



Regional Evaluation of The London Pilot of Maternal Mental Health Services



I've always wanted to be a mum... Everyone said to me "you're such the typical maternal person... you're such a natural"... I hated the first eighteen weeks of pregnancy... I remember sitting at the table crying my eyes out ... and I said to my husband "I can't carry on"... I don't really remember any of the birth in the end... suddenly they were saying "you're more high risk... we have to take you to theatre because baby's heart rate is dropping"... when they got him out, and they showed him to me, there was nothing... I was like... "I don't want to hold him. I don't feel anything". It was like my body was saying "you're not cut out to be a mum, you thought you were, but you can't do this"... Two months later I knew something still wasn't right. I was constantly down, constantly crying... So the GP referred me [to my local MMHS] and the therapist contacted me... It was the first time that I actually expressed everything, explained everything I went through, it was such a relief. Straightaway the therapist understood, like she was really listening... Without the service I don't think I'd be where I am now... I probably would have ended up taking antidepressants. I wouldn't have been as confident to get on with everything, go back to work and things like that... The service has made such a big difference... Now, those words "I'm not cut out to be a mum"... I know now, that is not my problem.

*To the staff: please don't give up... keep going, keep the sites building up as much as they can, be as big as they can, help as many women as possible. It's been a long time coming.
And thank you. Just thank you.*

Heidi (pseudonym)

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Dedication

We would like to dedicate this report to the women and staff who took part in the London regional evaluation of MMHS. Thank you for sharing your stories with us – your input will be crucial in shaping the future of this vital service, and we could not have done it without you.

Acknowledgements

We would like to thank Felicity Ballin, Chelsea Tudhope and Gemma Crabtree for all their hard work in supporting the set up of the evaluation, and in their work in helping us think through our recommendations and in proof reading the report.

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EXECUTIVE SUMMARY

The Maternal Mental Health Services (MMHS) programme

In 2016, the independent Mental Health Taskforce published its Five Year Forward View (FYFV) on behalf of NHS England, which stipulated that women required access to specialist perinatal mental health services at the local level. NHS England recognised there was a gap in service provision for those requiring psychological intervention specifically related to their birthing experience.

In 2019, NHS England published its Long Term Plan, which set out the need to provide appropriate care to women and birthing parents who develop moderate to severe mental health difficulties due to certain maternity experiences (birth trauma, tokophobia, loss, and child removal due to safeguarding concerns) through the development of Maternal Mental Health Services (MMHS) as this had not previously been provided within existing services.

In 2020 MMHS came into being, to address the gap in provision between specialist services designed to address severe and complex maternity-related psychological difficulties on the one hand, and generalist services designed to address common mental health problems on the other. The MMHS journey began with a pilot phase.

Regional evaluation aims & methods

A key element of the pilot phase of the MMHS was learning about what worked well and what could work better in the set

up and delivery of MMHSs, through several evaluations. This report focuses on the regional (London-wide) evaluation, which was designed to complement the national and local (service-level) evaluations.

This regional evaluation was undertaken by the McPin Foundation, and was commissioned and supported by the London Regional Perinatal Mental Health Programme. McPin is a research charity that specialises in mental health research using peer research methodology. The evaluation focuses on the personal experiences of staff working in the London pilot MMHSs and the women and birthing parents using these services. It draws on in-depth, semi-structured interview data – collected between February and May 2021 – in order to answer key questions around the needs of staff and women/birthing parents, the extent to which those needs are being met, and the lessons that can be learned from their experiences.

Findings

What we found through listening to the stories of our regional evaluation participants was striking. While we expected to learn about a certain degree of stress among staff and a number of benefits for women and birthing parents, what we discovered was a stark contrast between these two – a story of two halves: an unsustainable degree of pressure and stress experienced by staff who reported feeling insufficiently supported ‘from above’; and life-saving, life-changing treatment experienced by women. Staff who shared their stories spoke with passion and

commitment about their work supporting women and birthing parents. But many spoke of being ‘on their knees’. They do not complain, but they are concerned; concerned for colleagues, for the sustainability of their services, and mostly for the women and birthing people currently waiting for treatment and the many, many more in the wings.

Women who shared their stories spoke with courage about the circumstances that had brought them to MMHSs, and were highly reflective in their narratives about what, specifically, helped them to process the deep psychological pain they bore. Mostly, they spoke with passion and force about the kindness, skill, dedication and knowledge of MMHS staff, of their expectations being exceeded, and of the importance of sustaining and growing this new service.

Recommendations

The regional evaluation findings presented in this report indicate a number of recommendations going forwards, which are set out in full from page 63. In summary, these are divided into recommendations around:

Service Development

MMHSs continuing to provide high quality, person-centred treatment; emphasising readiness within therapeutic endings; actioning the national guidance issued regarding fathers and partners; increasing awareness of MMHSs among potential referrers; promoting MMHSs directly to women; reviewing peer support roles and function; and addressing health inequalities.

Support for Staff

MMHSs developing/reviewing individual staff and team wellbeing strategies, and system leaders recognising the psychological and emotional impact on staff of working in MMHSs; MMHSs, system leaders, commissioners and transformation managers reviewing staff capacity with a view to ensuring service sustainability.

Resources

Integrated Care Boards and Local Maternity and Neonatal Systems leaders, commissioners and MMHSs reviewing funding, identifying funding gaps and potential resources; and local and national MMHS teams ensuring that lived experience input is adequately resourced within budgets.

Systems Change

Ensuring trauma-informed care is embedded within all healthcare provision related to the maternity journey.

REGIONAL EVALUATION OF THE LONDON PILOT OF MATERNAL MENTAL HEALTH SERVICES

INTRODUCTION

This report presents the findings from the regional evaluation of the pilot London Maternal Mental Health Services (MMHSs): *Ocean* (East London Foundation Trust), *Tulip* (North East London Foundation Trust), *Maple* (Camden and Islington Foundation Trust) and *M-TLC* (Central and North West London and North West London Foundation Trusts). It was undertaken by the McPin Foundation on behalf of Healthy London Partnerships.

BACKGROUND TO MATERNAL MENTAL HEALTH SERVICES

In 2016, the independent Mental Health Taskforce published its Five Year Forward View (FYFV), on behalf of NHS England. The FYFV stipulated that women¹ required access to specialist perinatal mental health services to meet their needs at a local level, either on an inpatient or outpatient basis. Following on from this, NHS England recognised the significant gap in service provision for women requiring psychological intervention specifically related to their birthing experience.

In 2019, NHS England published its Long Term Plan. This set out the need to provide women and birthing parents who have developed moderate to severe or complex

mental health struggles due to their maternity experiences, with appropriate care. The particular experiences noted as requiring dedicated service provision comprised: birth trauma, tokophobia, loss, and removal of a child for safeguarding reasons. These experiences were identified as being inadequately provided for within existing services – including IAPT, community perinatal mental health services, and mother and baby units.

In 2020, as a response to the need identified within the FYFV and the Long Term Plan, Maternal Mental Health Services (MMHSs - initially referred to as ‘maternity outreach clinics’) came into being, with the initial phase designed on a ‘develop and test’, or pilot basis. This means that pilot sites were authorised to – and did – develop different service models, in order to meet the needs of women and birthing parents at the local level. As a whole, MMHS provision comprises maternity, reproductive health, peer support and psychological therapy comprising a range of modalities. MMHSs are built on the approach of trauma informed care, which “aims to promote feelings of psychological safety, choice, and control²” and enables transparency and trust to build between patient and clinician, whilst promoting empowerment.

¹ For the most part in this report we refer to ‘women’, rather than ‘women and birthing parents’ because our sample did not include anyone who identified as a ‘birthing parent’, although services are inclusive to all.

² A good practice guide to support implementation of trauma-informed care in the perinatal period (2021) Blackpool Better Start, Centre for early child development.

COVID - 19 PANDEMIC

The MMHS pilots were developed and launched during the Covid-19 pandemic. Launching a new service within a pandemic undoubtedly had an impact on the MMHS, both on women/birthing parents and the

staff supporting them. Throughout this report you will note the impact that the pandemic had on the development, launch and delivery of the service.

AIMS AND OBJECTIVES OF REGIONAL EVALUATION

The **aim** of the regional evaluation was to gain an in-depth understanding of **what is working well and what could work better** in meeting the needs of women and staff within the London pilot MMHSs. There was a focus on *personal experience* throughout, intended to complement both the local evaluations which comprise quantitative data, and the national evaluation (also known as ESMI-III) which gives a national, overall picture of all Early Implementers between 2021/2022. Regional evaluation **objectives** were:

- To gain in-depth understandings of the experiences of women, staff and wider stakeholders (both positive and challenging) in the set-up, delivery, referral, access and receipt of MMHSs within the four London pilot sites.
- To understand the needs of women, staff and wider stakeholders regarding MMHSs.
- To understand the key barriers and enablers to those needs being met.
- To learn lessons from people's experiences to inform further development of MMHSs.

Due to time constraints, the first of these objectives was amended, and the research conducted for this evaluation focused on staff and women only, not wider stakeholders.

Key evaluation questions were:

- What are staff experiences of the MMHS pilots?
 - o What lessons can we learn from these recent experiences for further development of MMHSs locally?
- How have women experienced the pilots MMHSs?
 - o What lessons can we learn from these recent experiences for further development of MMHSs locally?
- How have the sites approached the set-up of MMHSs and what can we learn from the differences in approaches in relation to staff and women's experiences?

In light of the remit of the national evaluation, and to avoid duplication, we replaced our final question around approaches to service set-up with one around *staff experiences* of that set-up process.

METHODS

ABOUT THE MCPIN FOUNDATION

The McPin Foundation is a specialist mental health charity that specialises in centering the voices of people with lived experience of specific mental health challenges. We do this in a range of ways, from involving people with relevant lived experience in advisory panels, through to employing researchers who have relevant lived experience to work directly on projects³. These researchers draw on their lived experience as an additional source of expertise alongside their expertise as researchers. For this evaluation the researchers working on this project had lived experience of birth trauma and loss.

PEER RESEARCH

We used a peer research approach in this evaluation, meaning that the McPin researchers undertaking it have experience of maternal mental health struggles, specifically around loss and trauma. This enabled us to provide a trauma-informed, trusting and normalising research environment in which participants could feel comfortable sharing their stories.

DATA COLLECTION

In order to meet our aims and objectives, and especially given the focus of the regional evaluation on *personal experience*, we took a qualitative approach and used in-depth, semi-structured interviews with staff and women as our key source of data. In addition we undertook informal

information-gathering through attendance at online staff meetings, to learn about key issues that might warrant focused attention in interviews. Interviews with staff and women combined narrative and thematic approaches – allowing participants to tell their stories from the lead-up to and start of their MMHS journeys to the present, as well as asking them to reflect on particular aspects of the services as they elucidated on their journeys. Interviews took place between February and May 2022 and all were conducted via online video conferencing. In line with the approach taken within interviews, data analysis also combined thematic and narrative approaches, and was undertaken using the qualitative data coding and analysis software NVivo.

There were elements of the proposed evaluation methodology that Covid-19 – and in particular the imperative around online working – prevented us from pursuing, and other proposed elements which we amended for a variety of reasons:

- We had planned to run creative sessions with women, but considered that this could be problematic given our relative unfamiliarity with providing quality emotional support in online, group forums.
- We had also planned to run workshops with ‘stakeholders’ (referrers and partners) but agreed, after very limited response from these groups, to use the time available to focus on staff and women, and to consider referrers and partners in subsequent research.

³ For more information on the mental health peer research approach, please visit the McPin [website](#)

- Lastly, we had planned to conduct observations in meetings using a standard pro forma in order to understand the contexts of the services in which staff and women’s narratives could be understood. However we considered, after review, that the information this was intended to yield could be ascertained through informal observation and through the in-depth interviews with staff.

While these elements were not undertaken, the data collected through interviews alone were extremely rich, yielding deep and valuable insights into the experiences of staff and women, and useful learning for pilot services as well as subsequent MMHSs and other stakeholders.

In addition to the amendments described above, there were a further two elements of the original proposal that we re-visited and adjusted:

1. We had originally proposed to set up an ‘oversight group’ comprising

different stakeholders, but in the interests of time and workloads, this oversight was accessed through the central support function (which comprised the regional programme manager and peer support worker, both of whom were in close contact with services).

2. We originally proposed to produce a report for each pilot. However, we determined that a) doing so would place us at high risk of breaking anonymity, b) most of the experiences recounted – and the themes they revealed – were experienced across all four pilot services, and c) local evaluations were set up to yield service-specific data.

SAMPLE

The participant sample comprised 12 staff members working in all four services, invited for interview by McPin researchers^{4,5}:

Service manager	Project manager	Clinical Psychologist	Peer Support Worker & lived experience roles	Specialist Midwife
3	1	4	3	1

There were 11 women participants from three of the services^{6,7}, invited for interview

by McPin researchers via staff members supporting them. Interviews lasted between

⁴ This excludes a paired interview with two staff members working in central support unit.

⁵ Peer support and lived experience roles included various roles under the umbrella of peer support. We do not distinguish between them in this report, in the interests of anonymity – we label them all under the banner of ‘peer support’.

⁶ One of the services did not have any women suitable for interview.

⁷ This was below our initial target of 20, however the length and depth of interviews undertaken compensated for lower numbers in the richness of data collected.

one and two-and-a-half hours, with a number of them entailing multiple sittings in order to enable stories to be told in full, and in some cases to enable women to tend to their babies. At the time of their interviews, most of the women who took part had completed treatment in one of the London pilot MMHSs within the previous few months, while a minority were still receiving support. Some of the women had experienced mental health struggles earlier on in life, in addition to those that had come to pass during the maternity period.

We have chosen not to include demographic information about the women we interviewed, because our sample is so small and the local evaluations will be able to provide this information in a more meaningful way with their service-wide data.

ABOUT THIS REPORT

After this introduction there are a four main sections:

Section 1 presents *staff experiences* of bidding for, setting up and delivering MMHSs. It is structured according to key topics discussed in staff interviews and follows a loose chronological order.

Section 2 presents *women's experiences* of accessing and receiving support. This is also structured in line with the topics addressed in women's interviews, and also follows a loose chronological sequence.

In both of these sections, each key topic is approached by setting out the *positive* experiences and the *challenges* faced.

Section 3 provides *concluding thoughts* and outlines a number of *recommendations* for different stakeholders going forward, based on participants' narratives and discussions between McPin and the Healthy London Partnership.

Section 4 comprises *women's stories* – detailed, first-person accounts drawn from women's interview transcripts in which women describe their journeys into, through and in most cases out of MMHSs and mental health struggles.

A story of two halves

The first two sections of this report tell the story of what we found using the methods described above, as we strived to meet our objectives and answer our evaluation questions.

It is a story of two halves:

On the one hand we see the staff of the regional pilot MMHSs – highly skilled, unflinchingly kind, unwavering in their commitment to the psychological health of women and their families – setting up and delivering new services in the middle of the pandemic, under immense pressure, making sacrifices in their personal lives, concerned about the sustainability of their services and the capacity to meet demand, navigating multiple systems that hinder rather than help their work, feeling undervalued and insufficiently supported 'from above' but ploughing on despite these obstacles because of a deep commitment to

public service, and managing to stay positive.

On the other hand we see women benefitting in extraordinary ways from the MMHSs and the people staffing them; processing psychological pain, learning tools for managing effectively in their everyday lives, gaining deep self-knowledge and a stronger sense of self, and in turn growing in confidence to build better relationships with the people around them, return to work, take on new challenges with a sense of empowerment and increased inner peace, and parent their children in ways that they believe will set them in much better stead for their futures⁸.

And we hope that this report will bring this story of two halves into sharp focus. We hope it will inspire services to continue with the much-appreciated practices they already have in place, and develop where indicated and where feasible. We hope this report will encourage those with decision-making and fiscal power, to do what they can to create a sufficiently-resourced, enabling, supportive and understanding working environment – and through this, ultimately, a sustainable MMHS. As will be made clear, the risk of paying insufficient attention to what women and staff are telling us falls not only to women and staff themselves, but to the future generation of children being brought into the world

⁸ It is important to note that this evaluation was not designed for, and can therefore not reflect on, the long term impact of MMHSs on women's lives.



SECTION 1 – STAFF EXPERIENCES

In this section we present the reported experiences of staff interviewed for the regional evaluation, who were working in the London pilot MMHSs. We take a chronological approach, starting with the bidding and set-up phases before moving on to present experiences of service delivery. While there are a number of positives in this half of the story, these tend to exist *despite* the systemic and structural barriers that stymie smooth working, and are outweighed in number by the challenges.

Bidding & setting up services

Positives

Staff in MMHSs - service and project managers, psychology leads, and therapists involved in these early stages - reported some positive feelings about their experiences of bidding for and setting up MMHSs in London (even if these were coupled with significant challenges). These relate largely to a sense of excitement at being involved in something new, important and much in demand, and to a close alignment with personal values:

I actually really enjoyed it... It was probably one of the highlights of things that I've done in the last 18 months, one of the bits of work I've actually enjoyed the most... it was very labour intensive, but it was quite exciting too.

Service Manager

Particular factors noted as instrumental in setting up MMHSs successfully were:

✓ **Dedicated funds for bidding and mobilising**

Services who bid for, and received, dedicated funding for staff to lead the mobilisation phase reported feeling that this had been a key factor in the set-up process going well. One service manager explained it as follows:

We knew [MMHS] was coming on board and as part of my role, this just naturally fell to me... I was the lead but we had a project manager who coordinated the meetings and things and did I guess some of the operational bit... I think what worked really well was... asking for the funding for a project team and asking for quite a lot, and having dedicated funded project lead money I think was really key as well.

Service Manager

✓ **High quality staff**

Another positive factor that staff emphasised when discussing what had worked well in the set-up of their MMHSs, was the quality of colleagues in their teams – managers, psychologists, midwives, administrative staff, participation workers and peer support workers. This was highlighted and repeated often during interviews.

I'm proud of the clinicians who work in the service, they're all very knowledgeable and thoughtful... excellent staff... we were really very, very pleased... and they were all experienced enough to understand what the remit was... they had all worked with trauma, they had all worked with loss, they all really understood the clinical implications of it.

Service Manager

I'm really proud that we've been able to engage women with lived experience and set up a lived experience group. They are meeting regularly ... and helping shape the service in terms of leaflets and other communications and hopefully they're going to be on our interview panels... [It] is something I feel really proud of actually.

Psychologist

At one point we had four experts by experience involved ... coming to all of our mobilisation meetings ... involved in the clinical subgroup that was designing and developing what the clinical model and pathways would look like ... They also contributed on all of the interview panels for the initial rounds of agreement... a couple of them had to drop out ... so we pared back to having one expert by experience. [She] is really excellent. Invaluable, absolutely invaluable. They are experts by experience... yes, invaluable.

Service Manager

I became the chair of the communication group where we started to look at the website and posters and leaflets, as we'd all said ... it would be great if people knew [the MMHS] was around so they didn't have to struggle or suffer as long as we did ... the [website] they had up there was very clinical and clunky so we totally redesigned it ... There was resources on there - where you could go in an emergency, what signs to look out for rather than medical conditions ... because that's what we felt people would relate to ... I've never felt so confident in doing something and ... being so open and honest about what I went through ... I feel so empowered now ... Two years ago in my old job I was made to feel like such an outcast and was actually told it's best not to talk about my [maternal mental health struggles] ... 'best not to mention it' ... I was kind of made to feel bad and even taken off projects and events because I 'might not be able to do it' because I'd suffered with post-natal depression... [cont on next pg.]

✓ **Lived experience input at the start**

Many staff highlighted the importance of drawing on lived experience input at the early stages of the MMHS journey, from bid-writing stage to set up and mobilisation. This input was highly valued by service and clinical staff, and by the women involved:

...They'd all have meetings about me without me being there... With [MMHS] you just felt so empowered and so confident. I could feel things I was saying, even though [the other MMHS staff] were clinical and got all these qualifications, what I was saying was really important and they were learning from it.

Peer Support

✓ Collaboration with midwifery

A number of staff reported positive and helpful relationships with midwifery in the bidding and setting up of London MMHS pilots:

The way that we managed to work collaboratively and jointly between us and the senior midwives that were very much involved in the mobilisation phase, leading up to the appointment of our lead midwife, was really collaborative... You absolutely couldn't function these services without some direct midwifery dedicated time to them. Absolutely no way.

Service manager

✓ Flexibility

A particularly clear message to emerge from staff interviews concerned taking a flexible approach at mobilisation stage. There were many examples given of 'flexing' in this way: starting out with one staff model and pivoting to another; being flexible in the delivery mode for different treatments (therapy, peer support, midwifery); getting involved in tasks that were not part of one's assigned role; thinking of different ways of

promoting the service. Staff valued the opportunities that flexibility can bring:

First of all, when we were told yes the bid was successful, we then had to change our recruiting because we didn't get loads of applications... there's no complete recipe for this ... you have to be quite adaptive.

