

SURE START SOMERSTOWN

ADDRESSING POST NATAL DEPRESSION

Evaluation Report

May - November 2002

ACKNOWLEDGEMENTS

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DECLARATION

I declare this document to be a true, impartial report of the findings of the evaluative study into how the projects at Sure Start Somerstown address Post Natal Depression. The research was conducted in Sure Start Somerstown between May 2002 and November 2002.

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January 2003

List of Abbreviations

EPDS Edinburgh Postnatal Depression Scale
FMM Feeling and Moods Motherhood
FSW Family Support Worker
GP General Practitioner
HV Health Visitor
NESS National Evaluation of Sure Start
PND Post Natal Depression
PNDT Post Natal Depression Treatment
PNDSS Post Natal Depression Social Support
SP Service Provider
SSS Sure Start Somerstown

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PREFACE

STRUCTURE OF REPORT

This report is divided into four sections:

- Section one: Introduction. This section details the aims of this report, the research questions underlying it and its ethical underpinning. It gives a brief community profile of the geographic and cultural areas that makes up Somerstown, Portsmouth. It also defines Post Natal Depression (PND), states some of its causes and effects, and describes assessment tools. It describes how PND is addressed in Portsmouth City and, more specifically, discusses the role of Sure Start Somerstown (SSS) in addressing PND and how the SSS programme is performing against the Sure Start Unit Target.
- Section two: Methods. This section details how the information was gathered, including the preparation, interviews and supporting evidence. Interview schedules are reproduced in the appendices.
- Section three: Findings. This section divulges the results of interviews with Service Providers and mothers and analyses these findings. It looks at two key projects in detail, the PND Treatment (PNDT) Group and the PND Social Support (PNDSS) Group, as well as related work by Health Visitors (HVs) and Family Support Workers (FSWs). It describes and evaluates the services, measuring them against the research questions detailed in section one and assessing how the different agencies work together. This section tries to measure the differences made to the lives of these women and their families. It also identifies 'gaps' in the service.
- Section four. Conclusion. This section gives a summary of findings, validation and identified gaps in service and some recommendations for consideration by SSS management. It is organized under five sections:
 - Identifying Need
 - Quality and delivery of service
 - Matching Need
 - Involvement
 - How agencies work together

A summary of this report will be available in February 2003.

A poster with key findings is also available on request.

SECTION 1: INTRODUCTION.

By 2020, the World Health Organisation estimates that major depression, of which post natal depression is a sub-group, will be the second highest cause of death and disability in the world.

Less than a quarter of women who suffer serious post natal depression are diagnosed and treated.

(‘Majority of depressed mothers go untreated’ by Sarah Womack, Social Affairs Correspondent, Filed 27/08/2002. <http://www.telegraph.co.uk/news/>)

1.1 AIMS OF THIS REPORT

This report investigates to what degree different agencies working together in Sure Start Somerstown (SSS) address Post Natal Depression (PND). It is an example of SSS’s progress towards ‘making a difference’ in the Somerstown area and towards the specific government target concerning this.

The critical questions addressed in this report are ‘What are we doing?’ and ‘How well are we doing it?’

Furthermore, the Sure Start Unit wants the following questions answered:¹

- Are we reaching the right people?
- How well do the services we actually have match the needs identified before we began?
- Are the services of a high standard?
- Is the range of professionals and volunteers we employ appropriate to meet the need?
- How successful has been the involvement of parents in the planning and delivery of services?

The Sure Start Unit has also said that ‘Projects will be measured to see to what extent they meet Sure Start principles’:

- Co-ordinate, streamline and add value to existing services in the Sure Start Area
- Involve parents, grandparents and other carers
- Avoid stigma by ensuring that all local families are able to use Sure Start services
- Ensure lasting support by linking to services for older children
- Be culturally appropriate and sensitive to particular needs.
- Promote the participation of all local families in the design and working of the programme.

(Guidance on Local Evaluation August 2000)

¹ Henderson, Juliet, Wilkins, Katrina & Barnes, Jacqueline, ‘Getting Started with a Local Sure Start Programme Evaluation’, National Evaluation of Sure Start (NESS) <http://www.ness.bbk.ac.uk>

This evaluation attempts to answer these questions and is structured along these lines. It should be noted that two key projects, the PNDT Course and the PNDSS group, were thought to be successful by management before the evaluation started. Both groups are Sure Start initiative rather than enhancements of existing services. There was no permanent citywide support for mothers identified with PND at the time of this study, although one had been operating, but not in the Somerstown area.

1.2 COMMUNITY PROFILE OF SOMERSTOWN, PORTSMOUTH.

Sure Start Somerstown is made up of parts of four wards in Portsmouth: St Thomas, Charles Dickens, Havelock, and St Jude.² When Portsmouth was invited to participate in the Sure Start Initiative, this area was identified as having an appropriate number of families with children under four. The Indices of Deprivation rate all the wards in Somerstown as being well in the top half of deprived wards, with Charles Dickens being in the top 14%.

Much of the accommodation in the area is high-rise, social housing (that is, owned by Portsmouth City Council). However, there are some areas where large privately owned single-family occupancy properties are adjacent to similar properties that have been converted into bed-sits, which are multiply occupied by income support or low income families, and/or single parent families. Towards the south-east of the area there are also some predominantly Bangladeshi families in private rented accommodation of a very basic standard.

Many families have multiple and complex needs. It is important to acknowledge that, whatever the government targets are, PND is one of many things going on for these families. It may not even be the most important thing to them.

