful to support peer workers and help to define their role for the wider team.

Views from peers, mums and wider staff

Peer workers say:
'Because we have been through it, we can sit with mothers in their distress, knowing that it will pass.'
'Being a peer worker has brought me wider understanding of mental health diagnoses and the wider impact of trauma and adverse childhood experiences'
'Full time peer work would be really challenging for emotional and mental health. Sharing a full time post means both peer workers are able to manage their own wellbeing and patients benefit from two peer workers with different experiences of perinatal mental health problems.'

Mums say:

'Peer Support Workers make you believe that you can get through the hardest time of your life. They have first-hand experience of how you feel and what you are going through from their own experience. They are living proof that hope should not be lost'

'The Peer Support Worker walked with me as I got better. She made me feel normal and like I wasn't the only one – she was as bad as me and she still got better''

'She was like a bridge between the staff and me – I felt I could talk to her about anything with no judgements being made.'

Other staff say:

'Peer support benefits the ward because it offers something unique that no other member of staff can offer, despite the skills and relationships they have with the mothers. Peer support offers a walking, talking, real life example of a recovery story. The role benefits the ward massively by offering groups that are intuitive to the current mothers on the ward. Peer support benefits the ward by contributing into multi-disciplinary meetings, handovers, clinical notes and risk assessing.'
(Ward Manager)

'It is vital that we have peer support worker to be the mums' voice in staff only meetings to ask the difficult but needed questions about why is the service the way it is? Why do we keep doing the same as before?' (Clinical Psychologist)

Annex 4: Evaluation evidence for Scottish Perinatal Mental Health Services

Nurture the Borders

Nurture the Borders use the Warwick Edinburgh Mental Well-being Scale to evaluate their service. Nurture the Borders Annual Report states 'The average score of our service users at point of entry into service is 33. We see an average improvement of 15 points on exiting the service.' (Nurture the Borders, 2019).

This service is valued highly in the local area, with endorsements from health visitors, midwifery, social work and mental health services. Nurture the Borders' Cherish Project was also the winner of the 2019 MAMA Award for "Specialist Maternity Service of the Year" sponsored by The Royal College of Midwives.

Home Start Scotland

Home Start services use their own evaluative measure of family wellbeing, a 5 point scale across 4 domains, children's wellbeing, family management, parent's wellbeing and parenting skills. Their 2019 impact report (Home Start Scotland, 2019) reports average improvements of 1-1.5 points for families across the 4 domains.

Home Start Glasgow North ran a perinatal mental health peer-support project in 2014 targeted at women with perinatal mental health difficulties. In an area of socioeconomic deprivation, the service found that many referrals were for highly vulnerable women with pre-existing serious mental health problems or complex histories. The service delivered increases in parenting confidence for women as well as a rise in their personal confidence, self-worth and self-esteem. Issues of isolation and barriers to accessing additional supports were drastically reduced (Heywood, Sloan 2016). The results of this study regarding women's experiences must be interpreted with caution due to the very small sample sizes (4 interviews with women using the service).

Aberlour

Aberlour based their Perinatal Befriending Support Service on evidence from the Family Action Perinatal Support Project, run at four sites in England and found to be effective in reducing symptoms of anxiety and depression and promoting warmth in mother-infant interactions and improving social support (Barlow, 2012).

In 2016, Aberlour worked with the University of Stirling to evaluate their pilot Perinatal Befriending Support Service, finding that the service was linked to lower levels of anxiety and depression, greater warmth and less invasiveness in the mother-child relationship. Qualitative evidence also demonstrated increasing self-confidence and willingness to take part in social activities for the women supported by the service (Cheyne et al., 2016). The results of this study must be interpreted with caution due to the very small sample sizes (14 questionnaire measures, 9 interviews). The pilot was successful and the service has continued to expand over the last four years, consistently facing increasing demand and a waiting list for support.

Quarriers

Quarriers Maternal Mental Wellbeing Service conducted a qualitative evaluation of their service with the University of Stirling, which returned positive feedback on the service (Lucas et al., 2019). However low response rates mean this can't be considered a robust evaluation of the effectiveness of the service.