Psychologist

Yes, I'm a peer support worker but I feel like I do so much more than just clinical work... I'm really lucky to be involved in the whole development... of the service.

Peer Support

One of the things I really enjoyed working on this project is not knowing exactly how it's going to look but actually it changing quite a lot as well. It's been quite flexible. I think that's one of the good things about the team, everyone is quite flexible in things having to change at a moment's notice.

Service manager

✓ Support

The data from staff interviews points strongly to the importance of supportive relationships between individuals, MMHS teams, other departments and wider networks in forming the cornerstone of successful services. Every staff member

spoke very highly not only of colleagues' professional abilities and standards of care or management, but of the support they had offered to, and received from, each other from the outset. This encompasses both 'formal' support, for example in the form of supervision, and 'informal' support from colleagues. But support starts with the **self**; staff – especially those delivering therapy and peer support – spoke of the many mechanisms they had in place from the beginning to support themselves, drawing on relationships in their personal lives, and on internal resources (especially around the maintenance of healthy work-life boundaries) in what was widely acknowledged to be an emotionally demanding job:

[Setting up MMHS] has pushed me on the verge of re-entering my own therapy... there's a lot of containment that you have to do... Personally I have lots of support.... I'm very lucky. I couldn't have done it without my partner... who is incredibly supportive... without my mother who, the poor thing, has talked to me every single day probably during the set up.

Psychologist

From the beginning, I had a really supportive manager, really supportive supervisors and I can't say enough about my supervisors, they were really great, I could text her whenever I had a question or there was a problem, we had a really close working relationship.

Peer Support

Staff spoke about the importance of feeling part of **MMHS teams** where internal communication and support were strong:

The team is very supportive. I'm proud of, I think, that we work really well as a team. They are so supportive.

Specialist midwife

In addition to appreciating the support from individual colleagues and their own MMHS teams, staff also spoke about the importance of the **wider networks** they were part of.

I have this network that I access on a national level that we just created ourselves with a WhatsApp group. Once a month or so, all the MMHS psychologists get together and talk about the issues that we're struggling with. I find that helpful... it's bringing a broader range of teams ... so you get a broader range of ideas.

Psychologist

Staff in the London pilot MMHSs also reported finding the **central support function** useful:

It's been really helpful to have that oversight from them and to meet with them. It comes down to money in terms of what they can do [but] it's good to talk things through and to have that oversight in terms of awareness. Central support staff are brilliant in themselves as people, they're really lovely people.

Psychologist

Lastly, some staff reported a useful and supportive relationship with **commissioners**, which they linked to positive outcomes:

When I first started, actually we had a really, really great commissioner. They were really good at helping to guide, helping to be quite clear on roles and remit. I felt like they were really supportive.

Project manager

One service manager, in responding to a question about the extent to which resource and capacity problems felt within their control to address, replied with the following:

I have a really good relationship with the commissioners in [one area]... we have that relationship but I guess not everyone does... I've already had a conversation with [that commissioner] about money for next year ... 2023/24, so it's already in their mind that they might need to fund more money for this. I mean I don't have that relationship with all the commissioners I work with. So I guess it depends on the relationship you have with your commissioners...

Service manager

✓ *Working from home*

Despite the difficulties around remote working brought on by Covid (covered more fully later on), being able to work

from home was a positive experience for some staff:

Sometimes it was actually better that we were having a virtual meeting because I think we were meeting with quite a wide group of people that would have been a logistical nightmare to get all together in the same room.

Psychologist

I actually live quite far away from work so ... I would have over an hour's commute each way. So working from home quite a bit cuts out that ... I can literally just stop and go to [my children] and start doing what I need to do for the family life to maintain some level of balance. So that has definitely helped.

Service manager

Challenges

As noted above, the number of positive aspects of experience reported by staff involved in these early stages were outweighed by the number of challenges described. The main factors noted by staff as being particularly challenging in the bidding and setting up of MMHSs were:

☒ *Speed of events*

The speed at which staff were expected to bid for and mobilise services was noted as a source of difficulty by a number of

participants. For example, as one psychologist noted:

It was all kind of quite quick... I would have liked a bit more space and thinking time... It would've been nice to have not just time perhaps protected... but also a bit more of a run up.

Psychologist

Despite being highly qualified and experienced, and going on to build new services successfully and deliver effective treatment to women, setting these services up without sufficient time, in the context of Covid-19, left a number of staff feeling undermined and questioning themselves:

I was always thinking 'I don't know how to do this, am I doing this right? How do you do that?'... I just ended up feeling like I was not doing anything very well.

Psychologist

It's that imposter syndrome I sometimes think people get when you're doing a job and you really don't think you know what you're doing.

Project manager

☒ **Lack of choice**

Some staff reported a lack of choice concerning their involvement at the early stages, and feeling somewhat aggrieved by this – irrespective of the excitement and pride they also felt being involved in these new services. The disquiet seems to come from the way instructions were

communicated to them, rather than the mandate itself:

I didn't really ever feel asked about it... I did feel genuinely quite blindsided by it... I didn't honestly feel like I had a lot of choice...

Service manager

This lack of choice also applies to other areas, for example the expectation that services would involve peer support workers from the outset, with some staff feeling there had been insufficient discussion around the role and function of peer support.

☒ **Lack of resource for bid and mobilisation stages**

The lack of resource reported by staff refers to interrelated issues of having insufficient funds and insufficient staff numbers at the early stages of setting up. For staff who had to bid and/ or set up MMHSs in addition to their usual workload, things were particularly challenging. Even those who had dedicated resource for their time bidding for and setting up MMHSs (sometimes achieved through virement from perinatal), reported spending significantly more time on MMHS work than had been budgeted for, and had struggled:

It needed an awful lot of dedicated time... it was disproportionate. In theory I had half a day a week to dedicate to this new bit of service... [cont. on next page]

...At points I was doing MMHS work full time... It was hard and it took its toll in that particular period of time in my life, for quite a few months... The NHS has a fairly bad culture of just expecting more and more and more, and piling more and more and more on to individuals ... without necessarily always thinking it through and regardless of whether it's doable... It was never ending, and the amount of extra hours that all of us were working to try and get the service designed and set up.

Service manager

The thing we were really naïve about, slightly driven by the constraints of the budget, was how much project support and project management you needed to build into that bidding and mobilising phase... My own line manager was certainly available and supporting but ultimately, what we needed was more people doing the doing.

Service manager

The lack of staffing was directly connected to lack of sufficient funds:

There was obviously a funding issue... the money that became available to bid for... didn't really think about what other kind of managerial and strategic support was needed... In the bidding phase it was "right, there's this amount of money... [cont at top of next column]

...Go away and design your model"... we've shoe horned a model of what staffing we think we need based on the amount of money we've got. That didn't equate back to the data, that told us what the prevalence and the need was within our patch. The money essentially wasn't going to be enough to cover the prevalence.

Service manager

☒ Challenges around working with midwifery

Despite the positive relationships with individuals and teams in midwifery, and the recognised importance of midwifery and mental health working together to deliver MMHSs (noted earlier), some staff reported challenges in this arena at the early stages of MMHS – challenges around navigating systems which made such collaborative working difficult:

I think dealing with maternity, not the midwives, but dealing with the organisational structures... [has been challenging]. So thinking about recruitment and HR, finance of another organisation, it's hard enough in your own organisation but trying to navigate that when you're not a member of that trust was a real challenge... a huge challenge. On reflection... I probably would have added in from the beginning, having maternity project managers... I would have written that into the bid and... [cont on next page]

...factored that in to the whole project because I think you need to have those relationships with the maternity services. For example, [one of the hospitals] didn't have that much awareness about the service, actually if we'd had a project manager for maternity from the start with clear objectives, it would have improved those relationships and improved that interface between this service and maternity across the patch.

Service manager

☒ **IT problems**

Difficulties with various aspects of IT and IT systems were a prominent feature in many staff interviews. At the early stages of MMHSs this included problems with internet connectivity when working in certain buildings and not having the right hardware, and led to lost time in the working day and a significant sense of frustration:

We're still waiting for hot desking stations... the room has been benched but there aren't monitors up... there is still work to be done with IT, it's not been seamless by any stretch of the imagination and I think IT in the Trust in general is people's biggest source of frustration.

Service manager

☒ **Lack of estates**

Equally frustrating for staff was the lack of estates in which to base, or come together as, teams:

I had to pester people to get estates... We went and looked at places and we were quoted ridiculous amounts of money. There was an old, old hospital, those old Victorian buildings and for a room for six people they wanted £50,000 a year, seriously. It was a lot of money... I don't know what the rule is but the money for estates isn't counted, you have to find estates yourself which is a bit nonsensical because if you're asked to set up a new team, it therefore goes that you need to have somewhere for the team to be based.

Service manager

There were difficulties with getting our base in the health clinic, which was supposed to be ready by April, which it wasn't. So, there were struggles around that

Peer support worker

Finding suitable spaces in which to see women for face to face appointments was not only a source of frustration for staff, but was reported to have an effect on assessments and treatment waiting times:

It might not be appropriate to see [women] in maternity services where there are other women and it retriggers them... It's trying to navigate when it's suitable for the lady to come in but also whereabouts it's suitable, not only geography wise but appropriateness wise... If you can't see them, then you might have to delay it for the next week so then that has an impact on assessment, who gets an assessment within the timeframe, who gets treatment within the timeframe as well.

Psychologist

Of particular note was the *uncertainty* caused by not having guaranteed access to space:

Some of our team do have access to a bit of clinical seeing space, slightly ad hoc. I think we'd like it to be a bit more guaranteed... That has been quite a gap and an oversight in this whole process of setting these services up. There is no funding in the budget and no leeway in the budget to fund estates so we are begging, borrowing and stealing and locally negotiating through pre-existing relationships... 'We've got a space in such and such a place for half a day, one afternoon a month' type thing... You've got no occupancy agreements. That place might turn round and say "actually sorry, we've got a paying customer who wants to pay to utilise the space. We're going to need you to vacate with almost immediate effect".

Service manager

☒ *Difficulty recruiting clinicians*

Another significant challenge for staff bidding for and mobilising MMHSs, was recruiting clinical staff to provide treatment to women and birthing parents:

We didn't get loads of applications... I don't think we got any applications for the full time band 7... Across the whole of the perinatal services there are not enough psychologists, they're really thinly spread... I would just like there to be a nice big pool of psychologists

Psychologist

They just haven't been able to find and recruit specialist midwives and the people with the right kind of psychological training to staff these services as clinicians.

Peer support

We were having failed recruitment rounds and you're having to go back out to ad and set up all the interviews again and that was tough in those few months.

Service manager

☒ *Function and timing of peer support work*

Interviews with MMHS staff revealed two particular challenges concerning peer support work in the early stages of setting

up: First, there was a reported lack of clarity around the *role and function* of peer support (exacerbated by Covid), echoed by staff in a variety of roles:

It is a general issue where people don't know what peer support is and what it's for and therefore they struggle to accommodate it in their imaging of the service.

Peer support

When I started in the role, nobody basically knew what is perinatal peer support, there were lots of questions... it was a lot like not knowing what my role is basically and feeling like nobody else knew what my role is... at the time, it felt a bit like 'what am I supposed to do?...

Peer support

Everybody has had a thing around "okay so what's going to be helpful for the service user? To have a peer support worker? And how is that different from a psychologist or a nurse or a midwife, what separate thing are they going to be offering?"

Psychologist

Second, there was an issue around the *timing* of bringing a peer support function on board, which is connected to the *mode* by which it is brought in (in-house or contracted out). There was a sense among non-peer support staff that it may be more beneficial to bring peer support work in

later, once there were enough women using MMHSs who were 'ready' to benefit from it. This was most problematic where an MMHS had contracted the peer support function to a third sector provider, where there was less flexibility for peer support workers or a coordinator to get involved in other (non-peer support) tasks:

I was recruited to set up three peer support groups and it turned out that MMHS weren't ready for me to do that... We were all set up to go but they were having difficulty finding enough people to refer to me.

Peer support

If it had been an option, we probably would have left it until the service was mobilised properly...

Service manager

However, where peer support workers were employed by an MMHS service, they reported being involved early on as a positive thing – despite the challenges they also experienced – valuing the opportunity to define their role, get involved in other tasks and bond with teams:

I think it would have been much more difficult if I was coming in a few months later... I think it was really important to be there at the beginning because everybody was figuring things out and still setting up the service, we were doing patient leaflets, stakeholder leaflets, so I was part of all of that and we chose the measures we were using in therapy, the trauma and scales... [Cont. on next Pg.]

...so I was part of all of that and I think that was really helpful, just to be there at the beginning when everybody was starting and everybody was new, having that team building period, I think helped.

Peer support

☒ **Working remotely**

As well as bringing the benefits outlined earlier, working from home during the bid and mobilisation stages of the London pilot MMHSs was also reported as a challenge by a number of staff. For example, one service manager reflected that:

It was all virtual because we started mobilising in February time last year which is when we were all in lockdown... it was all online... I think that did impact the progress of the project because had we all been sat in an office together every day, things could have been done much quicker.

Service manager

☒ **Health Inequalities**

Some staff reported concerns around not sufficiently embedding the addressing of health inequalities into MMHSs at the very early stages, or potentially – inadvertently – exacerbating them. This was seen as a problem that would have continuing implications further down the line⁹:

⁹ The regional evaluation was not designed to explore health inequalities. The issue arose in staff narratives around concerns about the service. See local evaluations for quantitative information on the extent to which services are addressing health inequalities or not.

A new service is coming up, we target the GPs and the maternity services, but I feel an opportunity was missed in those early stages... to reach out to the groups that are harder to reach, before we were even taking referrals. Like through religious groups, community centres where we wouldn't normally get referrals from... There's not been a targeted focus on that... We had an opportunity to reach out first to those harder to reach groups and develop those links, introduce ourselves and do it in a bottom up way, go to the root where people are on the ground. I think that's an opportunity missed... If we're going to try and improve the outcomes of women from hard to reach communities or BAME backgrounds... shouldn't we try and make those links first, make it easier to make those links first, because [the other links] will naturally happen – through maternity services, GPs, IAPT, other psychological services, perinatal services, they will already get tapped in that. [You] would have to propose this in the bid.

Psychologist

☒ **Stress and pressure**

As implied throughout this report so far, the early stages of MMHSs pilot services in London had the potential to be stressful and pressurised for staff, especially in the context of Covid, despite the sense of excitement it held:

We were all stressing about where this team was going to work ... but then something else would happen and that's the next thing that we had to stress about.

Service manager

I don't mind doing extra in fits and spurts, but it when it starts to become really consistent ... I just can't give that of myself because my family really loses out... March '21, by that point, was when we were absolutely on our knees. Everyone involved in the bid, we were all on our knees... Certainly those early weeks and months were tough, really tough.

Service manager

☒ *Lack of support and understanding from 'above'*

There was a sense in staff interviews that many of the challenges outlined above (the speed at which things took place, the lack of resource, the lack of choice, the difficulties in recruitment, the problems around IT and estates, the complexities around working in a multidisciplinary way, the difficulties of addressing health inequalities, and the stress and pressure that all of these can bring) are par for the course when setting up a new service within the NHS – inevitable if unpleasant, or frustrating aspects of the job.

What appears to have been more frustrating for some staff is the felt lack of understanding and support from 'above', in relation to a number of issues. While those who felt supported by commissioners really appreciated this, others felt a lack of

understanding and open dialogue, and felt some frustration at the impact of this on their service:

There was no discussion... the commissioners came in with an agenda, 'this is how much money we've got'... I don't know how the decision was made... It's not like I think the wrong decisions were made, the things that were challenging about the process was there was no discussion... Sometimes things are said to you like there isn't any scope for discussion... Certain things are given to you as 'that's just the way it is' and there isn't that discussion about whether it makes sense for you as a service or not. All of the different big wigs and commissioners, heads of maternity, all those people... I don't feel like we got a whole lot of support from them, I feel like we just kind of made it work. I don't feel like there has been support really from anybody apart from the support we give each other on the ground...

Service manager

[My wish is] just for commissioners and NHS England to be realistic. I think that would be the support, having higher level policy makers and commissioners be more realistic of what the work is. Yes, that's what would be really supportive, if there was more realism.

Psychologist

Delivering services

In this section we turn to staff experiences of delivering MMHSs to women and birthing parents. While participants reported significant positive elements, challenges either persisted or arose anew. We begin with the positives:

Positives

Some of the positive experiences reported with reference to the delivery of MMHSs were continuations of positive aspects in the bid and mobilisation stages. High quality staff and care, flexibility, productive and supportive relationships with one's own and other teams 'on the ground', and the ability to work from home continued to be valued and seen as important in the successful delivery of MMHSs for many. Additional positive experiences emerged more clearly once clinical work was underway. The main additional positive factors were:

✓ *Providing effective, person-centred care*

The provision of effective person centred care came out strongly in interviews with MMHS staff in front line and managerial roles; knowing that they were delivering person-centred care seemed to provide staff with a sense of integrity. What this care looks like in practice was varied, and included having a general mindset or approach, using a specific tailored intervention, and facilitating choice over method and mode of treatment:

I would only deliver personalised care for my clients... There is a culture of personalised care that we are delivering but I would say that that shouldn't be specific to our service. I wouldn't be delivering a service to not be addressing the person sitting in the room... The service, it's very personalised, it's very trauma informed and shouldn't it be like that everywhere?

Psychologist

I do recordings for the women that I see and sent it to them... [the women] really like that individual approach. When I do guided imaging now... it's got their name in it so it's very personalised... I actually tailor it to their needs.. their relaxing place in nature for example... You adapt ... it just depends on the women. We tailor to the women... We just ask the women and they guide us to what works and what doesn't.

Specialist Midwife

There's so many times when we can get bogged down by IT this, data collation that, outcome measures, but it's actually remembering that this is about the person that's sitting in front of you. It's their experience and you're trying to provide something for them so you need to make sure that what you're providing for them works for them... It's keeping the service users in focus and their experience at the forefront.

Project manager

There's something about being able to be flexible and being able to really listen to people... all women are offered face to face or online and it's their choice.

Service manager

✓ **Knowing you're making a difference**

There was a very clear sense in staff interviews that once services had opened their doors to women and birthing parents, the treatments offered were making an important difference in people's lives. Women's narratives about their experiences of treatment and the difference it made will be the focus of the following section of this report, but it is worth noting the value of this for staff too, knowing they were making a difference:

It is actually making the difference with women. I'm going to get emotional now but yes, I've had some lovely feedback from women.

Specialist Midwife

We have the service up and running, we are seeing patients, we are getting positive feedback. We have a team of really dedicated clinicians who are passionate. I feel lucky to be part of a change... It has been an amazing experience.

Psychologist

✓ **Emotional support**

Once service delivery was under way in the London pilot MMHSs, emotional support needs were reported to be considerable given the 'harrowing', 'challenging', 'painful' nature of the experiences being dealt with. Service staff reported having strong structures in place to ensure that staff are supported emotionally, and to keep these under ongoing review:

I have a lot of structured support. I get specialist supervision... I get professional psychology supervision... we have reflective practice... I get EMDR supervision... Those were spelled out and thought about. Then some needs that have developed, the three leads, we meet weekly to think through some of the issues that are coming up and that's really essential... That has naturally evolved... That's the emotional support.

Psychologist

All the clinicians have support built in because it is recognised that this work takes an emotional toll on people.

Peer support

✓ **Peer support**

Despite the challenges around peer support in the early stages of MMHSs, noted in the previous section (around timing, mode and lack of clarity re: function), the peer support function went on to become better understood and highly valued within teams, by peer support workers themselves and

other staff, especially once details around role and purpose were clearer:

We got the idea, because nobody at the service knew what our role was either, that we should do a presentation. That was a really important step which really helped for us to define our role a bit more..., to put that into a presentation for ourselves but also for the others... that was really, really good, having worked on the presentation, having given the presentation and hearing from the other professionals, the value of peer support.

Peer support

It's well documented that people find peer support very helpful, to have those conversations or have that relationship with someone who's had a similar experience. I think there's something around having someone with a similar experience.

Service manager

✓ **Pausing to take stock**

One issue that arose inadvertently in some staff interviews, was the value of pausing to review and take stock of where things had got to. This came out through staff reflections on the process of taking part in evaluation interviews, with staff noting that they'd found it useful to reflect on the journey so far:

This is actually almost cathartic for me because I haven't really spoken about it.

Service manager

I've really enjoyed the interview process. I feel like from my perspective it helps me process and consolidate where we are as a service.

Psychologist

Challenges

As well as the positive experiences of delivering MMHSs, staff reported a considerable number of challenges. Some of these were persistent, or 'legacy' challenges, that had arisen in the bid and mobilisation phases and had not been resolved, had new implications, or become increasingly problematic with effects that were more keenly felt. Other challenges had more clearly arisen once delivery of treatment for women and birthing parents had begun.