The demographic data from 2000 plan to 2002 plan follows:³

	2000*	2001**
Total population	15,068	14,400
Population under four	598	689
Breakdown of (total) population by ethnic group* (see below for classification)⁴	(a) 12708 (b) - (c) 419 (d) 101 (e) 198	(a) 95% (b) 0.17% (c) 3.1% (d) 0.59% (e) 0.73%
Families with children under four *	525	619
Children under 4 with complex special needs	20	Data not available
Live births to mothers in Sure Start area per year	160	181

By March 2002, the number of children under four in the area had increased to 840.

² Portsmouth City Council.

³ * May 2000 Delivery Plan. ** January 2002 Revised delivery plan; *** figures for March 2002 from Annual Review.

⁴ 1991 Census

1.3 SURE START SOMERSTOWN (SSS), PORTSMOUTH.

Ultimately the purpose of Sure Start is to improve the adult life chances of children who grow up in disadvantaged communities. These are the planned **outcomes** of the programme. These outcomes cannot be measured until the children have grown up, perhaps in 20 years or more. In the short-term, therefore, what we are seeking to measure is **outputs**: what the programme is actually delivering in terms of services⁵

Sure Start Somerstown is a 'wave 2' programme of a huge government plan. It started in May 2000 and has developed very quickly, currently supporting about 40 different projects. The programme is always developing, as local families and the surrounding community identify need, and SSS tries to address those needs with them.

The programme concentrates on four core activities

- improving social and emotional development
- improving health
- improving the ability to learn
- strengthening families and communities.

As well as this, 'hands-on' parental involvement in decisions made about the services and activities is crucial.

1.3.1 Reach statistics.

Families on the database who accessed the programme July 2002 - December 2002:

	<i>Children seen</i>		<i>Families seen</i>	<i>Pregnant women</i>	<i>Parents seen</i>			<i>Live births</i>
	<i>total</i>	<i>with special needs</i>			<i>total</i>	<i>With special needs</i>	<i>Lone parent</i>	
July 2002	209	6	207	23	203	8	72	14
Aug 2002	187	7	183	11	175	5	63	22
Sep 2002	171	4	167	10	178	7	63	11
Oct 2002	153	5	150	7	153	8	54	16
Nov 2002	168	3	168	5	153	6	61	12
Dec 2002	153	2	163	8	139	8	49	20

The total number of families who are members of SSS is 563. The SSS building is due to be refurbished imminently and, although every effort will be made to make projects easy for families to get to, a change in venue will probably result in these figures dipping temporarily.

⁵ 'Guidance for Sure Start Local Evaluators and Programme Managers on the Estimation of Cost effectiveness at a local level' p7, available from the National Evaluation of Sure Start (NESS) website, <http://www.ness.bbk.ac.uk>

1.3.2 Ethnic Breakdown

Declared ethnicity of families accessing services:⁶

		July 2002	Aug 2002	Sep 2002	Oct 2002	Nov 2002	Dec 2002
a. white	British	180	127	150	130	156	126
	Irish	1	1	0	0	0	1
	Any other white background	3	2	0	1	2	0
b. mixed	White and Black Caribbean	1	1	0	2	1	2
	White and Black African	6	4	7	3	6	5
	White and Asian	0	0	0	0	0	0
	Any other mixed background	1	1	2	4	1	4
c. Asian or Asian British	Indian	1	0	1	1	3	1
	Pakistani	0	0	0	0	0	0
	Bangladeshi	14	1	5	4	6	6
	Any other Asian background	0	0	2	1	0	1
d. Black or Black British	Caribbean	0	0	0	0	0	0
	African	0	0	4	4	3	3
	Any other black background within d.	0	0	0	0	0	0
e. Other ethnic groups	Chinese	0	0	0	2	2	2
	Any other ethnic group	2	1	0	1	3	2

1.4 POST NATAL DEPRESSION (PND)

1.4.1 What is PND?

Post Natal Depression has been described as any depression experienced by any mother, regardless of age or background, within the 12 months following childbirth. Childbirth itself, especially if that childbirth is traumatic, can trigger its onset. PND is generally held to affect 10 – 15% of all new mothers.⁷ There are different levels of severity, but it should not be confused with baby blues⁸ or puerperal psychosis.⁹ Though all new mothers will feel tired, lacking in confidence and energy and will experience anxiety to some degree, a mother with PND may show, express or experience, a combination of several symptoms over a prolonged period. These may include anxiety, confusion, exhaustion, indecisiveness, loss of self-esteem, lack of confidence, no enjoyment of motherhood, hostility, shame, guilt, fear or helplessness.¹⁰

⁶ Monthly Monitoring Forms M3 July – November 2002

⁷ 'Impact of maternal postnatal depression on infant development'. Institute of Psychiatry website. <http://www.iop.kcl.ac.uk/iop/Departments/PsychMed/PeriNatl/childdev.stm>. Although most recent figures suggest this is much higher – nearer 20%.

⁸ A brief period of emotional distress, occurring between 3rd and 10th day after birth, - thought to affect 50-80% of women. Treatment is not normally needed. (Dr Howard Lee, 'PND – don't suffer in silence', <http://www.ivillage.co.uk/pregnancyandbaby/parent/postnatal/articles/>

⁹ A rare psychosis affecting between one and two new mothers in every thousand. Unlike PND the mother cannot hide the symptoms even if she wanted to. Ibid.

¹⁰ National Childbirth Trust website: <http://www.nctpregnancyandbabycare.com>

1.4.2 Causes.

There are different theories on what causes PND.¹¹ They can be broadly categorised as physical, psychosocial or bio-chemical. Indicators that would suggest a propensity to PND are:

- A previous history of depression
- Lack of support from partner
- Premature or otherwise ailing baby
- Mothering history
- Accumulation of coincidental misfortunes, such as bereavement, money problems.

However, a woman can suffer from PND when there is no obvious reason at all.

1.4.3 Effects

It is important to diagnose and treat PND as soon as possible. Not only does it taint what should be a joyful experience, but also maternal depression can impede a child's basic developmental tasks and needs. Much research has been conducted on the effect of parenting on early child development. A central feature of early parent-child relationships is "attachment security": the development of security confidence and trust between babies and their parents. (Shonkoff and Phillips, 2000). Research in Cambridge over 20 years shows five year cycles where very flat unavailable mothers result in babies and children who give up wanting any kind of attention. Parental mental health is one of the key factors that can influence early brain activity and long-term behavioural outcomes (Dawson et al, 2000).

Three British Studies (Murray in Cambridge, Kumar, Robson, Cogill in North London; Sharp, Haw, Pawlby, Kumar in South London) have shown that maternal depression early in a child's life is associated with subsequent cognitive impairments and behavioural difficulties.¹²

The vision of Sure Start is to *break* the cycle of disadvantage for children by the time children reach school. Studies indicate that early intervention is an effective way to do this. A study by Barlow and Coren on parent-training programmes for improving maternal psychosocial health concludes:

It is suggested that parenting programmes can make a significant contribution to the short-term psychosocial health of mothers Further research is needed to assess which factors contribute to successful outcomes in these programmes with particular attention being paid to the quality of delivery.¹³

¹¹ See Royal College of Psychiatrists website. <http://www.rcpsych.ac.uk>.

¹² 'Impact of maternal postnatal depression on infant development'. Institute of Psychiatry website. <http://www.iop.kcl.ac.uk/iop/Departments/PsychMed/PeriNatl/childdev.stm>

¹³ Barlow J, Coren E. Parent-training programmes for improving maternal psychosocial health (Cochrane Review). In: *The Cochrane Library*. Issue 4, 2002. Oxford: Update Software.

1.4.4 Assessment

If PND is undiagnosed or unassessed (and therefore untreated or unsupported) the long-term effects can be critical. The importance of early assessment, then, cannot be overstated. While any depression is traumatic, it can be completely debilitating when combined with the additional responsibilities of a new baby.

The Edinburgh Postnatal Depression Scale (EPDS)¹⁴, now re-issued as the 'Feeling and Moods Motherhood' (FMM) assessment tool is used to assess PND. Women are asked to read, or have read out to them, each of the 10 statements and the response that best fits how they had been feeling over the previous seven days is noted. The assessment tool rates the degree of severity of some symptoms that may indicate depression and anxiety. It is recognized that the FMM assessment tool does not include all the criteria for diagnosis of clinical depression. Indeed, in interview, Health Visitors (HVs) stressed that it was *not* a diagnostic tool, but 'could be helpful to indicate areas of stress'.

1.5 PND AND THE CITY OF PORTSMOUTH.

Though a service addressing PND *had* been running as a Portsmouth city project (outside the Somerstown area), it was not running at the same time as the Post Natal Depression Treatment (PNDT) Course or the Post Natal Depression Social Support (PNDSS) group facilitated by Sure Start Somerstown (SSS). The project was successful, and even had a waiting list, but a change in location and lack of regular funding means it operates now only on an ad hoc basis when resources allow. Since the running of the PNDT course and the PNDSS group at SSS, there has been a resurgence of interest in recommissioning another PND group in the city of Portsmouth, working through 'On Track', funded by Children's Fund.

1.6 Post Natal Depression (PND) and SURE START SOMERSTOWN (SSS)

1.6.1 Sure Start Somerstown's role in addressing PND

Sure Start Somerstown's role is to provide funding to meet the objective that the long-term cycle of disadvantage for families is broken. Targets set by the Sure Start Unit in London, against which SSS can measure progress, help to see whether SSS are successful in its ultimate objective.

SSS had a two-pronged approach to addressing PND. It funds a treatment course and a social support group, each of which addresses PND in quite different ways. Furthermore Health Visitors (HVs), dedicated to working in the SSS catchment area, are trained in PND and therefore fulfill their remit to enhance Primary Care Trust (PCT) services to SSS families. They are the main referrers of mothers to the two groups.

¹⁴ See 'Strengths and Limitations of the Edinburgh Postnatal Depression Scale' on website: www.PNDtraining.co.uk. A discussion of the merits of this assessment tool is outside the scope of this study. Copy of Feeling and Mood Motherhood assessment at Appendix.

Family Support Workers (FSWs), to a lesser degree, are involved in supporting families in times of stress and could be in a position to refer mothers to the groups, though this has not happened to date.

More details of this service provision are given in section three of this report. The way need is identified is different in providing support for women with PND than for other SSS projects. Though the women *can* self-refer, most women taking up the service are referred by Health Professionals. The families themselves, then, do not necessarily identify the ‘need’. Certainly the impulse for establishing the projects was driven by statutory agencies rather than the community and it should be acknowledged that for some projects this is entirely appropriate.

SSS provides the infrastructure - the building and administrative support - to facilitate these projects. Interviewees were asked to assess the impact of SSS on the projects. Their responses are recorded in Section Three of this report.