The main challenges reported in the service delivery stage of MMHS were:

☒ **IT problems**

Once service delivery was underway, IT problems took on an additional dimension, in particular with staff having to navigate different case note systems or not having adequate access rights to them:

I'm having issues with some of the access and how long it takes me to get access to these systems remotely... It's taking up to 15-20 minutes, even longer... I didn't realise how much of a challenge it would be and how time consuming it was. It's not the most productive use of my time... [Cont. on next pg.]

...In our MDT meetings, they're going "can you just pop and see what's on the hospital system?" I'm like "no"... It's particularly tiresome [and] really confusing, yes it's given me a few headaches... When I was a student many years ago they said "the NHS is thinking in a few years' time that there will be one system". They told me that in 2005. We're now 17 years on.

Midwife

☒ *Lack of appropriate clinical space*

Problems with estates also became more pressing once services were up and running and trying to offer women and birthing parents a person-centred service. Finding spaces in which to see people for face-to-face appointments was reported as particularly challenging, with the general lack of clinical space and the variations in availability between areas. Even when there were options in theory, these were reported as often unsuitable, because of connotations associated with particular buildings, restrictions around times they were available, or a combination of the two:

You can't operate in the same way as the main perinatal service which is "oh you can use children centres", not with people who have lost babies, had babies removed, all that kind of thing. It is not quite right... If you're seeing people in a children's centre you only have quite rigid times where you can use a clinic space... it's nearly always a Friday... it's the worst possible time to see new people on a Friday afternoon.

Psychologist

There's a hospital, years ago it was an asylum...It has connotations for people. I worked there... I got the feedback from people that a lot of people didn't feel comfortable coming there because of its history as an asylum. We've had a few people who have requested to be seen face to face and we've tried to accommodate that but I think in terms of estates, we don't really have any.

Psychologist

The lack of suitable estates not only impacted where appointments could be made with women and birthing parents, but was noted by staff as challenging in terms of impacting the crucial, informal support they could seek from colleagues:

I have often chatted with my colleagues online, after a client online, but it really isn't... I think that plays an important part in support really, just seeing, physically, people around, knowing that people are physically around you.

Psychologist

☒ *Working remotely*

Linked to the lack of appropriate space – and despite the benefits of working remotely – some staff reported missing the physical presence of their teams, both because of the personal connections they were keen to nurture, and because of the informal containment that staff can provide for each other:

I can work on my own but I have missed physically seeing the team. We're all jotted around. We never come together physically, not even once a week to see each other... I think that could be improved. I know there's the efficiency of doing everything online, but you lose that time where you just need to set yourself back and reflect. Sometimes that reflection is done with the people around you.

Psychologist

☒ **Retention of staff**

While recruitment of psychologists had posed a challenge in the early stages of setting up MMHSs, retention went on to prove difficult for some. One service had particular difficulties, as staff members moved on, took leave or found themselves in unexpected personal circumstances which took them away from clinical work. The impact of this was significant, with remaining staff taking on extra work in order to 'hold' women and birthing parents who had started treatment:

We had one [psychologist] leaving that couldn't take anything on, one that just left unexpectedly, and then we had one that had a full caseload, there by herself... Because of all these staffing problems... I've actually got a caseload of five people now... I'm certainly not a psychologist... but I've worked in mental health services for years... I've trained in lots of different modalities... I can hold them until we have more ...staffing... [Cont. in next column]

...it's a lot of listening, containing... It's something that I've had to take on because otherwise the service is going to crumble... I'm very glad that I was able to help out, but I'm also aware that this is another thing that I'm managing now that I feel quite overwhelmed by, because I've got a lot of other things to do. I don't even have any protected time for MMHS as it is, and now I've got a caseload.

Service manager

☒ **Emotional strain**

One of the key challenges to emerge from interviews with staff was the degree of emotional strain entailed in working in MMHSs. While this was understood and accepted as a routine part of the job, and while staff felt supported by their peers, it still effected many of them deeply. It seems to have been particularly demanding for peer support workers, and to be particularly difficult in the context of maternal loss:

It's hard at times because we're seeing women who have had multiple losses, child or neonatal deaths... sometimes with grief work there's no set formula and you just have to sit with them through the painful experiences and be with them on that journey and that can be really hard... I did the assessment ... then when I had to talk about it [with the team], I just burst into tears and it was really... I can feel it now... it just makes you think about how much you take on these things really and how it can affect you.

Psychologist

It can be a lot and I think it was a lot in the beginning. There are always stories in the referral meetings, even if you're not working with them but you feel like, oh my goodness, that sounds exactly like what happened to me and I think a sense of it is always there, it's always a very sad story that you're reading about every week and in the referrals or when you speak to the women. I feel like loss is the hardest to work with. I have discussed that with my supervisors and I've had training on baby loss, which I found helpful, but there is always just a bit of, it's really uncomfortable to talk to someone who is just grieving, who has lost a child.

Peer support

While clinical staff reported using structured supervision to process emotional strain, and while many recognised the importance of physical proximity to teams in containing emotions, there was a recognised need to consider best practice around non-clinical staff being exposed to distressing stories through referrals and referral meetings, and in other forums:

Hearing some of the people's stories and watching some of that stuff is a bit of a burden I guess, emotionally. My supervision is very much the operational side of my job, not much around the emotional part. The psychologists have very structured supervision. There's been lots of conversations, I think across the teams, around the supervision and support that we give to the psychologists and the therapists... [Cont. in next column]

...Some of the referrals are really distressing. When the service started I would get the emails all directed to my inbox... If you're in a team meeting you talk about it, it's different, but to sit there and read those referrals on your own, and it doesn't go anywhere, you're exposed to every single referral and you just sit there, nowhere for it to go.

Service manager

Baby loss and trauma and maternity really gets into people.

Psychologist

☒ Not treating partners

There were a range of interpretations, opinions and feelings among staff about treating partners within MMHSs – about what this does or should look like, and what the ultimate purpose of doing so is. Some felt it important to support partners in order that they can support women and birthing parents, while others felt that partners should be seen within MMHSs in their own right if clinically indicated. Navigating this aspect, with the range of positions it seems to encompass and the apparent confusion about what the mandate was concerning partners, was a challenge.

We thought that we could do more for partners than we were initially funded for. So we thought we could provide individual work and we can't. We're only allowed to provide group work, couple work for partners... [Cont. on next pg.]

...With my clinical hat on, the reality of offering somebody an assessment to tell them you can't do anything seems a little bit pointless. Actually there are two people who created that baby and there are two people who have lost that baby or... yes, the woman was the one who physically went through the delivery but that partner has experienced trauma... Quite rightly if you've only got a finite amount of resources, this needs to be focused on the woman but actually we've got all these men that are then expected to support their partners to be there but then haven't had their needs met. I think that's something potentially fundamentally wrong with the longer term plan.

Project manager

There was that message about partners, 'oh it's not really for partners, that's just signposting', which wasn't my understanding at all... There are fewer partners that need support but there are some that do need it and I think they should be seen in their own right. There was this argument 'wouldn't want a partner to be taking up a space that a woman could use' but actually often partners are not in the same place with something, sometimes both people need to be seen.

Psychologist

☒ **Health inequalities¹⁰**

There was recognition among some staff that addressing health inequalities was continuing to be a challenge within MMHSs (due in part to not having addressed this at bid stage), with an awareness that despite referrals being 'pretty representative' of the local population in some ways, things were far from ideal:

If we'd done [outreach work] before, at the beginning, it wouldn't feel like [hard work] now. We'd probably be having the trickle effect now actually of those people accessing the service... Getting your face known in the community, in voluntary groups that access people who don't always go to the GP or maternity services... you have to put in that work beforehand really.

Psychologist

☒ **Referrals**

Staff reported a number of challenges related to referrals into MMHSs. One concerned receiving referrals for women and birthing parents who may not be ready for treatment, which would have implications for successful therapy:

¹⁰ As noted in an earlier section, the regional evaluation was not designed to explore health inequalities. See local evaluations for quantitative information on the extent to which services are addressing these.

One time we had a referral for birth trauma and I looked at the baby's birthday and it was the same day as the referral. I was like 'is this a typo?'... This woman had had a very difficult birth that day but... you wouldn't be thinking about really diagnosing PTSD for at least four weeks. Someone may feel traumatised but there is an element of natural recovery process...

Psychologist

Another challenge around referrals concerned different elements of the wider mental healthcare system not sharing information, which meant women having to repeat their traumatic stories over and over:

If the women consent, we are happy to convey some of our information for example to IAPT but they do not do it vice versa. So if the woman has done an assessment at IAPT and they refer to us, they will not give us any information from their assessment. They'll just give us an overview, even with the woman's consent, they don't do it... We're trying to make it easier for the women because we're talking about very sensitive information, for an assessment we do go into quite a bit of detail... The whole point is continuity, you [shouldn't] have to keep going over the same thing... for the women as well as the staff, not having to repeat themselves, doing one assessment and then more or less doing the other... If you've done an assessment and you think "do you know what? Thank you. I appreciate you giving me the information but... you might be more suitable for [a different] service".

Midwife

The third challenge around referrals into MMHSs relates to accessing potential referrers, especially given the number of them, and the lack of capacity that staff reported for making the necessary links with them:

It's taking more time to develop links within IAPT services... we are struggling with how to get into GPs and develop those relationships with GPs. There are so many GP practices... That's a lot of people... If you think of the amount of time you're going to spend trying to get into all those hubs... In my role [I've not] had the time to really be able to investigate that as much as I would have liked... If commissioners want us to go out wider and to speak to more people, this is going to generate more work which is either going to increase your waiting times or we need more staff.

Project manager

The main challenge concerning referrals into MMHSs was the growing numbers of them and the predicted further increases as knowledge of MMHSs was expected to spread:

We've been swamped with referrals, I feel like the numbers have run away from me a little bit in terms of the demand. The demand is overwhelming and it's hard to keep up with that... The clinicians just feel swamped and they're running on empty... This is very defensive and reactive and it doesn't sit well with me.

Psychologist

☒ *Growing waiting lists & wait time targets*

Closely linked to referrals, staff reported that once referrals started coming in and caseloads were expanding, waiting lists for assessment and treatment started to grow. While there was a recognised inevitability to this, it was coupled by a strong sense of discomfort¹¹:

Unfortunately now, not only have we a therapy waiting list, we've actually got an assessment waiting list.

Service manager

Waiting lists have the potential to really spiral out of control. We're at three weeks now. I'm sure it won't be too much longer before we're at a four week wait and you really don't want to start seeing it going beyond that... I'm listening to all the clinical stories and you just think 'these women can't afford to wait'. If they've managed to reach out and ask for help then they need to be seen within the reasonable timeframes that we're setting. The service is new, it will develop a bad reputation if our waiting time to be seen is six, eight weeks or potentially longer.

Service manager

The complexities of managing waiting lists in the context of providing a person-centred maternal mental health service were emphasised by clinical staff:

Grief is an ordinary natural process, I wouldn't want to pathologize it, I probably wouldn't want to see a loss case before six weeks... For a tokophobia woman, you would want to see her ASAP, not as a crisis emergency but to put the proper support in place... If we're thinking about personalised care, it's not right for everyone to be seen within two weeks.

Psychologist

These complexities notwithstanding, staff recognised the need for processes to manage growing waiting lists, and some referred to specific approaches they had started to use, or would like to use:

We have a weekly referrals meeting so we discuss new referrals to the service and then we have a look at the existing caseload and make sure that everything is up to date - has this person been called, has this person been advised about how long they might wait, what's the issue there, that kind of thing.

Psychologist

As indicated earlier in this report, staff also reflected on the mounting tension between *managing waiting lists* on the one hand (and through this managing the expectations of women and birthing parents), and *promoting MMHSs* on the other so that service delivery could match need. There was a widely-recognised, fundamental tension between the two:

¹¹ It was recognised by staff that in some cases – specifically trauma – that waiting may be necessary, in order to determine whether psychological distress had naturally resolved or turned into eg PTSD.

I have promoted the service, which is a good thing, but obviously there's only one of me... I've put the posters up, now I'm seeing all the referrals going on, I'm thinking "we're going to be quite inundated," and we haven't even gone out to the GPs yet who are probably going to be our biggest referrers.

Midwife

☒ **Lack of capacity & resource**

The challenges around numbers of referrals and growing waiting lists point to a central challenge in the delivery of MMHSs; the lack of adequate resource. While in the bid and mobilisation stages this lack manifested in the need for more project and management support (from both maternity and mental health sides, and in the form of both project management and commissioner understanding), once treatment had got off the ground this broadened to an additional need for more clinical staff:

Everyone is stretched, everyone is being expected to just be on that cusp constantly of having a bit too much.

Service manager

I suppose the hope is that NHSE and the CCGs will appreciate that funding hasn't been adequate... We will be able to demonstrate that there's a need for the service certainly, but actually the ability to deliver the full extent of what commissioners and the long-term plan is outlining is unclear at this point... We can split what's been offered from what the reality is in terms of need.

Psychologist

☒ **Sustainability of services**

Closely linked to the lack of resource, and despite the clear need for MMHSs among local populations, was the concern expressed by a number of staff around the ultimate sustainability of MMHSs, as they stood. The relatively low number of clinical staff within services, alongside high demand for those services in local areas, as well as the potential for staff absences, meant that there was very little resilience within the system, and a concomitant possibility of services not being viable:

Now we're operating the MMHS, it's such a tiny bit of service with such a few amount of people in total compared to almost any other service. It's really hard to keep it as a sustainable model like that because all you need is one person on planned leave and someone to suddenly go off sick and you're really struggling to keep the service upright because you've only got three or four staff in total, not all of whom work full time. So clinically it's really hard to sustain.

Service manager

In response to a question about what could be better within the service, a number of staff echoed the sentiment in this service manager's reply:

More staffing. Definitely more staffing so that we are in a more sustainable place... so we might be slightly stretched but that we've got good enough capacity for the demand that is clearly there. Because there is nothing worse than working in a service that can never meet a target of when you can see these women... [cont. on next page]

*...than constantly chasing your tail,
running an endless waiting list.*

Service manager

So far we have set out one half of the story; it is a story of staff struggle – of commitment, perseverance and solutions-oriented thinking in a context replete with challenges. In the following section we turn to examine the other half of the story – women’s experiences of engaging with the London pilot MMHSs.



SECTION 2 – WOMEN'S EXPERIENCES

In this section we share the experiences of women who were interviewed as part of the regional evaluation, who had received, or were receiving, support from one of the London pilot MMHSs. We present our thematic analysis, in chronological order, starting with women's experiences of *accessing* services then moving on to their *engagement* in the different treatments available and the felt effects of those treatments. (All quotes in this section are anonymous - narrative testimonies from the women can be found in Section 4 of this report. These testimonies – shortened versions of women's interview transcripts – set out in some detail participants' accounts of their journeys into, through and out of MMHSs and maternity-related mental health struggles.)

The story we tell here is overwhelmingly positive, with a few areas for development which women thought could be considered in future planning, but which in no way detracted from the remarkable benefits of the treatment they'd received. The challenges that women did experience were mostly a reflection of the rules governing MMHSs (for example restrictions concerning partners), and of issues in the wider elements of the system surrounding – and referring into – MMHSs.

Access and assessment Positives

For some women, gaining access to their local MMHS was a positive experience. Particular factors reported as influential in making it positive were:

✓ *When healthcare professionals are proactive in referring*

Those women who had been referred into MMHSs by a healthcare professional – as opposed to self-referring – appreciated being 'picked up' by healthcare staff who recognised their need for specialised support:

I spoke to my GP and she got me in touch with the [MMHS] service... [A psychologist] from [MMHS] got in touch with me... She phoned me, and I remember, I was so happy that she phoned, like that happiest I had been in months.

The Health Visitor was really on it, she got me to fill out the post-natal depression and post-natal anxiety questionnaires, she did them with me, she talked about the new service, she made it very clear that it was available.

One woman articulated very clearly the value of referrers taking time to understand women's experiences, to validate them, and to be mindful of women – like herself – who might be adept at 'masking' internal struggle:

[The specialist midwife] actually sat down with me...she was like "you're someone who needs extra help" ... She was asking me questions to the point where I was like "okay, you know what, I'm not fine"... How she did it was very nice. We were just talking... she sort of validated my experiences. I knew what I'd been through, obviously, but I didn't know that they were enough to cry about... [cont. on next pg]

If you're asking me what helped, it's just having that conversation I think, just having that conversation... Anybody that doesn't have a normal pregnancy, catch them. Anybody that doesn't have a normal birth, catch them... It's not always people who visually need help... Obviously help them too, but there are people that need help who 1) don't even know they need help or 2) present that they don't...

✓ ***When women don't wait long between referral and assessment***

Regardless of whether women were referred into MMHSs by a healthcare professional or had referred themselves, they also appreciated it when there was a relatively short waiting time between being referred and being assessed:

I got a call [for an assessment] within 24 hours [of the referral], which was amazing...

✓ ***When there is space for expression and clarity about process***

Once in touch with MMHSs for assessment, women reported really valuing certain aspects of the assessment process: having a *safe and validating space* to express themselves and articulate their struggles; having *clear signposting around next steps* and when these would take place, and understanding the *rationale* for those next steps. Together these elements of

assessment gave women reason to feel reassured and hopeful:

[The assessment] was the first time that I actually expressed everything, explained everything I went through, it was a relief... Straightaway I felt like [the psychologist] understood, and she was really listening... actually listening to me... It felt a bit of relief, like "okay, I've got something here that's going to actually help me."

There were three women there and they start asking question and they say "okay, we think that you may have ... trauma from the birth and maybe this part of the service will be helping you" and that was good.

After the assessment I was called and told "this is what we've set up for you, we've got some counselling, got a specialist maternity loss midwife, then your general pregnancy care overall will be under an obstetrician at the hospital... She spoke about how each of those things would help me, like, what they would do, like "the counselling will help you with this, the midwife will help you with that", that was useful.

Challenges

For a few women, accessing the service had been more difficult, due to other parts of the healthcare system not working optimally with MMHSs (or due, at root, to some of the more fundamental issues

discussed in the previous section). So although these factors are not about MMHS *per se*, knowledge of them is important when thinking more broadly about providing effective care, including around access. The particular factors that made access difficult were:

☒ ***When healthcare professionals do not pick up on need***

Some women reported telling healthcare professionals – for example GPs and health visitors – that they were struggling with their mental health, but receiving dismissive responses, which left them feeling unheard and unsupported:

It wasn't easy to access to the service...I asked for some help to my health visitor, to the GP. They just say 'you're doing well, you keep breastfeeding the baby'. I was saying I was tired all the time. They were saying 'that is normal, yes, sleep when the baby asleep. Have some rest'. But I didn't feel okay, so after two months feeling really bad, I just wanted to stay in bed and I didn't want to see my baby, I went again to the GP and I say 'I am struggling a lot. Also, I am thinking with a sombre feeling ... and also when I was breastfeeding in the beginning it wasn't good'. The GP say 'yes, I think you should keep doing the breastfeeding because it's the best thing for the baby.' ... I felt that I was asking for help and no one listened to me.

We had a visit from the home birth midwife who discharged me from their services. She wasn't very helpful when I talked about feelings, about not feeling okay, she was quite dismissive.

No-one had ever mentioned [MMHS] to me. I didn't see my GP at all throughout my miscarriage... When I went to the hospital and had the scan... you just get sent home and that was it... just 'wait for it to pass', you don't really get anything else, like there's no follow up.

I look back on my pregnancy and I just wish that I had access to the service earlier because I do think it probably would have saved my massive nosedive into the depths of post-partum depression if I was able to have caught it earlier. I think the frustrating thing is that I did ask for help, actually on more than one occasion and I wasn't able to get it because I wasn't considered severe enough. I think that was not on really because I did get severe and it was awful. And to think 'why did I have to go through that, to get help?'

☒ ***When women find MMHSs 'by chance'***

As highlighted in the staff narratives section of this report, publicising services has entailed careful consideration of the requirement to balance the *needs of women* with *capacity of staff*, and services have chosen a 'soft launch' approach to prevent unmanageable waiting lists and associated risks to women. Nonetheless, it is worth noting that women who felt that they had found the service 'by chance' (for example by searching the internet for appropriate support, or by dint of being pregnant again, with unresolved trauma from previous pregnancies), were unsettled by what they

imagined might have transpired had they not discovered that MMHSs existed:

I just researched it myself... that's how I came to the service... I was able to recognise in myself that I needed more help, and it just by chance that I found it... I just Googled like 'maternity counselling' or 'miscarriage counselling' in [my area] and yeah it was just by chance that I came across the MMHS...

If I wasn't having [my second baby], I wouldn't have accessed that help, when actually I would always have suffered from having [my first baby]... If I wasn't pregnant with [my second baby], I would have been so easy to get lost... If I hadn't accessed MMHS I would still be in my spiral of nonsense.

☒ **When women get 'bounced around'**

Some women also reported that although they 'got there in the end', they had accessed the MMHS through a somewhat circuitous route, mainly because they were initially referred to IAPT services, and been referred from there to MMHS (sometimes via repeat visits to their GP). This meant – among other things – that women were telling, retelling and telling once more their most recent traumatic maternity stories, and in some cases this was in addition to the telling and retelling of previous maternity traumas which were in turn, for some, triggering of more distant traumas, including within the healthcare system.