1.6.2 Progress Towards Targets

The Government Target concerning PND is

All local Sure Start programmes to have agreed and implemented, in a culturally sensitive way, ways of caring for and supporting mothers with post natal depression. (SSS Revised Delivery Plan January 2002).

The national average for mothers with PND measured against the number of mothers with the potential to have PND (that is, within 12 months following the birth of a child) is generally accepted to be 10%. Within the Somerstown area, given the potential for isolation and withdrawal that high-rise living promotes, this figure is higher. Latest figures show it to be 17%. (see table below), though recent (unpublished) research suggests this figure is much higher.

Actual figures for the period 1 April 2001 to 31 March 2002 are shown below¹⁵

Number of mothers with a live birth within this 12 month period	178 ¹⁶
Number of mothers identified as having PND (depression in the first 12 months of their baby’s life)	31
Number of mothers with PND identified who are ‘appropriately supported’.	23
Percentage of mothers identified with PND	17%
Percentage of mothers with PND receiving appropriate care	74%

The annual milestone to measure progress towards the Government target quoted above is

100% of mothers with post natal depression identified. Additional 20% (each year) of mothers with post natal depression receiving appropriate care by the end of 2001-01 (total 60%). (See Revised Delivery Plan).

¹⁵ Figures are taken from the monitoring form M5 submitted to Sure Start Unit September 2002. Figures cover the period from 1 April 2002 to 31 March 2002.

¹⁶ Figures from Health Visitors’ Caseloads

The first part of this target is impossible to attain. It can be said, however, that an assessment on PND is conducted by the HVs dedicated to working in the SSS catchment area on *every* mother at the six week stage. However, no assessment tool is infallible and the Edinburgh Postnatal Depression Scale (EPDS) or Feelings and Moods Motherhood (FMM) assessment has its critics. It is used as an indicator of how mothers are feeling and is not separate from the overall care of HVs to their families and ongoing, if less formal, assessment is also conducted. The FMM assessment has been used in SSS only since August 2002, when an additional Health Visitor was recruited to the team. Before this time, a less formal assessment of mothers' psychological well-being was conducted on the 6 week check, relying on standard clinical assessment tools. Therefore it is stated that 100% of mothers are assessed and those that present indications of post natal depression at this time have been identified.

The second part of the target looks for continuous improvement (20% each year) in the appropriate care provided for women who have been identified as requiring this care. It should be recognized that the two groups running at SSS are not the only options for mothers and severe cases may need to be referred to clinics. Some mothers may opt for a course of medication. Opting for medication does not preclude mothers from joining either the PNDT course or the PNDSS group or both.

As the table above shows, the percentage of mothers who were identified in March 2002 as having PND, and who received (or are still receiving) appropriate care in Sure Start Somerstown is 74%, (or 23 out of 31). This well surpassed the March 2002 target of 60%. However, when this report was researched only 12 mothers had accessed either or both groups. Since the research was conducted a third PNDT course has run, treating 10 mothers, and a new mother has joined the PNDSS group. Robust figures about which specific support women have chosen were not available within the timescales for producing this study. Furthermore, numbers fluctuate because families move in and out of the area at a rapid rate. Therefore, some mothers with PND, who were receiving support, may leave the area, while other mothers, already identified as having PND, may move into the area.

The following chart suggests some categories of appropriate support that a future study might find helpful to investigate. Then a much fuller picture of support could be established.

	Mothers with potential for PND (within a year of childbirth)		Mothers with PND identified		Appropriate support (see legend below)						
	Live births	Total of children under 1 year seen	no	%	A	B	C	D	E	F	total
2002											
July	14	86									
Aug	22	83									
Sep	11	72									
Oct	16	68									
Nov	12	74									
Dec	20	53									

- A. Attended or currently attending PND Treatment course **or** PND Social Support group **or** both, not including medication and/or hospitalisation.
- B. Attend either group **and** take a course of medication or have been in hospital or specialized mother and baby clinic.
- C. Take medication only.
- D. Receive support from Statutory Agency (Health or related service) only, not including hospitalisation, not including SSS PND Treatment course **or** PND Social Support group.
- E. Hospitalisation, with or without other care packages, not including SSS PND Treatment course **or** PND Social Support group.
- F. Support offered by HVs declined or other kinds of support (such as family).

Because information is not available to date it is not know what happens to women who are not attending either the PNDT course or the PNDSS group. Therefore, these mothers should also be monitored, to ensure they are receiving (or have declined to receive) appropriate help, within the categories suggested above. While Health Professionals are undoubtedly tracking their clients, this process should be more transparent in this circumstance.

Notwithstanding the success in meeting targets, we should not neglect the fact that some mothers may *not* be receiving ‘appropriate support’ and this should, if necessary, be addressed as an urgent matter.

SECTION 2: METHODS OF ENQUIRY

2.1 ETHICS

Given the nature of this case study, steps were taken to find out whether the subject matter needed to be referred to the Local Ethics Research Committee. After consultation with National Evaluation of Sure Start (NESS) and Sure Start Somerstown Manager, it was decided that this was not necessary.

All participants (mothers and service providers) were assured that their comments would be confidential* and anonymized and that any tapes would be double locked. Mothers were given an information sheet with these details to keep. They were also assured that any data concerning them personally would protect their rights under the Data Protection Act. They were asked to sign a consent form to say that they understood the purpose of the evaluation and had participated voluntarily in the study.