It was a bit of a roundabout. I'd been referred to IAPT before, after we lost [our second baby] and I found that process excruciating ... because you go through kind of triage where you're telling the story and then they basically said "I don't think we can do anything for you, we do CBT, off you trot"... So this time I was like "okay, I'll go to IAPT but here we go again."

I asked for some help to my health visitor, to the GP... then I checked online... Someone called me back... I start crying on the phone... and they say 'we can't help you but I will send someone to help you'. Just after someone called me from the [MMHS]... It seemed for me the service was difficult to find.

☒ **When there is a felt lack of clarity around process**

One woman reported that she had had a 'long' wait (two months) between her assessment and the start of treatment, during which time she described herself as 'mainly functioning and okay, with fairly regular crisis points'. The problem here was not the wait time *per se* but the lack of clarity she felt through it – left with unanswered questions around the treatment mode and process – which exacerbated her distress:

I had asked by email how many sessions I was going to be offered and what kind of therapy I was going to be offered, but I wasn't clear because... [cont. on next pg]

...I hadn't had an answer to those questions in the responses to my emails, so I wasn't clear what the answers to those questions were.

Engaging in treatment

All women interviewed for this evaluation reported having their needs and expectations met, and many reported that any expectations they had, had not only been met, but exceeded beyond their imagining, regardless of how they had accessed the MMHS.

All women who took part in regional evaluation interviews stated very clearly that they were doing so – although it was potentially an emotionally demanding, draining and triggering experience in itself – because they wanted to give something back to the services which, in their eyes, had given them their lives, or quality of lives, back¹². General statements about the positive effects of MMHSs, and the difference they made in women's lives, include:

I honestly don't think I would be where I am now without the support from MMHS.

Even yesterday my husband said to me "you seem a lot happier" and it's true...

Because I received this help, I am feeling good and I can keep going with looking for the job, taking care of my baby, keep going with my life.

Now I'm in peace... when I face trouble... I can deal with it.

Thank you so incredibly much for allowing me to access the service because it's not only changed my life, but it's also changed my family's life and my little girl's life, because she now has a mum who is able to be happy.

I knew I wanted help, I didn't know I would feel so much better by the end of it.

It's given me my family, our baby is such a happy little boy.

Now... when I look to the future it's not feelings of despair and desperation. It feels good and comfortable.

It's made me know how to be a better person, a better mum, a better person to myself, better sister, better everything.

¹² Of course we cannot know from this evaluation what the experiences might have been for those women who did not volunteer to take part.

Women were also asked to imagine there had been no MMHS, and to express whatever came to mind. Their responses were equally powerful:

I would be really struggling... probably taking antidepressant medication and not really dealing with the problems.

I probably would have been put on medication, anti-anxiety medication.

I don't think I would even be able to cope without this service.

[I would be] a big blob of desperate fear and emotions.

I would have still been in my spiral of nonsense.

I probably would have no friends.

My whole life would have been literally crumbling around me. I wouldn't even know where to go, I wouldn't speak out.

[I would be] in a black hole... in bed asleep. For a year.

It's quite scary to think that... I don't know what would have happened.

Without the service I would never be me.

[I would be] in despair.

I had thoughts of killing myself, so I probably wouldn't be here.

But what was it about the treatment – the therapy, the specialist midwifery, the peer support – that enabled such positive results? We now dive deeper into women's experiences of treatment to gain a more detailed understanding of what it was, from their perspectives, that enabled them to heal – or begin the process of healing – and continue with their lives¹³. We start with psychological treatment, or therapy.

Therapy

Positives

Many of the positive factors can be traced back, at root, to the therapeutic relationship, but what does this comprise? Which aspects of the relationship did women find most instrumental in enabling their recovery and growth? According to participants, the key enabling factors were:

¹³ The majority of women we interviewed had received therapy, and so the majority of data we have concerns women's experiences of this form of treatment, and the balance of attention is skewed towards this. Short sections on specialist midwifery and peer support follow afterwards.

✓ *Flexible delivery mode*

I could do it from my home, so if [my baby] was unsettled, then he could just be sitting with me it wouldn't be a problem. I don't have to take him out or get a babysitter, or anything like that, so that was good.

[The therapist] phoned me and said she would like to meet up with me and do an assessment... The first time she came to my house, which was really nice... Then we did a couple of ... video link appointments, then we did appointments in the hospital as well. So, she was very flexible always.

✓ *Skilful, knowledgeable, flexible, kind psychologists*

Women reported being able to build effective, trusting relationships with their psychologists, which enabled them to approach sessions with the openness and honesty required for real change. The particular qualities that women appreciated in psychologists, and saw as instrumental in relationship-building and successful treatment, can be understood to fall within four overarching categories: **skill**, **knowledge**, **flexibility** and **kindness**:

She was so flexible, always very flexible, she worked around me.

Very knowledgeable, definitely knows her stuff.

A master in what she does.

Very approachable.

She is very warm... able to challenge me and have the warmth.

She showed a different type of kindness... a professional kindness.

Persistent ... how do I describe her persistency... a relaxed persistency.

✓ *Plural modalities*

Women appreciated not only the therapists' skill, experience and knowledge, but also that they drew on different therapeutic frameworks and tools according to what women brought to sessions, finding it useful to have therapists who could adapt and flex according to need. Specifically, women reported appreciating the person centred approach taken, the access to Eye Movement Desensitisation and Reprocessing (EMDR) therapy to process trauma if required, the use of tools from Cognitive Behavioural Therapy (CBT) to manage unhelpful thoughts, the teaching of mindfulness techniques, and the use of a more psychodynamic approach which allowed them to delve a little into past experiences and understand how these had shaped their maternity experiences. The point here is that access to a *range* of approaches (discussed further in

subsequent sections) was seen as key to successful treatment:

One thing was talking about my experience, but also we did some EMDR... and we did some mindfulness... It was all so useful.

✓ **Maternity focus**

Women reported repeatedly that the maternity focus of the therapeutic support they received was fundamental to success, noting the importance of clinician's specialist understanding of both 'normal' and traumatic physical and psychological experiences in the maternity process:

I tried the more maternal mental health service because they would understand a little bit more about what I'm actually going through. Rather than just general depression, it can have so many different branches. I think, because it was more specific, I thought "yeah, I'll choose that one then."

It was really helpful because it was with someone who was specialised in that area... [the psychologist]'s had training in maternity loss and trauma... just to have that knowledge.

✓ **Non-judgemental listening**

Women highlighted the importance of non-judgemental listening within the therapy setting, reflecting on how this created the requisite safe space to talk freely and openly:

Rather than telling me "oh it's alright, when you have the next one it'll all be different" or "oh, it's only baby blues", all this kind of stuff that I was having before, she was actually listening to me.

I said to [the psychologist] "I can't bond with my daughter" and you can't say that to other people because they think you are a bad mother... I had some really unpleasant feelings, I thought it would be better if [my daughter] died, and [the psychologist] was absolutely fine, she acknowledged how I felt, she explained that is part of post-natal depression, anxiety, that when we have a problem, we try to find a solution as best as we can, depending on our frame of mind. I was in a bad place at the time.

I was given the space to talk and not be judged for all these feelings, because I think as a mum you hear these horror stories of kids getting taken off their parents because they're not with it' or they're experiencing all these things in their brains, and you're worried that all of a sudden your baby's going to be taken off. One of the things that [the psychologist] reassured me of was "we don't want to take your baby off you, we want your baby to be with you. So don't be afraid to talk about these things."

The relationship that I had built with [the psychologist] was wonderful and I do feel like that is why it was so successful... I felt completely able to divulge these very, very ugly details of my life but she was able to be there with me and make me feel like I was still safe in the room. That is definitely feedback that I would like to give, that that relationship she was able to build with me over quite a period of time was significant and substantial in helping my success story.

✓ **Clarity around process**

Women also reported appreciating clear signposting within the therapy sessions:

[The therapist] would do a brief summary and then “okay, we’ll meet in two weeks”... and then we’d always set up our next meeting at the end of the current one so I always knew when the support was coming and that there was a plan.

✓ **A space for processing psychological pain**

With the creation of a safe space through the steps taken above, women were able to process psychological pain:

One of the reasons that I can talk about the experience without really going there is because of having done the work of having unpacked the experience and really excavated it for its most traumatic material. It doesn’t feel so dangerous to me.

You have all these thoughts and feelings, but actually in a really busy life you don't give them the space or the depth. And it's sometimes very difficult to do... it's hard to give it that space because you've got a baby and working, you just get to the functional bit. And [the psychologist] gave it that space to work through that.

I was having these nightmares of the birth ... but through EMDR work with my therapist, I’m able to look back on it now and I’ve been able to move forward with my life... I went through the traumatic scenario while using these grounding techniques to make it seem like I was still okay... associating it with a positive area... Before I wasn’t able to speak about my birth without getting very, very, very upset, almost shutting down. Now I’m able to have a full conversation, with a little quiver in my voice, but that’s it. I’m able to look at it quite objectively now.

✓ **Help piecing together a maternal mental health story**

With the groundwork laid through the skill, knowledge, flexibility and kindness of therapists, their capacity to draw on different therapeutic modalities, their maternity focus, the clarity provided around next steps, and the non-judgemental listening they provided, women were able to begin piecing together a clear story of their maternity experiences, making sense of what they had recently gone through:

You can have a story, there can be lots of disclaimers... lots of twists and turns, but when you have a simple 'this is what happened, this is why', it's... I don't know how to explain it. You just have to find your story. That simple story.... For me, when I'm doing the 'are you sure's'? I can curb it and just know what my story is without going down all the nooks and crannies.

Telling my story... having this interview... it's a testament to [the therapy]... Not that I'm not feeling on the edge of tears, it's always going to be sad, but ... being able to do this interview is partly because of having had the privilege to use that service.

I'm here [in the evaluation interview] and I'm able to say my story properly, concisely, because it's part of what's happened in therapy.

This piecing together was aided in part through the reflecting and summarising that therapists did:

[The therapist] really précised what I was saying because... there were times... I'd fall over myself, buzz around all over the place, and she was very good at listening and extremely good at summing up where I was.

At each session we would start ... 'what do you think you might want help with?... At the end of one she'd say "this is what we've talked about today." Like, she would do a brief summary... and that helped to set it in my mind.

✓ **Piecing together past and present traumas**

In addition to helping women assemble – and narrate – a concise maternal mental health story, therapy also enabled women to understand how other aspects of their lives had shaped their maternity experiences, helping them to make sense of the recent and distant past and the events and relationships therein, which had come to cast a long shadow in the present. Many of these experiences can be understood as adverse childhood – and adulthood – experiences, and women reported that dealing with these in MMHS therapy was a key to success:

She also looked for the root causes of the problems I had, she even went back into my childhood a bit as well and we discussed my childhood, so it was a lot deeper... She gave me excellent professional input.

Part of the reason the [maternity] experience was traumatic was because it kind of pinged off other traumatic events that happened in my life which I wasn't really aware of before.

It has massively supported and changed me and it's also made me look at the relationships I have but also the experiences that I've grown up with and everything. [That] has helped me move forward in being a mother and trying to figure out this new phase in my life.

What therapy really did was it helped me to identify all the parts of my life that influence how I am today. I told the therapist I was sexually abused when I was a child and it made me realise that even that is affecting the way I parent, because I had a lot of fear, distrust... Because my situation wasn't dealt with properly so I was reacting to that. Even though that was not what I was in this therapy for, discussing it helped me analyse and identify the reason why I am the way I am. I learnt so much about myself... What I got out of it the MMHS service was a total 360 degree overview of my whole life and my whole being.

It helped me look at things from a different perspective. It helped me analyse other things and it helped me identify 'this is the reason why I react like that'. So it helps me to react even better.

✓ **Other contributing factors to the success of therapy**

In addition to the conditions and process outlined so far, women reported other factors which made MMHS therapy

particularly positive. In particular, they reported that it had provided them with:

✓ **Validation:**

The therapist walked a fine line with me between trying to help me self-validate and validating me, she saw that I needed to hear it because I'm not hearing it from enough people. She saw that I needed somebody to say, 'this is fine'... She was endorsing me ... there was a validation.

What was actually very useful to me about the EMDR was helping me to frame what had happened to me as trauma... I was having flashbacks, and I was having racing thoughts but because they weren't of a battle field and bombs exploding... I wasn't quite able to really seriously say that that was what was going on with me. The therapy helped with that.

I was worried about if my son was doing well or not, if I was doing the right things with him... [The therapist] said "look, you are the mum, you know your baby more than anyone else, you know what's right." That was the main thing... knowing that I'm doing the right thing, I know what I'm doing, and stop double-thinking myself.

✓ **Normalisation:**

It made me feel like "okay, I'm not the only one that feels like this".

✓ **Vindication from blame and treating shame:**

It showed me that it wasn't my fault, that it was something that happened to me that was beyond my control.

The therapy helped me realise that it wasn't my fault, it's not my fault that all that went wrong.

I talked to [the therapist] about [all of the traumas], and she said to me "now I feel like you don't feel ashamed or anything like that. This is very good." And that's why I'm talking... about this... Not like before, now I don't feel ashamed.

✓ **Tools for reframing unhelpful thoughts:**

Even now when I'm feeling like "what kind of mother am I?" I'm able to take a step back and be like "what are you saying that based on?" It's never really anything.... It's just a feeling. I'm able to recognise that that feeling is not a true fact.

Before, it was like 'I am feeding [my daughter] and failing her'. [Therapy] changed that narrative I had in my head. At one point I remember thinking 'I'm not going to do this, I can't do this'... That switch in thinking significantly helps.

I was constantly worried about the future and medical things happening, things going wrong. And [the therapist] helped me to see 'live in the now, stop stressing about six months' time, live in the now. Is [my baby] okay now? Yes. Are you okay now? Yes. Stop worrying about what might happen because it probably won't. That was definitely one of the things that she helped me see.

I started to feel like "why am I doing so much for [my baby] and not for [my older son]?"... I remember sharing that with the therapist and she said to me "if [your older son] could communicate with you right now, he would probably say to you "mum, do everything possible to make sure that my brother is going to be okay"... now I think about that, it was such a turning point... they're siblings, they love each other. [My older son] wants his brother to be safe... That was a big turning point for me... I don't even know if the therapist knows that that simple thing really changed the way I see everything.

✓ **Tools for calming the mind:**

It went beyond just talking... [The therapist] gave me some strategies to use in life which I was then practicing... being mindful, focusing on one thing at a time... not getting obsessed with negative thoughts, trying to look at things as a bigger picture.. have time for myself, mindfulness, head space... It really helped.

I remember telling [the therapist] that I don't breathe... I literally hold my breath all the time... So we did a lot of breathing and I was like "oh my gosh, it feels so good to breathe"... It sounds really basic but it's been really good, just that feeling of clarity, silence, breathing connection... I still do that regularly whenever I feel a little bit stressed out.

✓ **Partner support:**

Not all partners were offered treatment within MMHS services, however, some women did report their partners being offered support (although it was not clear what this would have looked like had it been taken up), which the women in question appreciated, thinking it was a good idea – even if their partners didn't:

[My partner] was offered support, and I actually thought that it might have been good for him... because he was getting a bit angry, it was his way of dealing with things.... But ... because of his personality... he was able to deal with it himself.

It was actually offered to [my partner] but he felt that he did not need to take it and I mean you can take a horse to water but you can't make it drink... The whole process did happen to him as well though, he was in the delivery... he went through quite a traumatic experience too but I think he felt like he could deal with it by himself.

✓ **Tapered, signposted endings:**

A number of women raised the issue – unprompted – of therapeutic endings, and spoke positively about their experiences of well-managed closing processes. In practice this entailed a gradual reduction in the number of sessions, having the option to extend and return (even if this was not taken up) and – most importantly – finishing when women felt ready:

I was doing every week. Then we went to three weeks. Then we went to a month... It's not "we're done now, you go and if you still have anything you need to say take it up with your GP"... We had a proper closing out.

Effects of therapy on women

As well as feeding back *in general* terms on the positive difference that psychological therapy had made in their lives – as highlighted at the start of this section – women also spoke in detail about *specific* effects that going through the process outlined above had had on them:

➤ **Development of self-knowledge**

Through the 'excavation' of current and past experiences and the crafting of their maternity and broader stories, women developed a *self-knowledge* that felt new:

I became a better person all round and calmer, more understanding, more in touch with myself... I learnt so much about myself. Even now I'm like "wow, I really did learn so much about myself".

I get times in my life where I feel like I can just take on the world... What the therapist made me understand, which no-one ever had before, was that there is probably some positive anxiety fuelling that, but that I need to learn to manage it... because if I get anxious, my mood is low, and I struggle to cope.

I didn't get excited [when I got pregnant after a miscarriage], I didn't want to tell people... At the time I didn't realise that was actually a way of coping with it, by not telling people it almost makes it not real, which I didn't really figure out until I had help from the MMHS counselling.

➤ **Development of self-concept**

As well as developing deeper self-knowledge, women also developed a stronger sense of self:

In the therapy, it came up that I felt that I had lost myself... Through the therapy I feel stronger in myself... I think that reclaiming of myself has been a massive thing through the therapy.

I've always wanted to be a mum... . But I do remember when they got [my baby] out and they showed him to me, there was nothing... It was like my body was saying "you're not cut out to be a mum"... Now, those words "I'm not cut out to be a mum"... I know now, that is not my problem.

I didn't know who I was as a child, I didn't know who I was as an adult. 'Am I cool? ... Am I nice? ... Who am I? Am I funny? Am I clever?' I didn't really know who I was. I think what a lot of this [therapy] has been about is sense of self... working out who I am, who I am as a mum, who I am as me.

Women often made direct comparisons between MMHS therapy and other therapy they had engaged with previously, stating that they had found MMHS therapy much more helpful, especially in its capacity to be maternity-focused at the same time as attending to the broader story of women's lives:

I did have a private counsellor, and it didn't work. It didn't help at all. We talked about the trauma, but it didn't make it go away.

I've had therapy before and [MMHS therapy] didn't seem anything like it. [Before], they were reading off a book... point by point, you've got to do this, we've got to do that, and it just seemed to be like you were being dealt with like a number... it's like you're in school and every single student's the same... I don't think therapy should be like that, it should be like what the maternal one is doing by being individual to each person.

➤ **Ripple effects**

Through the processes described above, women were able to develop a sense of confidence, which spurred them on to better navigate, and move forward in, key areas of their lives:

Work and Education

Some women, with the confidence and tools attained through therapy, felt able to return to work or education, in some cases linked to job-seeking:

I'll be returning to work mid-May, part time, for three days a week. I honestly don't think I'd be able to work without the support I've received.

I had always wanted to apply for a Masters and my therapist actually encouraged me to do that. So that is a success story in itself – that despite my mental health issues... [therapy] also has positively impacted my life in the fact that I have pushed myself even further than I ever have before.

Relationships

Most important – and commonly cited – for the women interviewed in the regional evaluation, was the effect of MMHS therapy on the relationships in their lives. They reported improved relationships with their babies, with other children if they had them, and with their partners, parents, siblings and friends:

*Before, when I was stressed, really struggling to cope ... it would put more pressure on my **partner**, because then he had to deal with it... The therapy had a positive [impact] ... because I'm in a better place, which means I'm probably nicer.*

*The relationship with my **daughter**, when she was first born, it makes me emotional to think, but there was a point where I felt completely disconnected because of the birth and the trauma... How I feel directly impacts her. So I need to make sure that I'm doing okay because then she will do okay. Kids will mirror what you put out there... My relationship with her has significantly improved, that disconnect has completely gone, in fact we're both connected at the hip now and yes, she's the best thing to ever happen to me.*

*It's had a positive impact with **friends**... At first, when all this happened, I didn't want to talk about the whole experience I'd had, because I felt people wouldn't understand. I was staying away from friends, I wasn't speaking to anyone. I didn't want to meet anyone. I'm fine now, I'm kind of back where I was before, enjoying speaking to friends and spending time with them.*

Of particular note, women reported an improved relationship with themselves, achieved through adjustment to, and acceptance of, their maternity experiences and broader life stories:

The most important thing is the therapist helped my relationship with myself. She took me from "not deserve" to "deserve". I'm a human being, I deserve... First she worked on my acceptance – "accept yourself, and if you accept yourself you will accept your surroundings and other people too".

Challenges in therapy

While the women interviewed for this evaluation were extremely positive about the treatment they received, there was one area which some felt was missing within MMHSs – *treating partners* – and a second area which some felt might benefit from a little extra consideration – *endings*:

☒ *Absence of partner support*

As evidenced earlier, some women reported that their partners *had* been offered support, although they had chosen not to take up the offer. Other women however reported that their partners had not received the such an offer, and expressed disappointment that this was the case, suggesting that this be reconsidered in the future:

I asked my therapist “is my partner can use the service?” She say “no, I afraid the service is just for woman”. I [think] it would be good to offer the service also for men, for ... they have been through a trauma... it was a traumatic situation for me, but it was a traumatic situation for him seeing me there on the bed. And he need to take care of me and the baby and the house, and everything, so I think it would be good for him to have someone to talk about how he feels... He was supporting me a lot, but in this way that he was supporting me, he was like, then not taking care of himself.