2.2 METHODS OF ENQUIRY

2.2.1 Preparation.

The evaluator and Service Providers discussed the idea of evaluating their projects. The Service Providers were told the purpose of the evaluation and they, in turn, agreed to ask the groups whether they would like to take part in the evaluation. Information sheets had been prepared for invited participants prior to the interviews. (See above). This told them the purpose of the evaluation and assured them their views would be confidential and anonymous. It also suggested the sort of things it might be useful to discuss, as well as details of the interview itself (date, place, time). Consent forms listed some statements. Participants were asked to agree to these statements before signing their consent to taking part.

One of the service providers for the PNDDT course wrote to each of her members, past and present, told them the purpose of the evaluation and asked them whether they would be willing to participate. After speaking with them again she organized the date, time and venue of the focus group interview. At the start of the interview, the evaluator handed out the information sheets and consent forms, discussed again what the evaluation hoped to achieve, and the vital importance of the contributions of the participants.

The evaluator talked with the mothers attending the PNDSS group in a short meeting arranged by the service provider prior to the interview. Again the purpose of the evaluation was discussed, stressing the vital importance of the contributions of the participants, and any questions were answered. Information sheets and consent forms were given out at this time.

Codenames were chosen by the participants of both groups to protect their identity.

* Child Protection Issues excepted.

2.2.2 The interviews.

2.2.2.1 Mothers:

For both the Post Natal Treatment Group and the Post Natal Social Support group, focus group discussions were used to interview mothers as it was felt that they would be more confident in a group environment. These focus groups were semi-structured, loosely following a list of prepared topics, which the mothers knew beforehand. The session was very informal with free narrative being encouraged. These discussions were taped. The service providers were not present in these discussion groups.

The mothers involved were invited to individual interviews if they felt they wanted this, either as well as or instead of the focus group interview. None of the mothers felt they wanted to do this. Mothers were given a small gratuity in recognition of the value of their contribution.

2.2.2.2 Service Providers:

Service Providers were interviewed in some detail, individually. All but one of these interviews was taped. Extensive notes were taken during the untaped interview. Service providers also gave freely of any supporting documentation and any evaluation they had conducted during the running of their groups. A draft of appropriate sections of this report has been referred to Service Providers to confirm accuracy.

2.2.2.3 Other interested parties:

Health Visitors were seen in two short structured group interviews as their work commitments prevented longer interviews being scheduled. They were given a sheet of possible areas for discussion prior to the interview. The first interview was not taped due to equipment failure. The second interview was audiotaped. Two members of the HV team were only able to attend one interview

The evaluator also attended a home visit with one of the Health Visitors, in order to observe the process that identifies PND in practice. This was not taped but notes were taken. There was no intervention by the evaluator in this process.

Family Support Workers were also asked what they thought about how the SSS programme deals with post-natal depression and how this could be seen in the work they do supporting families. This structured group interview was taped. Participants had prior notice of the questions. (All questions and interview schedules are held in the appendices).

2.2.3 Supporting evidence.

Individual projects have provided their own evaluation documents. These demonstrate how satisfied parents and families have been with the services provided. These documents are included as appropriate. There have also been articles published on how SSS addresses PND and copies of these articles are held in the appendices.

2.2.4 Difficulties

2.2.4.1 Data

It has been very difficult to access some data or establish accuracy.

Costs for the PNDT course were amalgamated with costs for general Health support, making it difficult to assess this accurately. An approximation of project costs has been given. No attempt has been made to compare project costs with costs of reactive treatment as time constraints would not allow the kind of investigation that would have made the comparison worthwhile.

2.2.4.2 Administration

Tracking (as suggested above) was not at all transparent.

Some paperwork relating to project application of PNDT course was missing or incomplete. This made it much more difficult to gain an accurate description of the project and its aims and objectives prior to project delivery.

SECTION THREE: FINDINGS

3.1 POST NATAL DEPRESSION TREATMENT (PNDT) COURSE

3.1.1 General Description Of Project.

This course is run by two Health Service professionals, a Health Visitor (3 hours per week) and a Psycho-dynamic Therapist¹⁷ (10 hours per week). Both of them work for the Portsmouth City Primary Care Trust, providing a non-urgent service. Their brief is to treat ‘mild to moderate’ cases of PND, but it is difficult to define because mothers’ conditions change. Posters are placed in General Practitioner’s (GP’s) surgeries. (A copy of the poster is held in appendix).

The course provides treatment for a maximum of 8 mothers in group sessions over a 10 week course, each session lasting 1½ hours. Continuous support is also available outside these group times throughout this duration of the course. The group currently meets one day a week, on a Wednesday morning at the Sure Start Somerstown (SSS) Centre. Two groups had been run when this report was researched, though a third has since been started. Each group coincidentally had 5 mothers attending.

A crèche is provided. The course does not run in school holidays. Though this was considered, complications of providing child-care for older children or additional crèche facilities, combined with the fact that people go away in the school holidays and break the continuity makes this logistically unviable.

The course and the crèche are funded by SSS and are therefore free to mothers.

The mothers track their own progress with a weekly mood review. At the end of the course the mother’s GP is sent a formal discharge summary making sense of their experience. At present the women do not have a copy of it, but the Service Provider (SP) is considering changing that procedure.

The SPs are clear about the boundaries of the course. If any issues are raised outside their remit, the mothers are referred on to the appropriate service.

Though no mothers have asked to repeat a course, the SP has not ruled it out. The mothers themselves thought it unlikely to be necessary, as they had learned the coping strategies and *“just needed to put them into action”*.