It was a shame for me ... that [my wife] couldn't be involved... it's our narrative. It's mine and [my wife's] narrative for the kids, not just mine. I do think there's a question mark around that... because it is a couples' experience quite often.

☒ *When endings fuel apprehension*

As also evidenced earlier in this report, most women interviewed had very positive experiences of therapeutic endings. However, two women reported feeling apprehensive about their endings. This apprehension took root where the emphasis in communication (including that at the beginning of the therapeutic process) had been on the *limited number of sessions* rather than on the *option to extend or return later on* (within specified timeframes) should the need arise:

I was even getting anxiety coming up to the end where I was feeling like, “She’s just going to leave and that will be it”.

I know that you obviously only get six sessions, but maybe if there was a way to sort of let people know that without making it such a big point. Because... people might see it as like “oh it’s ending soon, I don't think I’m ready.” And they might not feel right to say that they don't think they're quite ready to end it.

Specialist midwifery

We interviewed only a small number of women who had received specialist midwifery support and only one who, up until the time of interview, had received this type of support alone. Nonetheless, these few women offered very positive feedback and some thoughts on what it was that made MMHS specialist midwifery support so valuable for their mental health in their maternity journey. The key enabling factors were:

✓ **Kindness, knowledge & reassurance:**

Women who had received support from a specialist midwife reported appreciating the kindness, knowledge (in particular that which bridges both physical and mental health), and reassurance demonstrated:

One of the game changers was when I talked to [the MMHS midwife] after my 12 week scan because... new fears had come; 'what if the anatomy scan is going wrong? ... what happens if and what happens when'... She literally helped me with statistics; 'the worst things happen before 12 weeks'... She gave me percentages ... a reality check, the actual studies behind the knowledge. You can read it a hundred times online, but you don't believe. If someone who's actually in that profession is telling you, it's much easier to believe it...

[The midwife] came to the 20 week scan... the doctor all of a sudden went a bit quiet... I really felt all of a sudden really insecure... [The midwife] said "don't worry, she's just been typing in the results, it's not because she's spotted anything and not telling you... I know your fear is that someone is not telling you something, so I can tell you, if there was something she would have said'. [It was] reassurance for the medical procedure within the hospital.

I did not know before meeting [the specialist midwife] that the hybrid person between the medical midwife...

...and the psychological midwife did exist. I think it's very valuable combination, and particularly for someone who has had quite a bit of a bad experience with medical professional... I think that was a game changer, to have someone who knows medicine and has psychological training... Having this hybrid person, is I think the most crucial part of things.

✓ **Highly personalised care:**

Women also reported appreciating the highly personalised care provided through MMHS's specialist midwifery, including the depth of midwives' knowledge of women's triggers and how best to manage these:

She knows me well enough now to know that I'm normally only panicking when there's a valid reason, and I need to have it addressed in a medical way rather than just 'let's address the fear' way... She has suggested we have a quick tour of the birth centre ... sort of pre-empting any potential anxiety coming at birth. She wouldn't have suggested that not knowing my story.

Please include this in the feedback... [The midwife] recorded a breathing exercise for me ... she basically asked me where my safe place would be and recorded a meditation journey to that safe place for me. I mean, that blew my mind, that is so tailored and such an extra mile as a service.

✓ **Tools for coping through pregnancy and labour:**

In addition to the kindness, knowledge and reassurance provided by specialist midwifery, and the highly personalised care offered, women reported valuing the tools it provided them with, for coping outside of MMHS interactions:

It's a great service because it's offering you not just psychological support, but actually hands on 'what do you do in that situation x? What do you do in the situation y?'... She did quite a few exercises... She practiced with me a few of the exercises to refocus some of the fear... deal with the anxiety.

[During the C-section, I did] some of the breathing that [the midwife] had spoken to me about, like the relaxation breathing, trying to stay calm, that was the main thing. I remembered just lying there, trying to stay calm, and try to focus on my breathing.

✓ **Providing continuity, consistency and presence:**

Finally, women reported valuing the continuity and consistency of having one specialist midwife to support with their mental health. This presence provided them with a much appreciated sense of security throughout pregnancy, and again after birth, and prevented the need for them to keep explaining and re-explaining their mental health situation and triggers:

If I have to narrow down two things [about what worked well] it was the tailored approach, and one dedicated person... She is available. She is reachable... The continuity ... not having to explain yourself every single time you speak to someone, is very, very valuable... You don't have to explain your triggers and your situation. That's why the relationship is so important. Actually, I think that's the crucial bit of the whole service.

Peer support

We only interviewed one woman who was receiving peer support through MMHS (as well as therapy), so the data which speaks to this aspect of the service is very limited. However, this woman noted the important role played by MMHS peer support in providing a *safe* and *normalising* environment:

[The peer support worker] has been absolutely incredible... I don't know many mums, so having [the peer support worker] there was... an extra person to be able to open up with... she's extremely normalising, very open... With [the peer support worker], I'm able to really talk about being a mum... I get to have proper normal mum type conversations.

In this section we have presented women's experiences of accessing and engaging in treatment within the London pilot MMHSs. The story we have told is one of overall success, with women receiving high quality care from staff they experienced as

dedicated, kind and knowledgeable, and through that care, developing self-knowledge and acceptance, a stronger self-concept, and a sense of confidence in their relationships and in their capacity to follow their dreams and weather the storms that life would inevitably send their way.

Bringing the two halves of our story together – that of *staff struggle* on the one hand (albeit alongside job satisfaction) and of *women's success* on the other – invites a central question: How can more of a balance be achieved here? How might MMHSs be enabled to continue providing the same quality care for women, and develop their services to reflect women's feedback, at the same time as attending to staff wellbeing? In the concluding section that follows, we present a number of suggestions that are aimed at striking this balance.

SECTION 3 – CONCLUDING THOUGHTS & SUGGESTIONS

Before presenting the suggestions aimed at bringing the two halves of our story into closer alignment, we present staff and women’s perspectives on the *need* for MMHSs. Together, these narratives make a strong case for implementing the recommendations that follow.

The need for MMHSs

Staff perspectives

Many staff referred to the “gap” that had existed in the space between perinatal mental health services (catering to women with pre-existing mental health conditions and/ or severe maternal mental health difficulties) and IAPT services (catering to a general population, not maternity-focused):

It’s absolutely transparent, the service need and the gap that was there... Now we are clinically live and we’re seeing the positive outcomes and hearing some positive feedback from women who are going through our service.

Service manager

Staff referred to the need for MMHS in terms of its role not only in helping women to manage present maternity difficulties, but also in preventing problems in the future, both within women’s lives and in the lives of the children they are raising:

If [women] have had a really traumatic birth or a loss or a death and then they come in [to MMHS] and they’ve had a completely different experience, then they’re taking that forward for the rest of their life. Just... to be able to support them in their journey going forward, because they’re making the children of the future.

Midwife

Women’s perspectives

Women also reflected the need for MMHSs very strongly in their narratives, with some regretting the absence of such a service during previous maternity difficulties, and all giving very raw accounts of the maternity challenges they had faced during their most recent maternity experiences, including developing severe anxiety during pregnancy, miscarrying, having medical terminations, having traumatic labours and births (with inductions, instrumental deliveries and emergency caesareans commonly cited as precipitating factors), and giving birth to very sick or disabled babies who were subsequently admitted to neonatal intensive care units – all with the added stress and isolation that Covid-19 brought. They spoke not only about the events that engendered their need for maternal mental health support, but about the ways in which those events had effected them:

I started getting panic attacks, I couldn’t sleep, I couldn’t bond with my daughter at all, so I developed, I suppose, more like post-natal anxiety... [cont. on next pg]

...this ongoing sense of dread, just like, racing thoughts, not being able just to be in the moment, but constantly thinking like 'oh my God, my daughter will be severely disabled.' It was just getting out of control... At one point actually, I thought maybe, it might be the best thing if she died... I felt really overwhelmed, I felt like I wasn't connecting with what was going on, a bit of depersonalisation. Basically, I felt like I was not fully part of the world.. I couldn't sleep, I was just waking up sweating. I couldn't eat, I lost lots of weight, it was just awful.

We lost the baby. And that was kind of shocking for me... When I first got pregnant again.. I thought 'okay good, I'm pregnant' and then I started to feel even more like, 'okay, did I do the right thing?'... I just... started staying in bed most of the time... I would actually get ready for work, and then go back into bed because I just felt sick all the time. And not sick through the pregnancy. Sick from just life.

When we come home, I think the first two, three months I, was going down and down. I wanted to just stay in bed all the time.

Women also echoed the sentiment expressed by staff around the need for MMHSs as a form of early intervention, or 'future proofing' as one woman described it. Another woman spoke of her predictions

about how her children might have grown up had she not accessed therapy through MMHS:

I think of the future and the kind of mum I would have been [without the service] and the kind of experiences that my kids would have had... Maybe I would have a more withdrawn child or maybe I would have had a rebellious child... It would have been because of the fact that I just didn't know how to parent. I didn't trust myself in parenting. Maybe I would have been too lenient or not lenient at all. I just would have been unconscious... at what cost and to what detriment to myself and what detriment to my kids?

Unintended harm¹⁴

When considering the need for MMHSs, of particular note within the regional evaluation were staff and women's narratives around the unintended harm experienced within other parts of the healthcare system. While it was recognised that certain unavoidable events and interventions may be traumatising, there was a strong sense, especially from women, that the way they had been communicated with had exacerbated the extent of their distress:

I had started to develop symptoms of pre-eclampsia... and my ob-gyn told me at that point that I needed to be induced... [Cont. on next pg.]

¹⁴ 'Unintended harm' is a catch-all phrase encompassing a wide range of experiences, including feeling disregarded, dismissed, belittled or frightened by healthcare professionals.

... she told me that I was going to die if I didn't get induced and my anxiety shot through the roof and I agreed... she told me that I was going to bleed out on the floor in my house and nobody would find me, which is like, looking back... the words are just awful but at the time I just went into survival mode... Fast-forward to after the birth... I ... had these feelings that I felt like I was going to die, all the time, which looking back is obviously the root of the conversation I had with the ob-gyn about dying but I genuinely felt that at any point, I would die. I have never felt like that in my entire life.

Woman

One of the things that lots of [women] say; "nobody said sorry. Everyone is trying to cover their back" or "if only someone had explained this to me at the time". The majority of complaints and distress is about how people were communicated to.

Psychologist

It was very clear that [my baby] wasn't well when he came out... There was a point when it seemed like the talk around the resuscitation table had gone from... "how do we save this baby's life" to "what can we learn from this interesting experience about saving this baby's life". And at that point I said "hello?" and then the Paediatrician came over and sort of remembered that we were there.

Woman

What I hear from women's experience is that you're treated not like a person. You're dehumanised.

Psychologist

The whole miscarriage situation was badly treated. We went to the hospital, I was like a deer in headlights... I couldn't speak... I was there ... clutching my pillows, they were really rude... I couldn't say 'baby', I couldn't say that word... but they used all that language, they kept repeating it... In the reception there was like this murder show on... a lot of intense sounds... I was so deer in headlights. You'd think that the worst day in the world is the day when there's no heartbeat, but actually the worst day in the world is when I went to hospital and [was treated like that], it just made me feel like shit.

Woman

So, with the staff and women in this evaluation clear on the need for MMHSs (some of which stems from unintended harm caused further 'upstream' within the healthcare system), and with the clear imbalance in the two halves of our story, what should happen next? What can be done to make MMHSs even better in the eyes of the women and birthing parents using MMHSs? What can be done to support MMHS staff to continue providing first class clinical care? And who should be doing these things?

Below we share a number of suggestions aimed at different stakeholders. Most of

these stem directly from interviews with staff and women, while some stem from analysis and discussion between McPin evaluators and the London MMHS central support function. The key to using this table of suggestions will be to keep it 'live'; not to let it to lie dormant, but to use it as a springboard for open dialogue between stakeholders, so that ideas for service development are grounded in the lived realities and needs of those using and working within MMHSs.

Table of recommendations

ACTION REQUIRED	ACTION FOR	EVIDENCE BASE FROM REPORT
Service provision		
<p>Continue providing high quality MMHS treatments</p> <p>Review and implement lessons learnt from this evaluation, utilising women/birthing parents' feedback regarding the range of therapies/interventions provided to inform on going service provision and development.</p> <p>Services aim to offer women a mixed approach to therapy (CBT, EMDR) and flexibility around delivery mode.</p>	<p>Local MMHSs</p>	<p>Women were extremely positive about the treatments they had received through the pilot MMHSs (psychological, peer support and specialist midwifery), expressing a wish that services would be not only maintained but developed and widely available.</p>
<p>Explore the capacity to offer individualised therapeutic endings</p> <p>Provide personalised care, emphasising readiness when deciding the process for ending treatment/s.</p> <p>Therapeutic endings could include:</p> <ul style="list-style-type: none"> • Gradual decrease in session frequency and offering step down approach as a part of the discharging process. • Step-down approach, which could include peer support / third sector. • Shared information via leaflets, websites, apps. 	<p>Local MMHSs</p>	<p>Women reported appreciating it when information about therapeutic endings emphasises their readiness, rather than the limited number of sessions available to them.</p> <p>Women also reported appreciating a gradual decrease in session frequency, as this allowed them to 'test run' their capacity to manage without such intense support.</p>

ACTION REQUIRED	ACTION FOR	EVIDENCE BASE FROM REPORT
<p>Clarify the offer to fathers/ partners</p> <p>Teams to action guidance that is due from the national perinatal mental health team regarding partners and fathers.</p> <p>MMHSs to develop local guidance on the recording of interventions that are offered to fathers and partners of women who access MMHS.</p>	<p>National perinatal mental health team</p> <p>PMH Programme Team</p> <p>Local MMHSs/ Trusts</p>	<p>Staff interviews revealed a lack of clarity, and tension, around treating fathers/ partners, and staff had differing views on what constitutes ‘treatment’ and whether fathers/ partners were eligible.</p> <p>Women highlighted the need for partner support, noting that partners also endured emotional distress through the course of the maternity journey and beyond.</p>
<p>Identify potential referrers to share the service specification of their local MMHS</p> <p>MMHSs should develop a communication and engagement strategy to increase awareness of MMHS provision to local stakeholders.</p> <p>Local evaluations can be used to identify sources where referral numbers are low, and potential referrers can be targeted (i.e., webinars).</p> <p>Ensure that MMHS provision is included in trust perinatal mental health websites.</p>	<p>Local MMHSs</p> <p>Regional Maternity and Perinatal Mental Health Programme</p> <p>London Operational Delivery Network</p> <p>Local Maternity and Neonatal Systems</p> <p>Primary Care Networks</p> <p>Local Authorities</p> <p>Perinatal Mental Health Champions</p>	<p>Women shared that they would like referrers to know more about the importance of the service, and the specification of the service, to ensure safe and more timely referrals.</p>

ACTION REQUIRED	ACTION FOR	EVIDENCE BASE FROM REPORT
<p>Promote MMHSs directly to women and birthing parents via websites, leaflets, apps and any other platforms accessible to the public.</p> <p>Develop a co-produced communication strategy in partnership with peer support workers, lived experience practitioners, maternity voice partnerships alongside trust communication teams.</p> <p>MMHS should consider digital poverty when developing their service promotional information.</p> <p>Services should refer to the NHS England Accessible Information Standard.</p> <p>Ensure that MMHS provision is included on trust perinatal mental health websites.</p>	<p>Local MMHSs</p> <p>Maternity Voice Partnerships</p> <p>Perinatal Mental Health Programme Office for health improvement and disparities - formerly known as Public Health England</p>	<p>Some women found it difficult to access information on the maternal mental health services when trying to find an appropriate service for support. Others mentioned that it would have made their experiences less difficult if they had received online and offline information regarding what the services provide.</p>
<p>Review peer support roles and value in MMHS</p> <p>Peer support is provided through NHS roles or third sector organisations and opportunities and obstacles of both should be continually discussed and reviewed.</p> <p>MMHSs to clearly identify the roles of peer support in their team and align the service model to reflect this.</p>	<p>Local MMHSs</p> <p>Perinatal Mental Health Programme – Lived Experience Practitioner</p> <p>Local Networks</p> <p>Third Sector Organisations</p>	<p>Different staff experiences of bringing peer support in to MMHSs indicate the need for carefully weighing up the pros and cons of bringing it in house vs. contracting to a third sector organisation. Bringing it in house allowed services flexibility around task involvement, however contracting it out – to an appropriate organisation – played an important part in addressing health inequalities, through links with community organisations and the breadth of peer supporters these have on their books.</p>

ACTION REQUIRED	ACTION FOR	EVIDENCE BASE FROM REPORT
<p>Peer support roles - Consider the following:</p> <ul style="list-style-type: none"> · Expertise of the peer support worker · Supervision · Well-being · Job planning · Activities within the role · Diversity · Engagement and outreach · Training <p>MMHSs may want to consider viewing the Peer Support Video via the Transformation Partners in Health and Care website by clicking here.</p>	<p>As above on page 65</p>	<p>As above on page 65</p>
<p>Address health inequalities</p> <p>Review the ambitions in addressing health inequalities in the original proposals.</p> <p>For services to refer to their LMNS Equity and Equality strategies.</p> <p>Explore health inequalities work in the local area via the networks.</p>	<p>Local MMHSs</p> <p>LMNS</p> <p>Local Networks</p>	<p>Staff recognised the importance of thinking about health inequalities and how MMHSs were going to address these, early on in MMHS journeys. They noted how early thinking and planning would give the best chance of success in reducing inequalities.</p>
<p>Support for MMHS Staff</p>		
<p>Develop wellbeing strategy for MMHS teams and all individual staff members.</p> <p>Teams to link in with Trust wellbeing strategy and interpreting these for their service.</p>	<p>Local MMHSs</p> <p>ICB mental health transformation leads</p>	<p>Staff recognised the need for teams and their individual members to have plans in place to support their wellbeing, given the nature of MMHS work.</p>

ACTION REQUIRED	ACTION FOR	EVIDENCE BASE FROM REPORT
<p>As a trauma informed care service, the MMHSs should include the following within their models:</p> <p>Individual staff</p> <ul style="list-style-type: none"> - Allocated time for self-reflection - Clinical Supervision - Access peer support networks within individual roles <p>Ensure this is included within job planning agreements.</p> <p>MMHS Team</p> <ul style="list-style-type: none"> - Build in 'pause and reflect' activities every 6-12 month - Staff well-being away days <p>ICB mental health transformation leads to be aware and recognise the impact on staff working in MMHSs; the heavy workloads, emotional energy, stress and pressure on them.</p>	<p>Local MMHSs</p> <p>ICB mental health transformation leads</p>	<p>Staff also identified that taking part in regional evaluation interviews had been helpful in enabling them to pause and reflect on/ take stock of where things had got to, and that the process of reflection had been 'cathartic'.</p> <p>This was not something staff requested, however McPin evaluators noted the absence of a sense of being valued and recognised by those 'above', during staff interviews, and believe that it is crucial in maintaining staff morale and thereby the sustainability of MMHSs.</p>
<p>Review roles and capacity of MMHS teams</p> <p>As a part of the service review, MMHSs to review job roles and descriptions in line with service provision, expectation and capacity.</p> <p>For teams to develop a workforce strategy with commissioners and transformation managers.</p>	<p>ICB mental health transformation leads</p> <p>Local MMHSs</p> <p>Commissioners</p>	<p>Staff noted that during the pilot set up phase, current workloads were under-recognised and unsustainable, as were increased workloads due to the pandemic. Expectations around the demands of service set up and support for this did not feel like considerations from "above". Staff noted that ensuring they have the capacity to set up a service is crucial to morale and emotional well-being, and through this to service sustainability.</p>

ACTION REQUIRED	ACTION FOR	EVIDENCE BASE FROM REPORT
<p>Teams to consider using the NHS Demand and capacity high complexity model.</p> <p>Plans should also include risk management for sustaining a service during annual and sick leave.</p>	<p>ICB mental health transformation leads</p> <p>Local MMHSs</p> <p>Commissioners</p>	<p>Staff noted that during the pilot set up phase, current workloads were under-recognised and unsustainable, as were increased workloads due to the pandemic. Expectations around the demands of service set up and support for this did not feel like considerations from “above”. Staff noted that ensuring they have the capacity to set up a service is crucial to morale and emotional well-being, and through this to service sustainability.</p>
<p>Review central support function</p> <p>Discuss with key stakeholders funding the MMHS central support team. Review the central support function for the second phase for services in 2023/24.</p>	<p>National perinatal mental health team</p> <p>Mental Health Programme</p> <p>Regional Mental Health Team</p>	<p>Staff found the central support function useful in sharing information and providing practical and emotional assistance.</p>
Resource		
<p>Review the allocated funding and actual spend for MMHSs. Identify funding gaps and potential resources</p> <p>Local Maternity and Neonatal Systems (LMNS) and Integrated Care Board (ICB) mental health transformation leads and commissioners to support the findings and recommendations from this report...</p>	<p>ICB and LMNS transformation leads and commissioners</p> <p>Local MMHSs</p>	<p>Women shared how crucial the service has been in facilitating their journey from being unwell to having a positive experience in all areas of their lives. They shared that these services should be available to all who require them, and they shared the need for more services.</p>