3.1.1.1 Starting up and attending

Despite the perception of overwhelming need (17% of mothers in Somerstown area identified as having PND), there were not enough women for the first group to function without outside referrals. This was accepted, as it still benefited SSS mothers. If the course had not run, the SSS mothers would have lost valuable support to which a government commitment had been made. The service providers were aware of the need to raise the profile of the group (see quarterly monitoring form July

¹⁷Psychodynamic means forces of the mind. (Psycho = mind, dynamic =forces). Her specialist training is in understanding what happens to people related to their experiences and how they make sense of them.

2002). Since then the awareness has grown and the second group is comprised entirely of SSS mothers.

However, the issue is complicated because one GP's surgery is half in SS area, half outside. One woman phoned up after seeing the poster, to find out she was outside the catchment area and there was no other provision of this kind for her to access anywhere else in the city. It is recognized that, as SSS funds the course, SSS mothers should take priority. However, it is very hard to turn down mothers in need who happen to live outside the SSS area. But a new wave SS, and the take up of PND intervention with Children's Fund, with input from our Service Provider and evaluator, is helping to roll out some of the working practices of this service across the city.

At the time of this report the second course had just finished and enough mothers were booked on the intended third course to make it feasible. Although there is no waiting list as such, mothers who want to attend the next scheduled course have to wait until it starts. The nature of the course means mothers are not able to join a course part-way through.

3.1.2 Costs

A full cost-benefit analysis has not been conducted on the projects in the SSS programme to date. It is intended that this will be done imminently. Interested parties should apply to the evaluator or the manager, SSS for further details.

A cost comparison between this service provision and the potential costs involved if this intervention is not conducted is practically impossible to establish with any accuracy. As assessments by Health Visitors would be done whether mothers opted for this course or for other support, costs for this assessment and referral procedure are not included. However, Sure Start funds two full-time equivalent Health Visitors and their input into the procedure should be taken into account. (see Delivery Plan May 2000, p67).

A summary of project costs is shown below:¹⁸

	£
Salaries of service providers (annual)	
• Health Visitor	4,680
• Psychodynamic Nurse Counsellor	7,000
• Extra time that is not claimed but should be costed – for home visits, phone support etc.	1,000
Crèche	3,500
10% - facilities/resources at SSS (building, services, admin support)	1,600
Other sundry costs and expenses?	•
Estimated total	17,780

The cost of this early intervention should be compared with short and long term effects that may result if the early intervention and long-term coping strategies given by this project were not provided.

¹⁸ Figures from budget provided by Sure Start Manager.

Some negative costs of medical treatment are suggested by, for example, costs of psychiatric consultants and support staff, cost of residential care in psychiatric hospital or specialized mother and baby residential homes. But the costs of catastrophic events, such as cost to statutory agencies for support for families where mother is no longer available at all (through, for example, suicide), or long-term social effects of children who have had ‘flat’ mothering, (as suggested in section one) are incalculable.

Of course, mothers accessing the PNDT course (and the PNDSS group, see below) may also be accessing (or have accessed) residential care, one-to-one psychiatric counselling and medication. However there is a clear indication that the cost of intervention, of the sort being delivered at SSS at an early stage, is much less than at a critical stage. The cost of providing these services is “*a drop in the ocean compared with what it may cost if not treated.*” (Service Provider).

3.1.3 Structure of PNDT course

3.1.3.1 Ground-rules

The group is run under conditions of confidentiality, trust and mutual respect. The Service Providers demand that the mothers commit to attending every session. The ground-rules also make it clear that the Service Providers take on the responsibility of ‘looking after’ the participants. It is made clear to the mothers that it is not their (that is, the mothers’) responsibility to support the other mothers in this way.

3.1.3.2 Timings

Run by Health professionals, this course provides structured intensive support for mothers in the form of group treatment sessions over a 10-week course. This results in 9 weekly 1½ hour weekly sessions, with a booster session 4 weeks after the last session. Continuous support is also available throughout that time.

3.1.3.3 Model and structure

The model of therapeutic intervention used is bio-psychological and takes into account vulnerability, socio-cultural and precipitating factors, helping women understand what has contributed to their depression.

Although the sessions are structured around evidence-based research combining cognitive and behavioural techniques and increased social support, they respond to mothers’ needs.

“We don’t do it in strict order. Depends who’s there. Week on mothering was very emotional. Sometimes follow through with another session. Need a bit more time. Depends how quickly they take it on board – or recovery time. Restoring them.” (Service Provider.)

The mothers themselves described the course as ‘*structured but flexible*’.

The ideal number of participants is considered by the service providers to be 6-8 mothers.

There are three phases in the group:

- Behavioural interventions
- Cognitive Behaviour therapy¹⁹
- Relapse prevention and evaluation.

This is an example of the plan, although some of the weeks are changed around in response to mothers' input:

Session one: Understanding and managing post natal depression, including mood monitoring.

Session two: Debriefing – women talk about their own experiences, myths and cultural influences.

Session three: Pleasant activities – how we deal with problems.

Session four: Experiencing of mothering –unrealistic expectations.

Session five: Relaxation

Session six: Self-esteem

Session seven: Assertiveness

Session eight: More helpful thinking.

Session nine: Challenge internal critic

Session ten (booster): Putting it all together to provide a 'toolkit' to empower mothers to identify and monitor her own signals, to identify when she is experiencing depression and to differentiate this experience from day-to-day feelings. To reframe the experience of PND as a learning experience, developing the skills to cope and hopefully be less likely to develop PND following another delivery.