ACTION REQUIRED	ACTION FOR	EVIDENCE BASE FROM REPORT
<p>...from the ESMI-III (Effectiveness and Implementation of Maternal Mental Health Services) and from local evaluations, to uphold and enhance the services in line with the Long-Term Plan “life course approach” focus. MMHS and PMH programme to agree plan for disseminating this and local evaluation reports within the PMH programme/Mental Health Transformation Partnership board/ MH Trusts/Regional MH Team, LMNS and ICB system leaders.</p> <p>Seek funding opportunities to enhance the service offer. Develop business cases in collaboration with maternity colleagues. For example, the opportunity to utilise “Start for Life” funding should be explored as an option to provide further support for women and birthing people.</p>	<p>ICB and LMNS transformation leads and commissioners</p> <p>Local MMHSs</p>	<p>Women also shared their views on where they thought they would be had they not accessed the service – on medication, with unresolved traumas that would render them unable to live full lives and parent mindfully. This indicates a need to increase funding, in order to grow services and develop them. Staff interviewed agreed that more funding is required to ensure the sustainability of MMHSs. All interviewees recognised that their team was very small and more funding would be needed to build resilience, to ensure services can continue without pausing to new referrals. Team members also recognised the need for further funding to allow for expansion of the services in line with Long Term Plan ambitions.</p>
<p>Budget for lived experience provision in MMHS services</p> <p>Lived experience is key to meeting the long-term plan ambitions and personalised care objectives. Therefore, MMHS and ICB mental health transformation leads should include this within their business planning as the standard. An appropriate budget and resources should be allocated for successful implementation.</p>	<p>National MMHS team</p> <p>Local MMHSs</p>	<p>Staff recognised the importance of including lived experience at the start of developing any service. However, they recognised that this requires significant resource to be organised and supported appropriately, particularly within short time constraints.</p>

ACTION REQUIRED	ACTION FOR	EVIDENCE BASE FROM REPORT
Systems Change		
<p>Ensure trauma-informed care is embedded within all healthcare provision related to the maternity journey</p> <p>For MMHSs to explore further opportunities for trauma informed care training for all staff involved in supporting women’s maternity journeys.</p> <p>ICBs, Local Authorities, LMNSs, to promote the trauma informed care training provided by Health Education England to all staff involved in supporting women’s maternity journeys.</p> <p>LMNS Equality and Equity Plans to include the promotion of trauma informed care training in maternity services.</p> <p>PMH programme team and National PMH team to continue raising awareness of the importance of trauma informed care training.</p>	<p>Local MMHSs</p> <p>Local Authorities</p> <p>ICB mental health transformation leads</p> <p>LMNS</p> <p>PMH programme Team</p> <p>National PMH team</p>	<p>Women and staff acknowledged the unintended harm caused by the care they received in the maternity period which had not been trauma-informed. They noted that this in part precipitated the subsequent need for MMHS support.</p> <p>Interviews entailed recognition of the need to look further ‘upstream’ in the system and reduce or eliminate what was experienced as anxiety-inducing treatment and communication.</p>

SECTION 4 – WOMEN’S STORIES IN DEPTH (pseudonyms used)

In this section women’s voices take centre stage; we present the testimonies of eight of our 11 women participants as they reflect on their journeys into and through MMHSs – as they begin to look to the future and as they express their heartfelt gratitude for what they report as the life-changing and life-giving support they received.

Heidi

I’ve always wanted to be a mum. I wasn’t bothered about my career, I’ve always just wanted to be a mum... Everyone said to me, “You’re such the typical maternal person.”... Before I had a baby, everyone would look at me with kids and other people’s babies, and go, “Oh, you’re so maternal, you’re such a natural.” I hated the first eighteen weeks of pregnancy. I had severe morning sickness, wasn’t keeping anything down, lost a lot of weight, I was in tears constantly. I ended up in hospital three times because I was dehydrated...and I had to go on a drip.

I had a period in pregnancy which I enjoyed, started to feel the kicks, the sickness subsided... But then there was the sciatica, swollen feet, water retention, pain in my knees, acid reflux, so I didn’t really enjoy pregnancy. Then I got pre-eclampsia, right at the end... so mmm, it wasn’t the greatest experience... The sickness was the worst part. It was exhausting, I couldn’t get out of bed. Everything I ate and drank was being brought up. And I remember sitting at the table, crying my eyes out over dinner, and I said to my husband “I can’t carry on... I can’t do this ever again. Once this one’s over, that’s it, I’m not doing it again.” I was really low there, really low.

Two days before the baby was due my waters broke. I went straight to the hospital, they said, “we’ll keep you in but your husband’s got to go.” So I was left on my own, on a bed, contractions constant, I don’t remember a single break. I was in this new experience, on my own and it was scary. Then suddenly they were saying “you’re more high risk”. So [My husband] came to the labour ward and they told me I was pre-eclamptic.

Then I kept hearing the baby’s heartrate going down, and someone saying to my husband, “if I tell you to, press the emergency buzzer, and the button getting pressed and everybody rushing in. And they were saying “we have to take you to theatre because baby’s heartrate is dropping and we’re going to try and get him out with forceps”... And then, while all this is going on, they give me this form, and they’re like, “you need to sign this form to consent to a Caesarean emergency and to remove your womb if we need to.” All my life I’ve been petrified of Caesareans, absolutely petrified, so when they said they might have to do a Caesarean, I’m already scared anyway, and that’s scaring me even more. In the end, it was forceps and an episiotomy. I don’t really remember any of the birth in the end. But I do remember when they got him out, and they showed him to me, there was nothing.... [cont. on next pg]

...Nothing. They gave him to my husband.. [he] kept saying “look, do you want to hold him?” And I was like, “No, I don't want to, I don't want to hold him. I don't feel anything. I feel nothing for him” I'm not crying, I'm not anything. It was like my body was saying, “You're not cut out to be a mum, you thought you were, but you can't do this.”

So I was in hospital for five days. Thanks to Covid, two hours a day I had my husband there, the rest of the time I was on my own with this baby... The connection is the worst thing, there was no connection to him early on. After I got home I went for my check-ups, and it was just “Oh, it's just baby blues.” But two months later I knew something still wasn't right. I was constantly down, constantly crying. Then, one time I was talking to my GP about something medical, and I said I was quite worried whether I was going to be okay. And I started crying, and that's when she said “there's a new service out, it's a trialling period but I think it would work.”

So the GP referred me and the therapist contacted me. It was the first time that I actually expressed everything, explained everything I went through, it was such a relief. Straightaway the Therapist understood, like she was really listening. Rather than telling me, “it's alright, when you have the next one it'll all be different,” or “it's only baby blues,” all these things other people were saying, she was actually listening to me. Just being given the space to talk and not be judged for all these feelings. There's always been a stigma around therapy and mums having postnatal depression... the thing that was good in the service straightaway, you feel comfortable that it's okay to talk, to have these feelings...

Before I was so worried. I was worried about if my son was doing well or not, if I was doing the right things with him. I was always going, “Am I doing the right thing here? Should I be doing that, should I be doing this?” I developed health anxiety. My husband was always the one that was the hypochondriac... and all of a sudden it flipped, I was worried about every little thing, constantly worried about the future and medical things happening, and things going wrong. Therapist said, “Look, you are mum, you know your baby more than anyone else, you know what's right.” So I'm more confident now. Yeah, I'm okay now. And she helped me to see that we just have now, like is he okay now? Yes. Are you okay now? Yes. That really stuck with me. The now.

And the service was flexible with the way that you are, the form of therapy doesn't have to be structured in a certain way and that's how they deal with every single person. It was flexible to think, “who are we dealing with here... let's work out the best way for this person”. Just talking to you as a person not a patient, not feeling sorry for you like you're this broken little thing they have to creep around, but treating you like a person... I've had therapy before and this didn't seem anything like it. Before they were reading off a book, point by point, you've got to do this, got to do that and it felt like you were being dealt with like a number... Whereas, what the maternal one is doing, being individual to each person, like someone's actually listening to me. And at the end Therapist didn't shrug it off and say, “That's it, you're done, you've had your time, see you later, done, gone.” She said if anything ever changes and you feel like you're struggling again, just call us, just come back to us and we will try and help. That was important. [cont. on next pg]

Because I feel like my body let me down, I had these feelings of, "Maybe I'm not cut out to be a mum, maybe I'm not cut for this after all. Like I said I've always wanted to be a mum, and everyone always said "you're such a maternal person, you're a natural", but from the beginning I didn't feel like a natural, I felt like "I don't know what I'm doing, maybe being a mum isn't who I am after all. I mean those feelings didn't pass straightaway, but now, those words, "I'm not cut out to be a mum"... I know now that is not my problem. So like with having another baby, I'm no longer saying, "It's never going to happen." Now, I can go, "if we have another one then we'll do this next time," like that. That's where I'm at now.

Without the service I don't think I'd be where I am now. If the service wasn't there, I probably would have ended up taking antidepressants. I wouldn't have been as confident to get on with everything, go back to work and things like that. Okay, I'm going to get upset now. The service has made such a big difference. I can't even say it... it did, it really did. I just don't know where I'd be right now if I didn't have it. Sorry. I'm crying but I'm happy, to express how I feel, I'm doing this [interview] because I want this service to be there for other women, to get them through, like it did with me. And to the staff - please don't give up... keep going, keep the sites building up as much as they can, be as big as they can, help as many women as possible. It's been a long time coming. And thank you. Just thank you.

Monica

I became pregnant in October 2020 and it was a surprise pregnancy. It's the best thing that ever happened to me but a complete surprise, I was not prepared, I wasn't in the best position mentally, or with myself and my partner, and I felt like a bit of a mess. But I carried on and around February I found that I was starting to get really, really anxious, incredibly anxious. Around that time there was a woman in the news, she was murdered, and around that time I felt my anxiety spike. I felt like "I'm bringing a life into this world and it's not a very good place for a girl to be". I'd get scared about really unnecessary and dark things, I had this uncontrollable crying, and heart racing, this worrying about things that were beyond my control completely, about scenarios that didn't even exist. I knew something was not right.

Looking back I've been dealing with intrusive thoughts all my life, but they got really bad towards the end of the pregnancy. Initially I went to my midwife, around the 22 weeks mark, and I told her "I'm having these anxiety issues, I'm starting to not feel like myself, I'm starting to feel quite low" and she referred me to the perinatal mental health service. But because I was not considered severe, I didn't receive any help. I was like okay, I'll just carry on and keep on going. I made it all the way to the end of the pregnancy and I was still having quite severe anxiety issues, but I'd been told it was not severe, so...

When I went to my 38 week appointment, I had started to develop symptoms of pre-eclampsia. My ob-gyn told me that I needed to be induced and said I was going to die if I didn't get induced. My anxiety shot through the roof. She told me I was going to bleed out on the floor in my house and nobody would find me. [cont. on next pg.]

Looking back, the words are just awful but at the time I went into survival mode. I went through an induction process that took four days, they did a hormone drip, they inserted rods, the first lot failed, the second lot worked then stopped, then they broke my waters. My partner was finally allowed to join me at this point - I had gone through that whole process by myself because of COVID, I could see my partner for an hour a day. That was very, very hard, especially with anxiety and things not working, I felt so out of control and that's where it started to go severely wrong. I made no progress and then I started to feel more and more out of control. I got an epidural, which I didn't want and then I couldn't move. So, it was a series of events that meant I was completely out of control with my body and then at one point, I had asked, please can I just have a c-section, I can't do this anymore. The physician told me no, you need to do this, then my baby went into distress and I needed to be rushed for an emergency c-section. In the operating room, I felt disassociated, I completely lost myself and then my baby was born.

She wasn't breathing properly, she was put into the intensive care unit and I was wheeled into a hospital bay. I was by myself, without my baby and without my partner because he was not allowed to come with me. I was in the hospital for seven days after that and that is where I had a breakdown of sorts, an episode, a mental breakdown. I was very upset, I felt completely out of control and felt like no-one was listening to me. With COVID and staff shortages and the hospital being so busy it was very easy to fly under the radar. I was in there for seven days because my baby was septic at this point, or they were testing for that, and I spoke to the midwife. I was like "something is not right, I feel completely off, I'm having really dark intrusive thoughts and I don't feel like myself". Immediately, within an hour, the head midwife came and spoke to me and I was referred to the maternity mental health service. Even that initial discussion with the head midwife, "I'm here, I'm listening to you", made me feel very comfortable. Then, knowing that I was going to have the service, I didn't feel abandoned, I knew I was going to have the service following up with me when I got home, that was very nice.

I developed post-partum depression, crying about not being able to take care of my baby properly, worrying what would happen to my baby, what happens if she stops breathing. I had these feelings that I felt like I was going to die, all the time. Looking back, the root was probably the conversation with the ob-gyn about dying, but I genuinely felt that at any point, I would die. I was having recurring nightmares of the birth, I was having flashbacks in the shower where I would look at my scar and be back in the operating room, it was like I was hovering above myself in the operating room, watching everything happen to me. I have never felt like that in my entire life. I am quite a strong person so to have that stark contrast was concerning. I felt so low and not myself that I didn't feel like living anymore, which is a really scary thing, to go from being a very motivated person and happy with life, to not wanting that.

Someone from the MMHS service contacted me and told me what they were going to offer me, so initially the first 12 sessions, [cont. on next pg.]

...and it was always communicated that if I needed more, I would get more. therapist was very clear that if there were still underlying issues I can access the service again, even up until my daughter is one I can be referred right back. It's a nice safety net of support.

I had 12 sessions. At the beginning I was talking to my therapist a good two to three times a week, just at the very beginning, and then it gradually faded to once a week, then once a fortnight and then once every three weeks. The last few sessions it was more like a checkpoint thing because I felt like I could cope. The treatment has massively supported and changed me, it's made me look at myself, at the relationships I have, but also the experiences I've grown up with, and helped me to know how to move forward with life.

The relationship I had with my therapist was the best that I've ever had in my life. The therapy actually truly worked. I'm a sexual assault survivor, so I went through quite a terrible situation when I was younger, and I felt very comfortable to talk to the therapist about that situation. She made me feel very comfortable and safe. I'd tried other therapy services they didn't work because I didn't feel like I could tell the whole story, I didn't feel safe. So the relationship with the therapist was wonderful and I feel like that is why it was so successful. She was so calming and I felt completely able to divulge these very, very ugly details of my life. She was able to be there with me and make me feel like I was safe. The relationship that she was able to build with me was significant and substantial in helping my success story.

We did this EMDR therapy, where I went through the traumatic birth while using these grounding techniques, to make it seem like I was still okay. Before, I wasn't able to speak about my birth without getting very, very, very upset, like shutting down. Now I'm able to have a full conversation, with a little quiver in my voice, but that's it, I'm able to look at it objectively now, "it happened but I'm safe".

The therapist taught me to know when things are getting bad again. So, I now know a trigger for me is lack of sleep. This past week I haven't gotten very much sleep at all and I had a nightmare about the birth within four days. I realised I need to make sure I'm okay, clearly things are afoot, and I made sure to get a full night's sleep. So I feel like the treatment has also given me tools to work on myself which is really empowering as well, so self-regulation, knowing the signs if I'm not doing well. I have a checklist; "have I eaten? Have I taken a shower? Have I had alone time?" Those things can massively affect your mental health and I didn't realise it until I went to the service, like maybe I will calm down if I'm actually taking care of myself. Also, the breathing techniques, and if I'm really in a state of panic, I go back to the EMDR, that grounding work.

Through the therapy service I also realised I've dealt with anxiety for most of my life, it's has been there from childhood. I now understand it, and that pregnancy can enhance those mental health issues. It also came up that I felt I had lost myself. It came out of that narrative of not feeling in control and wanting a piece of myself back. So, I've always wanted to do my Masters in education, I had always wanted to apply for the Masters but never did, and my therapist encouraged me to do it. [cont. on next pg.]

So when my daughter was five months old, I applied and I just got news that I've been accepted, with a full scholarship. It's incredible. I feel now, through the therapy, I feel stronger in myself. I have been through all of this and yet here I am, still standing, with a beautiful daughter. I think that reclaiming of myself has been a massive thing through the therapy, realising that I don't need to meet other people's standards, I am good enough all by myself, and I have control of my own life. It made me look at the relationship with my own mother, her generation, they put their children first always, I saw her put us first, to the detriment of herself, she lost herself in a sense and I don't want that for myself or my baby. So it's about taking the bits that I loved of her but realising that I don't have to become just a mother like her, I am still me.

Also, therapy helped me look at the relationships I have with others. My relationship with my husband, we had gone through a difficult time when I found out I was pregnant, but through the therapy I was able to look at that relationship and see that it is something I really want. My therapist told me that people can be happy, healthy parents separately if needs be, and being told that it is okay, if needs be, to separate, was like a revelation, like a flip switch and I felt more power. My parents have been in a relationship for a very long time and they are unhappy but they've stayed together for the kids. Before I felt like I wasn't choosing it, like we had to stay together, whereas now it feels like a choice I have control over. Now I know that if this relationship is not serving me positively, I'm okay to separate. That in itself was very, very empowering.

The relationship with my daughter, when she was first born, there was a point where I felt completely disconnected because of the birth and the trauma and the c-section and breast feeding and all of these things that you think are going to be quite natural and they end up being very, very hard. At a point I did feel completely disconnected from my her, it makes me really sad that at the beginning I felt so disconnected, I didn't feel like her mum. But through the therapy I was able to flip that disconnect to quite a bond. For example, I was able to notice that breast feeding exclusively is not working for me and that's fine, it's ok to switch over to the combination feeding. Breast feeding is advertised and pushed on mothers - "breast is best" - and that's pressure. Just hearing from a health professional "if your mental health is suffering, stop putting so much pressure on yourself", that switch in thinking significantly helped. That changed my relationship with my daughter because I stopped looking at her as "oh she's always on me" or like "I'm failing her", it changed that narrative in my head.

The relationship I have with my daughter now, she is everything to me, 150% everything, she's amazing, she is funny, she is everything I would want a kid to be and more. And how I feel directly impacts her, so I need to make sure that I'm doing okay because then she will do okay. That disconnect has completely gone, we're connected at the hip now and yes, she's the best thing to ever happen to me. Without the service, honestly I had thoughts of killing myself, so I probably wouldn't be here. It sounds so scary to say out loud but if I hadn't had access to the therapy I don't know where I would have ended up, I felt like there was no way out. I shudder to think of what would have happened. It was essential for me. The therapy, the constant support that stretched out so long, it has honestly changed my life. [cont. on next pg.]

Now I'm able to look at things objectively and when I get anxious I have the tools that I need. I have the fallback that if I do need help still, I still have it, that support is there. That has helped me move forward in being a mother and trying to figure out this new phase in my life.

I'd like to say thank you. It sounds so flippant but thank you so incredibly much. The service has not only changed my life, it's changed my family's life and my little girl's life because she now has a mum who is able to be happy.

Amy

My pregnancy was pretty good. From a physical point of view low risk, no issues really. I was pregnant during lockdowns, I'm a teacher so I felt at risk and anxious, exposed, at work, but after the first trimester my Head was happy to let me stay home, so then I had quite a cloistered pregnancy.

I had a home birth planned and booked and I started at home, I had my mum and my partner there and two lovely home birth Midwives, I had my pool and it was all very lovely and really how I had wanted it to be. The reason that I transferred into hospital was because it was taking a very long time to dilate and I was getting very tired. The home birth Midwives would have been happy to carry on at home if I'd wanted to, but I wanted some pain relief.

We transferred with the idea that I was going to pop in, have some pethidine, have a nap, very possibly be able to get into the birth centre rather than the labour ward, maybe have my water birth anyway. But the Obstetrician wasn't happy with how long I'd been in labour and was very keen to induce me straight away and it was like "oh my god this isn't what I thought was going to happen, I thought I was going to have pethidine and a nap, why are we talking about induction?" I was very worried and really quickly spiralled out of being able to manage the pain, very quickly into a state of real panic.

For some reason it took a very long time to get any pain relief. I ended up having an epidural and that was what I needed. I had the epidural, I had the induction simultaneously, within five hours I was fully dilated and ready to push, and then it all went south. I pushed for about 40 minutes. My baby was nearly crowning by the time his heartrate started to not recover very well after each contraction, so the Midwife said to my partner she was going to press this button and that lots of people were going to rush in and that it was probably going feel quite overwhelming but that she needed to do it because she was worried about the baby's heartrate. In rushed what felt like ten people, I don't know exactly how many it was. It felt like ten people rushed in, stood around me and shouted in different ways to push, it was very clear that I was pushing for my baby's life. People would shout different words of encouragement or command to get him out. I had an episiotomy, they used a bit of ventouse too, but I don't really remember any of that happening. [cont. on next pg.]