A group approach is used as it is considered that

- It is cost-effective
- Women can share similar experiences/fears/expectations
- Isolation will be lessened
- It is likely to engage the women in social activity
- It provides opportunities to hear and express distorted thinking - women will challenge her own beliefs about mothering and self
- It provides the opportunity to learn critically from one another.

3.1.4 Details Of Participants.

At the time of interview (July 2002) two courses had been run reaching a total of 10 mothers. Mothers from both groups were interviewed. Only one mother, from the first group, did not attend the focus group interview. Therefore the total of mothers

¹⁹ Cognitive Behaviour Therapy

– this takes three weeks and is an important part of the course.

The service is based on a study by Zeiss, Lewinson and Munoz (1979). They say the components that are critical for successful short-term Cognitive Behaviour Therapy for depression are that:

- There should be a detailed but sensible structure and action plans. These should help the mother to 'own' her own behaviour and thereby change her depression.
- The mother should be advised and helped to develop skills or strategies, which will make her feel more in control of her daily life. The skills learnt should be appropriate for the mother concerned and fit in with her plan.
- Mothers should be able to use and keep using these skills outside the group.
- Mothers should be encouraged to recognize that their 'recovery' is because of their own increased skill and not be reliant on the therapists.

interviewed was 9. Of the 9 mothers, 5 were married, 1 was divorced and 3 were living permanently with partners. The ages of participants ranged from 22 to 35 years.

The total number of children of the mothers was 16, the youngest being 7 months and the oldest 12 years. The most recent arrival in Portsmouth came a year ago. One mother had lived in Portsmouth all her life. All the mothers described themselves as white British. Two mothers had special needs.

Both Service Providers, a Psychodynamic Nurse Counsellor and a Health Visitor, are trained in PND assessment and treatment. Both have had a professional interest in PND for several years.

3.1.5 Difference between the two groups

As one of the service providers pointed out, the make up of the group changes the group dynamics.

Both groups very different – first group gelled very quickly. First group had women talking to each other, initiating conversation, being very open. Very upfront. Personal things about relationships. It happened really quickly. Very hungry for it.

SPs recognised they had different roles to play in the second group compared with the first group. The second group, for example, did not readily use examples from their own lives, so the SPs had to use examples from their work base.

If we're doing CBT we do 2 sessions on tuning into your thoughts and feelings, and how that makes you behave. It's brilliant if they give examples, - tell me about your last bad day. First group we could have had 20 examples every group. This group they went um er, and because it's only an hour and a half, we gave them examples so that's been different. Feels like it's a more distant academic process rather than it belongs to you.

In that way, for the SPs, the second group was a more 'difficult' group to manage and they had to adapt their working practice to meet the needs of the mothers. However, it must be stressed, this did not make any difference to the benefit the mothers gained from the second course.

Mother have not come back to repeat a course, but the SP has not ruled it out.

3.1.6 Interview Details

The structure of the interview was organized under headings, addressing the questions that the Sure Start unit wanted answered. (See Section one of this report).

Something the Sure Start unit is concerned to establish is how the service contributes to the fulfilment of Sure Start principles (see Section one of this report). Not all of these principles are appropriate in this particular case study, and these have been identified in the final section of this report.

Interview schedules are held in the appendices.

3.1.6.1 Identifying need (Referrals and Assessments).

Sure Start question: “Are we reaching the right people?”

First it is important to get behind the figures. As one of the Service Providers explained, the figures for mothers identified with PND are not constant and this makes it difficult to plan a strategy to address it.

It’s like premature births. You can’t predict it. Sometimes there are so many [with PND] that you don’t know what to do with them all. Other times you don’t get any for a while.

She suggested that running groups across the city with a greater degree of flexibility, perhaps providing transport, would be worth considering.

There are 6000 – 7000 deliveries in the city per year. It would be more cost effective to draw from a larger pool of potential participants and run groups in partnership across the city with other agencies.

The complications about SSS and non-SSS mothers attending the course, experienced at the start-up of this project would be overcome if such a scheme existed (see ‘start up’, para 3.1.1.1 in this section of this report). (Note: On Track, associated with Children’s Fund, is in the process of setting up PND course or group for the Paulsgrove area of Portsmouth, but the details are not available to date).

3.1.6.1.1. Referrals

Mothers can self-refer but are more often referred by other Health Service professionals, usually either Health Visitors (HVs) or General Practitioners (GPs). The SPs target health practices and consequently the service is advertised in GPs surgeries and Health Centres in the Sure Start area. (Copies of the poster and covering letter are included in the appendix.) However, not all the mothers interviewed knew the course was going on before they were referred. One mother said she “*didn’t have a clue. Didn’t even know what it was.*”

Mothers were asked how they came to join the PNDDT Course. Most were referred by their HVs, one through her GP and one through a stalwart of Sure Start, who knew of the initiative and was a person who had experienced PND herself. Of the mothers in the group only 2 recognized that they had had an assessment that they thought was EPDS or FMM assessment. It may be that the assessment is done but the mothers, because of their condition, do not actually take this on board. One mother expressed particular dissatisfaction with her HV. (It should be noted that, as some of the mothers were from outside the SSS area for the first course, their HVs would not have been from the dedicated SSS HV team.) Another mother commented, “*It depends on the individual Health Visitor*”. For further discussion on referrals, please see section 3.3.1 on Health Visitors.