Then it was very clear that my baby wasn't well. He was taken away to the resuscitation corner while I was stitched up, then he went up to the neonatal unit, I went to the maternity ward and my partner went home and it was awful because we didn't know if he was going to be alright. I woke up surrounded by women with their babies on a ward, I was the only one without my baby. Two nights of that, one night at home then all of us in the 'baby hotel' in the hospital, then all of us home. Very quickly they weren't worried about him, he responded well to antibiotics – it turned out he had pneumonia. There was no concern about his health, but I think it took us a while to get our heads around that. We were home and it was lovely, but we both felt pretty battle wounded and found it difficult to just feel alright.

I can't remember how long it was until the Health Visitor came but it can't have been more than a couple of weeks. She was really on it, she got me to fill out the post-natal depression and post-natal anxiety questionnaires, she did them with me, she talked about the new service, and she followed up by phone. It took a long time between her referral and the materialisation of the service - the referral process was complete by the end of June, beginning of July and I didn't have my first appointment until end of September with a Counsellor. In that time I would say I was mainly functioning and okay, with fairly regular crisis points. I was having a lot of very dark and negative thoughts around disaster fantasising, a lot of fearful thoughts about my health, his health, my partner's health. Not really able to leave my baby in a room on his own.

Then September came and I started to have appointments with a woman who is trained in EMDR trauma therapy. The first session was just talking and afterwards I thought "if that's what it's going to be like I'm not sure it's for me" So in the next one, when she asked how I'd found it last time, I was honest and said "I need trauma therapy". I was really encouraged by her response, she seemed genuinely grateful for the feedback and was like "okay, so we focus on birth trauma". She explained EMDR, how it worked, what it would entail, and that is what we focused on.

I found it gruelling. I dreaded the sessions and then I would feel worse afterwards than I had done before, I would feel drained and very fragile. Then, after maybe the third session, I knew it was helping because I was able to look back and go "oh I haven't thought about that thing for long" or "oh it's been a while since I've had a thought about that". It felt like it was worth it quite quickly. It's a therapy that focuses on specific moments and we had identified a finite number of moments in the experience that were triggering or traumatising. We had a session that focused on each of those key moments and then we also identified some patterns of thinking or behaviour in my current life that seemed to be responding to the trauma, so things I felt anxious about, things I would avoid, things I would try not to think about or do or talk about, we identified a finite amount of those and then worked through some of those too. It was a bounded and specific treatment that helped me to process a specific event. I understood that I wasn't going to be cured and all fine straightaway once it was done, but that it was a necessary first step in trying to be well. It helped me understand why what happened to me affected me so much, that it wasn't my fault, that it was beyond my control. And it's given me some ways of helping myself when I feel overwhelmed. There is an element of EMDR of being able to do it yourself, and I have used it a couple of times.
[cont. on next pg.]

It's given me a framework to contain some of those feelings. Having unpacked the traumatic experience and excavated it for its most traumatic material, it doesn't feel so dangerous to me anymore. I feel like the work from the EMDR has also helped me to identify some stuff in my life I need more help with because part of the reason the experience was traumatic was because it pinged off other traumatic events that happened in my life which I wasn't really aware could be triggered in that way. I'm fascinated by the whole thing, so aware of how incredibly complicated it is caring for birthing mothers. What was very, very useful to me about the EMDR was helping me to frame what had happened to me as trauma, I don't think I would have done that for myself and I don't think I would have been able to recognise the symptoms in myself, if I hadn't had that guidance. I was having flashbacks and racing thoughts but because they weren't of a battle field and bombs exploding, I wasn't quite able to seriously say it was PTSD. The therapy helped with that.

The therapy came to a natural end and that's something I really liked about it. I didn't feel like there was a deadline by which I had to be better. The Counsellor said normally it took between ten and twelve sessions but she made it clear that I wouldn't be cut off if it needed longer. When I had my last session I felt like I didn't need any more, like it was done. Overall I found the service caring and vital.

Kasia

It all started on a Monday, I had a hospital appointment, they did all sorts of tests, and they didn't like the doppler. But they said "it's not life threatening, come back the next day and we're going to listen to the baby's heartbeat." So I turned up the next day, the consultant was there, they listened to the baby's heartbeat, it was fine, but they decided to do an emergency c-section because they were worried about the abnormal doppler. They felt maybe the placenta wasn't working properly, they thought my daughter might have anaemia and might need a blood transfusion. So I turned up at nine thirty and my daughter was born two hours after that. I must say, the c-section was fantastic, but the problem was my daughter, it turned out she wasn't well.

She needed breathing support, she had to be resuscitated. I didn't even see her when she was born, she was taken to a neo-natal unit straight away, and then when I saw her, about twelve hours after that, for the first time, I thought she looked kind of weird. Her face was asymmetrical and very small, and I just knew something was wrong. She wouldn't breast feed, she took two hours just to drink a little bit of expressed milk. She was put on a tube to feed her. No-one really knew what was wrong with her. She didn't have anaemia, she didn't need a blood transfusion, she didn't have an infection, so at first, they didn't know. But me and my partner, we thought there was something wrong with her jaw, the left side seemed smaller. And her left eye seemed smaller.

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We spoke to the consultant and they said, "we think she might have a condition." It's basically a very rare condition, one in 40,000 births. It can cause really serious disability. Now we know it's not that bad, her case is mild, but at the time we didn't know. It was so awful, they had to run all sorts of tests. They checked the heart, kidneys, everything, stomach, it all came back normal, thank God. I'd actually expected twins at first, but didn't know that, and then I'd had some bleeding, so I went to check it out, and that's when they'd told me that one baby's fine, but the other one had stopped developing. So basically the doctors reckon what happened was that when I lost the other twin, it caused some kind of blocked blood supply, or blood reduction to part of the embryo.

But whilst waiting for the tests, I couldn't really cope with the whole thing. It went on for several days and it was so horrible. I started getting panic attacks, I couldn't sleep, I couldn't bond with my daughter at all. I developed, I suppose, post-natal anxiety, I just couldn't cope with the whole thing. It was like this ongoing sense of dread, racing thoughts, not being able just to be in the moment, constantly thinking 'oh my God, my daughter will be severely disabled, she might die'. It was getting out of control. At one point, I thought maybe it might be the best thing if she died because some children with this condition, they have heart problems and kidney problems and really severe disability.

I was exhausted. I felt really overwhelmed, like I wasn't connecting with what was going on, like I was not fully part of the world, things were happening and I was just looking at them, watching them like in a movie. It was awful. I couldn't sleep, I was waking up sweating, I couldn't eat, I lost lots of weight, it was just awful. I really needed professional help so I called my GP and said "look, I can't sleep, I can't drive, I'm struggling to look after the kids, it's really bad." She got me in touch with the MMHS service. I was put on antidepressant medication as well. I do think they helped, but what helped me most was the therapy.

The therapist phoned me and I was so happy when she phoned, the happiest I had been in months. She said she would like to meet up and do an assessment, she was so flexible, always very flexible. The first time she came to my house and she was just listening to my story, no judgement, very approachable, very nice, very knowledgeable. It was her personality as well, she seemed very open minded, non-judgemental. I said to her "I couldn't bond with my daughter", I wasn't bonding with her, it felt really like a duty, really hard, and you can't say that to other people because they think you are a bad mother. [cont. on next pg.]

I had some really unpleasant feelings, like I thought it would be better if my daughter died, and the therapist was absolutely fine, she acknowledged how I felt, she explained that part of post-natal depression and anxiety, when we have a problem, we try to find a solution as best as we can, depending on our frame of mind. I was in a bad place at the time, so my solution matched that. The therapy helped me to process what I viewed as a very negative thing, and I see her in a different light now, because at first I could only see the condition, I wasn't looking at her as my daughter. The therapy really helped me to see past it, and see that she's just a little girl, a lovely little girl, walking around furniture, standing on her own a little bit, chatty, quite chilled, funny. You know she's got a lovely smile.

I can't honestly imagine what I would be like now without the therapy. One thing was just talking about my experience, but also we did EMDR. I think that really helped me process some traumatic visions regarding my daughter, which I couldn't stop thinking about, they were making me really panicky, really stressed, so she helped me to process them. I can't tell you how it works, but she had these two fingers, and I was watching them, and by the eye movement, she helped me to process it. I'd had depression and anxiety about nine years ago and as part of it I did some online therapy, and then I did IAPT as well. It was okay, but it was superficial.

This, with the MMHS therapist, we actually processed the bad memories, and she gave me some strategies to use in life, which I was then practicing. For example I've got some tendencies to be a perfectionist, so it's just about accepting 'good enough', being less harsh on myself. Sometimes, I feel very energetic, I want to do too much and it's about doing just one thing at a time. Not getting obsessed with negative thoughts, trying to look at the bigger picture. We did techniques like mindfulness and calm place, she was giving me tips on managing the anxiety. It was like I had a mental block where I was just thinking "she's going to be so disabled, I will have to look after her, she's going to be a burden". Obviously you don't want that for your child. And I was feeling guilty, like "is it my fault that she was born the way she was?" It helped me to process that block, move past the memories, look at it as just something that's happened, and see that there's a lot to be happy about - beautiful daughters, my work which I enjoy.

Also I enjoy being super busy, I get times where I feel like I can take on the world, but then I always burn out, because I can't keep it up. What the therapist made me understand, which no-one ever had before, was that there is probably some positive anxiety fuelling that, but I need to learn to manage it, otherwise I'm going to burn out, and if I burn out I get anxious, my mood is low, and I struggle to cope.

But it went deeper too. She looked for the root causes of the problems I had, she even went back into my childhood a bit as well and we discussed my childhood, so it was a lot deeper. I think the therapy had a positive effect on all the relationships in my life, because I'm in a better place, which means I'm nicer to everyone. Before I was really struggling to cope with any level of stress, so then it would put more pressure on my partner, because he had to deal with it. With friends, at first when all this happened, I didn't want to talk about the experience I'd had, I felt people wouldn't understand, ...[cont. on next pg.]

...I was staying away from friends, I wasn't speaking to anyone. I'm fine now, I'm back where I was, enjoying speaking to friends and spending time with them. It's had a positive impact on all the relationships in my life.

Without the service, without the therapist, I think I would be really struggling. I wouldn't be feeling well or happy. I still sometimes feel anxious, but I know how to deal with it. Without the service I would probably be taking antidepressant medication and not really dealing with the problems properly, and I wouldn't be happy. I wouldn't be enjoying looking after my two daughters. I know now my daughter will be fine, she'll need some operations but she'll be fine. She'll need a facial cleft sewing together, they have to cut her ear tags off, the cyst in her eye will be removed, she's got congenital scoliosis. We have a dietician, because she was very small when she was born. I don't think I would be able to cope with all that without this service, with the stress related to attending these appointments and never knowing what news I'm going to get. It really helped me to be able to look after my daughters and to feel happy. I'll be returning to work soon, three days a week. I honestly don't think I'd be able to work without the support I've received from MMHS. I think it's an excellent service and I'm so grateful I was able to be part of it, that I got support from them. It's well-targeted, very much to the point, in-depth, with a human face, I hope it expands.

Carly

When I got pregnant, me and my husband were really excited, we did a reveal of being pregnant, like an announcement to all our friends. We went on holiday, like a babymoon, we even did an early gender scan, we were so excited. We knew we were having a baby girl. We even had names. And then in May, I'm on the way to work, and I lost the baby. It happened on the Thursday. When I first came home, I got rid of all my pregnancy stuff, packed it all up, threw it out and went back to normal life. I took the Friday off work, on the Saturday morning, I woke up, got dressed, nice and normal, went for a walk. And then I went back to work on the Monday. I stayed until 4 then I saw my best friend and I broke down.

After that, I took time off. I would cry and cry in bed. There was nothing to hold. But then when I'd wake up in the morning, wake up and pretend to be normal.

And then I was pregnant again. It happened really quickly. I lost my baby girl in May and got pregnant again in June. It was nice at first but then I started to feel like, okay, did I do the right thing here? What about my other baby? Can I even do this again? What if it happens again? I started slacking at work. I stayed in bed most of the time. I would get ready for work, then go back into bed. Because I felt sick. Not sick through the pregnancy, just sick from life. I was feeling like, I'm not doing the right thing. Not just by being pregnant, just not doing the right thing, period. Like I can't get it right. September came, which was when I was supposed to have had my original baby, and I was really pissed at everybody, everyone's just going on with their regular life. I didn't lean in to the new pregnancy. I didn't even take pictures. I took pictures with my first one, but then I felt like, "what do I have to show for it? No baby". [cont. on next pg.]

I just felt like any minute now someone's going to say something bad has happened. I would get so scared and literally, physically paralysed thinking if I move a little bit, that could be the movement that makes it all go wrong.

One day I had a midwife appointment and they said my blood pressure was a bit high. I was 33 weeks. So, I get to the hospital, they told me I've got high blood pressure. To be honest, I didn't know what preeclampsia was, I didn't even know how to pronounce it. I'm thinking, "okay, thank you for telling me. See you". I called my husband, "I'm at the hospital, see you around five, I'll be home before you." But then I overhear someone saying, "Oh, there's a lady here with severe PET." And then someone came and I said, "Wait, is it me you're talking about?" She said, "Yes." And then I don't remember what happened after that. It was emergency, emergency, emergency. Everything went really quickly. I was moved rooms, and they said "your baby's coming tomorrow."

I didn't know what a C-section was, I didn't know what prematurity was. All I knew was that all of a sudden everything became something very serious. I went into surgery and had the baby. They must have put me under because I woke up and I didn't have my baby with me. And I didn't know why. And I broke down, like I actually broke. I was screaming, not even words, just wailing like an animal. They moved me to my own room.

They had taken my baby to the NICU and the next day, I got to see him. He weighed three pounds. He was the tiniest thing. He had the biggest head and the skinniest body. And he didn't look like a baby. He had oxygen, a splint, the lot. I remember thinking "I've got to be strong" so I'd talk to him, sing to him, expressed breast milk for him. My mum would say to me "you've got to eat something." And I was like "I don't want to eat. I've got to look after my baby." And probably by the 10th day, I had run out of battery. My whole skin turned scaly and broken from the stress. When I cried, the tears would sting my face. Then they said my son was losing weight. You know when you watch a time-lapse of a tree and the leaves fall off and it becomes bare, that's what I saw happening to my son. It felt like he was shrinking in my arms to become a nothing-born.

But we came home. And I carried on. And I think this is when I started to lose it. I wouldn't even leave my baby in the room with his dad because I was afraid something bad was going to happen. I didn't want to put anybody in the position where they would make something happen to my baby and I would literally have to beat them up. If something happens to him, what are you going to say to me, "Sorry?" Sorry is not enough. Like I will literally smash you. That's what was going on in my head. I was so tightly wound. Everybody has their threshold and I was literally on my threshold everyday, constantly on edge.

And then I went back to work. I wouldn't trust taking him to a nursery so I got my mum to come and help. She lives in a different country so she came and stayed. And then I got pregnant again, when my baby was one. [cont. on next pg.]

I didn't feel like I had any anxiety but they referred me to a more specialist team. I had this meeting with a midwife, I said "I'm fine", and she said "but it says here you've been through preeclampsia, an emergency C-section, prematurity, lost your previous baby, duh, duh, duh, duh, COVID. You do qualify for extra help". So she validated my experiences. Like I knew what I'd been through, but I didn't know it was enough to cry about. Mental ill health doesn't always look like someone falling on the ground. I'm presenting well, but in my head, I just knew something bad was going to happen to my child, it was just a matter of time. That thought was regular as the sky is blue. The midwife referred me to therapy.

I told the therapist a little bit about myself and she just listened at first. That was good because I wasn't doing a lot of talking. She showed me a kind of professional kindness, and that taught me to be kind to myself. And she had this like, relaxed persistence. I didn't feel pressured but I felt accountable. She would ask me how am I doing today and I'd be like "I'm fine, de-de-de". She'd be like, "mmm? Really?" and then I'd be like, "Okay, actually I'm lying. I woke up this morning, I got ready for work and I went back to bed." I realised I wasn't functioning properly and that didn't align with who I wanted to be.

I'd be like "I don't know what I'm doing, I'm such a bad mum". The therapist said "so you're saying you're a bad mum, based on what?" She helped me to not believe the lies that I was saying about myself. Now when I'm feeling like, "what kind of mother am I?" I take a step back and like "you're saying that based on what?" And it's never anything - it's just thoughts. I'm able to recognise they aren't true.

I would do this thing like, "I just wish I'd done something different" and she said to me "Don't live then, don't live in the future. Just live now," and that really helped. Sometimes when I flip back to the past and think, "What if?" I just focus on the now. I centre myself with that.

I was telling the therapist that I didn't breathe. I would literally hold my breath all the time. She said "When do you do that?" and I'm like, "When I'm doing things with my older son." And we realised it was fear, super concentration, anticipation that something bad was going to happen. So we did a lot of breathing exercises and that was really helpful. I still do it now, stop breathing, but I'm able to catch it and say, "Breathe girl, breathe," and it's less stressful. And I was getting challenges like, "Okay, when did you last go outside your house?" "Five days ago." "Alright, tomorrow try a walk for 30 minutes."

Another thing I struggled with was with this pregnancy I felt guilty, it was like I had done the older one an injustice and now I'm throwing everything I have into this new one and the older one got the short end of the stick. The therapist said "I think if your older child could communicate with you right now, he would say to you, 'Mum, please look after my brother'"
[cont. on next pg.]

And that broke my heart. It was such a turning point because I think about how I care for my siblings, and my two boys are siblings. It's not this pregnancy and that pregnancy - they're siblings. I'm able to hold on to those simple words "please look after my brother". I don't know if therapist knows that really changed everything.

What therapy really did was it helped me to identify all the parts of my life that influence how I am today. I told the therapist I was sexually abused when I was a child and it made me realise that even that is affecting the way I parent, because I had a lot of fear, distrust. I had thoughts like "okay, if anything happens to my children, this is what I'm going to do." It's not even happened, but I had already created a whole pack of tools to deal with it. Because my situation wasn't dealt with properly so I was reacting to that. Even though that was not what I was in this therapy for, discussing it helped me analyse and identify the reason why I am the way I am. I learnt so much about myself. I feel a type of peace now, a kind of comfortable peace, that comes from me accepting myself.

The therapy has given me a better marriage, a better relationship with my parents. Without it I think my marriage would not be good because I would take everything out on him. I would not have such a good relationship with my parents, I'd be fake, just, "How are you?" Good, fabulous" when inside it's all stress. With my older son, he wouldn't be as adventurous as he is. He likes to run a lot - old me, that's the end of running. Now, I'm able to let him run and sometimes he falls, he's fine. What I'm saying is I'm able to let him go. Our friends, they do this thing where they compare their son to my older son and before, I told my husband "I don't want to see them anymore, how can you be friends with people that are causing so much pain and making me feel terrible about myself?"

Now we laugh about it. Our friends are like, "Oh is yours not walking yet?" and I'm like, "No he drives now." I got that confidence. I'm comfortable and I'm confident in my child. I'm able to see my son for who he is. With my younger son, without this therapy I would still love him but the love would be a desperate love where I'd look at him saying, "please don't leave me", not like a normal "I love you, you're my kid" love. I would want to stuff him back in my belly. Without the service I would probably have no friends at the minute because in my head it was like, "How can you have friends? You've got to focus on your child." I was judging other people, like, "they're not focused enough on their child".

And at the end the therapist let me go when I was ready. We had a proper closing out. I was doing every week, then we went to every three weeks, then we went to a month. Even before it got to a point where I felt like I needed to ask "what do we do next?" she'd already covered that with me.

What I got out of it the MMHS service was a total 360 degree overview of my whole life and my whole being. [cont. on next pg.]

It's made me know how to be a better person, a better mum, better sister, a better person to myself, better everything. I've become calmer, more understanding, more in touch with myself, able to catch myself whenever I'm going somewhere unhelpful, able to detach, able to not throw myself fully into whatever despair I was feeling. It helped me show up for myself and feel proud.

Without the service I would still be in my spiral of nonsense. With my kids 24/7 out of desperation. I'd probably cry a lot more. I'd probably have had a lot of breakdowns. I'd be like a shell. I'd feel a lot more like an empty shell. I don't know the kind of mother I would be now. Without this service my whole life would have been literally crumbling around me. I would have been still doing everything but at what cost and to what detriment to myself and what detriment to my kids because they would have noticed as they grew older; "Mum, how come you don't let me play outside?" I know that to be a fact. There's no way I would have let him play outside. I would not have let myself be outside. What the therapy allowed me to do was actually lean in to being a parent, lean in to being a woman, lean in to being myself. It was like I was asleep and I'm awake now. I'm at a point now where I am able to talk about it all. I'm able to say it properly, concisely, I'm able to tell my story.

Janet

I grew up with a lot of trauma. My parents were terrible parents, my dad was abusive, my family is not close at all. There are also a lot of dead babies in my family, my mum lost one, other people lost theirs, so I grew up knowing about stillbirth and seeing how awful it was. I had vaginismus from the age of seven, lots of really bad doctor intervention, and later an abusive relationship. All of that was a lot of trauma. I potentially have OCD, obsessive thoughts and a lot of checking behaviour and I have body dysmorphia and Tourette's. So the whole idea of being a parent, I didn't ever think I wanted it.

I met my partner and he is a beautiful thing but I didn't think I wanted children. Then, in the pandemic, I found myself thinking "hmmmm" and I talked myself into having a baby. We got onto IVF really quick. We fiercely went to all the appointments but I didn't believe it was going to work. We put two in and that round didn't work, I bled before you were meant to bleed, it was very weird, very awful, howling on the floor. Then we tried again, with a five day blastocyst, and I got pregnant. But there was a problem at the scan, there was no heartbeat. I was in the hospital, like a deer in headlights, I had to go on my own, I was there with my pillows, clutching my pillows, I couldn't even say the word 'baby', I couldn't say those words while I was pregnant, it was almost banned, but the hospital staff used that language and they kept repeating it. I was like "you don't need to", but I couldn't speak for myself, I could barely be there. They had to put me in a room in my own. In the reception there was a murder show on the TV, a lot of intense sounds, it was awful, terrible. We ended up booking a private clinic to do the termination, but by that time, it was happening naturally. You'd think that the worst day in the world is the day when there's no heartbeat, but actually the worst day in the world is when I went to hospital and was treated like that, it made me feel like shit. [cont. on next pg.]

Then we went to a donor egg. We had the transfer, at first we were very jolly but it didn't take very long for joy to turn into intense grief, sudden intense grief. I didn't think it would work, I didn't believe it would work. But it worked, basically. It knocked me completely, I couldn't believe it. I didn't believe my baby was going to exist, I was so in grief and so traumatised. Even going with the donor egg, which has very high chances of working, even when I could see the scans and him fluttering around, hear his heartbeat, I couldn't think that there was a baby in me, I just couldn't. But I was pregnant.

I was put with the specialist mental health midwives straight away. On my early pregnancy form I'd put that I have vaginismus and they'd referred me straight away the specialist team. I also had quite a fear of birth, I was obsessed, obsessed, obsessed. The midwife told me about the MMHS service and the GP also told me, so I got two referrals. I got a letter and an appointment was made. I had a really boring pregnancy in the end. I still couldn't say "baby", he was "bump". I had a weird fallout after the 24 weeks when we found out he was a boy; I sort of had this gender disappointment, but now I'm completely besotted with him.

I started seeing the therapist from not very far into the pregnancy, I see her weekly. It's mostly online, though she's been to the house as well, she's met the baby, she's chatted to him. Online is really good for me because of the pandemic. I was shielding so I couldn't travel, that worked really well for me. I had an elective C-section, I felt like I was in space or something, and then suddenly my baby was held up in front of me and then he was in my arms and it was my baby. He knew my voice, he touched my nose.

Since I had him I've struggled with my age. I'm 44 now, that's been a really, really big, hard thing. I'm more used to it now, but I'm the oldest first time mum I know with a baby. I'm older than a lot of people I've spoken to, so I felt very othered. I've been grandma'd a couple of times. I've actually met a couple more forties mums now, apparently there's more in the next borough. And there's a mum coming down from a different part of the country next week who I know from Facebook, because that's how hard it is to meet mums in their forties, it's ridiculous. I feel like an outlier, that's one of the things the service has helped me with.

The therapist trod a very, very fine line between trying to help me self-validate and validating me. She saw that I needed somebody to say "this is fine, you're not too old". She saw that I needed to hear it because I'm not hearing it from enough people. If I'd met somebody who was getting pregnant in their forties, I'd be like "but you're not going to be there when they're older". Now I'm like "we're healthier than we've ever been and fitter than we've ever been". It helped me find my story, my narrative. With obsessive thoughts, how I have them, I'm always like "are you sure you're not too old for this, are you sure it's okay? Are you sure?" If you have a simple story like "are you too old? No, this is why, we're healthier than ever, fitter than ever", if you have that simple narrative, when the "are you sure?" starts, I can curb it because I know what my story is. The simple narrative can interrupt the unhelpful thoughts. I wanted to get to the bottom things so I could be a good mum for my baby. That was my hope, but I didn't know I would get to the bottom of things so well. I absolutely knew there was no way in hell I was going to let my shit come over to my baby.
[cont. on next pg.]

I wasn't going to think about the fact he was a boy, I wasn't going to think about how old I am, I wasn't going to have him just be a donor egg, I was going to get a good narrative for him.

I presented with certain issues, and these were the issues throughout, but through them came up stuff about family, my miserable childhood, my abusive dad, a lot of that was cycled through. She understands my medical situation, she's not patronising, she knows her shit, knows her stuff. She's very warm, but more than anything, she really knows her stuff. She was able to challenge me and have the warmth, which I think is quite impressive. I respect the hell out of her. She is extraordinary.

She is actually proper badass. She's really devoted to children and families and she has seen bad parenting, yet she was endorsing me having my baby and going for a second. There was a validation, her validation of me and my journey. I've had terrible therapy in my life, the very worst, and different counselling through pregnancy. I banged on everybody's doors, but having the MMHS psychologist who I could really talk to about how my mind works, and see it, we really made inroads in understanding how it works. It's really been about working out who I am. I didn't know who I was as a child, I didn't know who I was as an adult, "am I cool? Am I not cool? Am I nice? Who am I? Am I funny? Am I clever?" I didn't really know who I was. A lot of the therapy is working out who I am, who I am as a mum, who I am as me. I'd lost a lot of me during the pandemic, I had toweringly low self-esteem, so yeah, it's about who I am, that sense of self. The therapist got me the peer support worker and I started seeing her too.

The first time I met her I could barely look at her, I cried the whole time. The therapist was trying to introduce me, I sort of looked at her and just cried, cried, cried. The second time I met her I was keeping her at a distance. I told my story, like "this is my story, you're not going to do your thing", and she got that I just needed to do that. I found it really hard to let her in, to trust her, because she represented non-forties mums to me, so it took a while to be able to talk to her normally. Now I think she's awesome. She's very warm, warmth is the thing. Being able to trust her, that's been a huge, huge journey, the relationship has changed so much. It has really, really, really helped me, she's been absolutely incredible. She's extremely normalising, very open.

I was woefully unprepared for breastfeeding and the peer support worker helped me a lot with that. I'm able to really talk about being a mum, I get to have proper normal mum conversations with her. I don't know many mums, so having somebody there, who has to like me, ha!, the unconditional positive regard thing... I don't know what peer support is meant to do but it was an extra person to be able to open up with. When I have felt difficult, tricky, I can talk to her about how I feel and she is great. Even about her age, she represents a non-forties mum, I can still talk to her about that issue. I had a block to opening up, with all that I've been through, but having that space with her to be able to ask my stupid questions, it's helped me to be a mum, it's helped me feel normal. It's exceptionally powerful. I very much respect both of these women. Honestly, if you saw me at the beginning of the service to now, the difference this has made,... [cont. on next pg.]

I knew I wanted help but I didn't know I would feel so much better by the end of it. I'm crying, I can't... It's given me my family. My baby is such a happy little boy. I can't tell you how much I love being a mother. I'm completely besotted with my baby, he's just divine. He's very happy. Without this service I'd be a big blob of desperate fear and emotions. We wouldn't have been able to afford help, the amount of money this would have cost privately, and I wouldn't have met people as good as these people. I won't forget it. I'm really aware of how valuable this service was to me, it should be for other people too.

Liz

I was pregnant but had a miscarriage in October 2020. Obviously there was COVID then, and that featured quite strongly because I used to work in a school but I'd left the job under difficult circumstances and then couldn't get another job because schools had closed. And with the lockdowns, the miscarriage, I wasn't able to see my GP, unemployment ... yeah, it had a massive impact. You know, I've got a close relationship with my mum and my sister and my partner, but when I had the miscarriage it was difficult. My partner and I didn't deal with it very well, we didn't know what to do, we didn't really talk about it, we didn't know how, he didn't know how to support me. It's such a difficult situation, it's different to other losses or other grief, in my experience. So it was quite lonely. When I found out I was having the miscarriage I went to the hospital, had the scan, and then you just get sent home and that was it. They say, "come back if there's any problems", but that's it, just "wait for it to pass", and that's it. You don't really get anything else, no follow up.

Then I got another job, started a new job in a brand new school in lockdown, online, that was in January 2021. Then I got pregnant again. It definitely wasn't planned, it was a shock, and that was when my anxiety really started – being pregnant again brought on an anxiety I had never experienced before. I found it really difficult. I had already been referred to counselling by my GP before even the miscarriage, for something different, for depression, so I was having this other counselling but my needs had changed and I didn't feel it was addressing the anxiety around my pregnancy and processing the miscarriage, I didn't feel it was helping with that. I mean I talked a lot about the miscarriage and the loss, and the sadness, which did help, but I got to the point where I felt a bit stuck in that sadness and I didn't want to be stuck there. I wanted to move on, I suppose. I just felt like I needed more help with where I was at that time, as well as with where I had been.

There never was a definite reason for my miscarriage, no-one ever really said why, so when I was pregnant again I thought it would happen again, because I didn't know why it had happened in the first place. I was highly anxious, about having another miscarriage, I was constantly worrying, always expecting the worst, didn't really feel that joy, didn't feel excited, didn't feel happy, didn't want to tell people. At the time I didn't realise that was actually a way of coping – not telling people, it almost makes it not real so you don't have to deal with it. I didn't really figure that out until I had the help from the MMHS counselling. It got to the point where I thought 'I definitely need a bit more help with this, I'm not coping very well', so I Googled 'maternity counselling' or 'miscarriage counselling' [cont. on next pg.]

...in my area and I came across the MMHS. I checked their website and made my self-referral online. I got a call back within 24 hours about being able to access the service, which was amazing, especially in COVID. So I had the initial meeting online with the midwife from the hospital and a psychologist, they talked through what I had put on my self-referral form, and then we just talked a bit about what had happened, and the reasons why I felt like I needed the service, what my worries were, and then the psychologist and the midwife said they were going to talk about what they thought I needed, and they would get back to me. They called me back and said “this is what we’ve set up for you; we’ve got some counselling, we’ve got a specialist maternity loss midwife, and then for your general pregnancy care overall you’ll be under an obstetrician at the hospital, not just a midwife, you’ll have an extra layer of support” because I have Chronic Fatigue Syndrome as well. She spoke about how each of those things would help me, what they would do, like “the counselling will help with this, the midwife will help with that”. So then the counsellor called me and we set up our first meetings. I just saw the counsellor at first, then after a while the midwife came in to one of the meetings, and then she joined us in the process.

The counselling was really helpful because it was with someone who was specialised in the area, the counsellor’s had training in maternity loss and trauma, and she’d give me strategies to help me manage my anxiety. To be honest it was the first time I really felt like I had someone I could properly talk to, who understood and could help. She’d say to me “some of the things you’re feeling are what pregnant women feel who’ve not had loss, so some of the anxieties you have around the health of your baby, that’s normal.” Obviously, it was more compounded because of my miscarriage, but it helped me realise that sometimes, for some women, pregnancy is anxiety provoking anyway, and for me, it’s just extra, because of my experience. That made me feel a bit less alone, like I’m not the only one that feels like this. We went through strategies to help with my anxiety, suggestions of things I could do, like breathing techniques and practical exercises. And I think just having someone who really could relate to me, who has that knowledge around loss, who could understand, I found it really helpful. The counsellor was so understanding, she really listened and empathised.

We’d always set up our next meeting at the end of the current one so I always knew when the support was coming, and there was a plan. In each session, at the end, she would say “okay, this is what we’ve talked about today”, do a brief summary and then “we’ll meet in two weeks and maybe we’ll focus on this in the next two weeks.” Or sometimes she’d give me a little task to do.

I never felt rushed, or that it was going to be taken away, they always said, “if you need more support, if you want to see us, we’re here”. I saw the counsellor every fortnight, but she was like “if you need more support let me know.” I felt supported all the way up until I had the baby, even when my birth plan changed quite late. I’d always planned to have a vaginal birth, but I had a real flare up of my CFS towards the end of my pregnancy, and physically I was finding it really difficult to cope, I felt like I wasn’t going to be able to manage labour. So I spoke to the midwife and I said “I’m really worried about the physical side of things”,
[cont. on next pg.]

...and then because I was under the care of the obstetrician, I was able to have a consultation with her about it, which then ended up in us deciding that a caesarean was the best thing. The counsellor, once she found out I was having a caesarean, she called me to talk about how I was managing with the last minute changes, how I felt about it, that was really good.

But then even though it was a planned caesarean, during the surgery my daughter's heartbeat dropped, and it became quite irregular, so during the process of a planned caesarean, it became an emergency because they had to get her out really quickly because of her heart rate. I knew something was wrong. I remember lying there and I could hear the monitor next to me and I could tell there was something wrong. Because I was lying down, I couldn't see, but the next thing, the room flooded with all these people, all these doctors came in, and I heard them say "we need to get the baby out". It wasn't chaotic, but it was quick, quicker than before. I remember lying there thinking 'something terrible is going to happen. Something really bad's going to happen.' All my previous anxiety about losing my baby came flooding back really quickly in those few minutes. I was thinking 'my baby's going to die'. But some of the breathing that the MMHS counsellor and midwife had spoken to me about, like the relaxation breathing, trying to stay calm, I remembered that lying there, trying to stay calm, trying to focus on my breathing, waiting for them to get the baby out.

In the end it was fine. We were in hospital for one night. They said we could stay another night, but I just wanted to get home, and I didn't need to be there. I'd agreed with the counsellor and the midwife that I'd be in touch with them after I'd had the baby. The midwife said "when you've had the baby message me, let me know, and then the counsellor will call you or send you a text, and if you want to talk, we can talk. I know it's a mad time when you've just come out of hospital and just had a baby, but if you need me, if you need to talk, we can talk, or if you just want to text, we can text". So I always felt that the support was there if I needed it.

When we got home I messaged them to say I'd had the baby, and then we texted, and then I actually spoke to the counsellor within a fortnight of having my daughter, just to chat, see how things are going, "how're you recovering? How's everything going?" That was useful, to have someone there who understands your journey and understands where you've been and what that means for you, someone who knows you, knows everything you've been through, then sees you at the other end of the pregnancy journey. I spoke with the MMHS midwife as well, she came see us at home, she got to meet the baby. And I had a meeting with the counsellor and the midwife and we talked about how things were going and they asked did I feel like I needed more help with the loss or trauma side of things, like what was I finding difficult. They both agreed that the things I was finding hard were the same for any new mum, like "don't feel like it's just you", so I didn't feel so alone. [cont. on next pg.]

I talked about my caesarean recovery, physically and the emotional side of it, which had come to head in the past couple of weeks, just trying to come to terms with the caesarean and the effect it has on your body and emotionally as well. They said, "it's to be expected, but if you need more help with it, or if it carries on then let us know, we're still here, if you need any more help get back in touch with us." The midwife said, "we're here for you in the background, we are here, if you need us just text, we'll be here."

It was quite scary feeling like that bit of support's gone, I felt a bit of a loss, because I was so used to having them, but then the counsellor said "you've come so far on your journey, you've done so well", and I realised I had. And I know that if I need them, they're there. It's not just a discharge and goodbye. And I'm doing okay now. Do you know what, it's gone by so quickly, and in some ways I really hate that, because I feel time's going by so fast and I want to hold on to every moment. My daughter's so lovely, she's smiling now, she recognises people. It's still hard, but it's easier than what it was.

Without the service I really don't know what I would have done. I probably would have ended up going to my GP and been put on anti-anxiety medication, or counselling in the same service that I had before, that I stopped. I don't know what I would have done. I think I would have found it really hard. The MMHS service has been invaluable, I can't tell you. I always felt supported, respected, understood. Because you don't forget that loss, just because you've got a healthy baby now. Other people forget, miscarriage is just so taboo, no-one talks about it, but you don't forget. And pregnancy after miscarriage is so anxiety provoking, you're constantly worried that the same thing's going to happen again. It's a really lonely place. These were the things they really helped me with.

Leticia

The pregnancy was my first pregnancy. Everything was normal. It was in lockdown, so I felt a bit lonely. But I had my partner and the pregnancy was okay. But when I had the baby, a couple of days before they tried to do an induction and it didn't work, and then an urgent C section. It was very traumatic. After I had the baby, I was there with a C section, on my own mostly, because of Covid, and I had to take care of the baby and I couldn't do it. He kept crying, I was in the room with five other women and my baby was crying all the time and the other people were getting upset because they couldn't rest. I was in a lot of pain, it was really bad.

When we came home, I think the first two, three months I was just going down and down. I wanted to stay in bed all the time. I asked for help from my health visitor, and the GP. They just said "you're doing well, just keep breastfeeding the baby". I was so tired all the time. They were saying "that is normal, sleep when the baby sleeps. Have some rest then". [cont. on next pg.]

But I didn't feel okay, so after a few months the feeling was so bad that I just wanted to stay in bed. I didn't even want to see my baby. I was asking my partner take him away because I couldn't bear to see him.

I went again to the GP and said "I am struggling a lot". I was thinking with this sombre feeling. When I was breastfeeding, it wasn't good. The GP said "you should keep breastfeeding, it's the best thing for the baby. You are doing well". I felt like I was asking for help and no one listened to me. It was really tough. I couldn't take care of myself, practically, I just couldn't. My partner was the one saying, "go and have a shower, go out and get some fresh air", and I would say, "I don't want to go out, I just want to stay here in the bed".

And I started thinking "why did I do this? I was much more happy before. This baby he is just here, taking all my energy and my needs. I just want to be alone". So for the first three months I was in the bed. My partner was taking care of the baby all the time. Like "okay, I think he's hungry" and I was like "no, he can't be, let me sleep". And the baby was crying like crazy. We don't have family here. Being here without my parents or the parents of my partner. It got really bad. Our baby was born in a lockdown, and the Covid situation in [our home countries] at that time, it was really bad so they couldn't come. I think if I'd had the support of family or friends here maybe the situation would be different? Because we were just us. At night the baby was waking up a lot, so we had arguments during the night, "you go and pick him up", "no, you go and do it". Like that. The baby was waking up every two hours, every night. There wasn't time to cook, to clean, do whatever, it was all about the baby.

So I asked the GP again about counselling, and then a week maybe, I don't know the exact time because I was really out of place, but after some time someone called me, and I explained again what was happening. It seemed for me the service was a bit difficult to find, but I spoke to some different people and then someone from the service called me.

I had this first meeting with the team, and they said "okay, we think that you may have like, trauma from the birth and maybe this part of the service will help you, we are going to talk about it and try to find someone that will help you specifically with the problem you have". I think that was really good. Making it specific to me. The therapist said the best thing to do was EMDR, for the trauma. The thing is, I have a friend where I am from, and she uses this therapy. I always thought it sounded interesting, but I didn't think it would work, like this strange tapping thing, that is not going to help you – something like that does not work. But the afternoon when I started doing it, wow. It helped to process the trauma. It did.

But also, she helped me to have some tools that I can use in the future. Like I have a safe place, so when I'm feeling anxious or in some stressful situation, I can try to feel that I am going to that safe place and that helps me to relax. She gave me other tools to use like trying to remember that you are in the present. A couple of months ago I went to the GP to the cervical screening. [cont. on next pg.]

When I was there, it was like flash coming back to when I was in the hospital, and my head was doing a lot, and at that point I said “okay, what did she say? Where are you? You are in the GP. There is a picture on the wall. There is a chair”. I really used that tool that she told me and it helped me to be in the present, to say “I am not in the hospital, that is not happening again”.

But I think the most important thing for me was... she helped me find a way to understand what was going on in my head. I was always putting the blame, the responsibility, onto other people, like “why did they do the C section”, “why didn't they take care of me”, “why when I asked for help, they didn't help me”, like I am the victim and the rest of the people they are all against me. Doing the therapy helped me have a different picture, to understand it's not their fault, they did their best, they tried to help me.

Without the service I would be in a black hole. I felt weak. I didn't want to do anything with my partner, I didn't want to bond with my baby, I didn't want to do anything. I just wanted to stay in bed and sleep. For a year. If I didn't receive this help, I would be depressed, taking medicine, in bed, not working, asking for benefits. The service helped me to feel stronger, like I used to feel before having the baby. It helped me back to myself. And because I received this help, I can keep going, looking for a job, taking care of my baby, keep going with my life. With this help, I keep moving on.

Now, with my baby, the therapy has helped me to be with him. We go to swimming classes together now. And he's walking and babbling, and it's a completely different feeling I have. At that point, I loved him, but now it's like, the super love in my life.



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- Delivering high-quality mental health research and evaluations that deploy collaborative methods
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- Working to ensure research achieves positive change

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