3.1.6.1.2 Assessments

A great deal of emphasis is placed on making sure that the PNDDT course will be the right place for the mother under stress to receive help. The service provider comments, “*The bit you do outside the group is crucial to get them to stick with it*”. A psychodynamic nurse counsellor conducts two or three home visits, sometimes more,

over a long period of time, and then encourages the mothers to come into the SS Centre. Though the assessment is conducted rigorously, it is done gradually. So before women are ‘taken on’ everything possible is done to ensure that this is the appropriate treatment for each of them.

“It’s not always appropriate to be in the group or use their history in group”. (SP). On only one occasion has the assessment demonstrated that it would not be appropriate to place a mother in the Treatment group. This mother was referred on to another more appropriate form of help.

One consequence of this huge investment in time and effort, made even *before* the course starts, is that commitment from the mothers is sealed as far as possible, and there are no drop outs. This is unique to the way this kind of group usually runs. A deciding factor for the mothers themselves in agreeing to attend the course was being helped to recognize that they *“couldn’t cope any more”* (mother) and that it was all right to admit that.

Another unique way the group operates is the continual phone and personal support during the time the course runs. If, for example, a mother has shown distress or the SP feels an issue needs addressing further, the SP will contact the mother outside the group hours. Further, the SP arranges for mothers from previous courses to speak with prospective participants.

3.1.6.1.3 Appropriateness of course

It is recognized that Treatment and Support groups are not the only ways of addressing PND. It may be more appropriate, in some cases, to prescribe medication or recommend one to one counselling or hospitalisation. Some mothers on the course were also on medication. Nevertheless, all the mothers felt this course was the right one for them and could not validate it positively enough.

Even mothers who considered themselves quite *“in control”* recognized that the safe environment gave them permission to *“break down”* and own their feelings. Some mothers talked about *“opening up things that needed to get sorted out a long time ago”*. (quotes from different mothers).

In response to the questions, ‘Do you think this course was the right one for you? Or is it just the best on offer?’ mothers agreed that the course *was* the right one for them. They also agreed that it was the best on offer, though, as there was no other support of *this kind* available at the time, their options were considerably curtailed.

3.1.6.1.4 Gaps in identification, assessment or referral processes and suggestions

Mothers not identified as having PND

What has become evident through this study is that PND has often gone undiagnosed in the past. One mother said she was diagnosed with PND after the birth of her second child, only to realize that she had had PND following the birth of her first child.

Mothers with PND not referred.

Mothers were asked if they knew other mothers with PND who were not getting any support. All the mothers said they did know other mothers in this situation. One

commented that her “*doctor brushes it under the carpet.*” Mothers said that getting put on tranquillizers was the first and, sometimes, only option presented to them. They also suggested raising awareness of PND – perhaps putting flyers in ‘bounty packs’, given to pregnant women by midwives, would be a good idea.

Difficulties in actually attending.

All mothers recognized the effort they make in accessing the group. Some had been brought along by their HVs and one mother commented that she would not have attended if her HV had not “made” her come. The PND Social Support group (see next section) use their Home-Start volunteers to meet mothers at their homes and accompany them to the sessions (though they do not stay). Perhaps Home-Start would extend this service to the PNDDT course mothers if necessary.

Ethnic minorities

All the women interviewed were White British. This is not to suggest that ethnic minorities do not suffer PND but that there are complicated cultural difficulties that need to be addressed. The topic excited a lengthy discussion with one of the SPs:

Ethnic minorities - don't know about. Problem with interpreters – should be independent [but often relations]. Very hard – they interpret what they think you're saying. Real struggle with how you do that. Culture doesn't allow it. Not sure what to do now. In many cultures there's no word for depression and no word for suicide. The word they use is 'mad'. Admitting it in Bangladeshi world – no. Family dynamics are very different. Women have to have chaperon. Family dynamics very different. Bangla Women not assertive [Assertiveness is part of the course]. Have to be very accepting of culture. But never had anyone referred to me.

Families affected by PND

A father's group was held at the end of the first PNDDT group. Though four fathers were expected, three attended. It was intended by the SPs as a one-off information sharing and awareness-raising session, addressing the need “*to understand 'She's having an off day, what can I do to help'*” (SP).

Mothers whose partners attended confirmed that their partners started to understand: “*We sat down and talked for the first time in a very long time*”.

However the partners had some issues they wanted to address. The mothers said the fathers felt a bit let down that they had been encouraged (as they saw it) to delve into issues to find that further support was not available. The fathers intended to meet together themselves but this has not taken place to date.

The SPs acknowledged that they didn't make it clear what the session was for and felt they did not support the men enough.

“They came with their own agendas. It was very emotional.”

As the men said it was “*wonderful*” (SP) and the women said “*it helped*” and that the men felt listened to, the SPs are currently re-evaluating the idea and will run it again but differently. The SPs have suggested the following changes:

- Run one session at the beginning of the course and one at the end.
- Have a man to run it along with the SPs. This should be another Health Professional.
- Get one of the fathers to facilitate the sessions. Perhaps coming to the SSS drop in and raising awareness. [The Dad's group in the process of development currently at SSS could take this up].

A partners' group could, perhaps, be run in conjunction with the PNDSS group, making it available to a wider range of families. Some mothers suggested that there should have been more than one session.

Some mothers suggested their partners should have been actively encouraged to talk to Health Visitor. The issue of 'understanding' from partners seems to be under-examined. One mother said her partner only accepted her 'miserable behaviour' when she had been diagnosed with PND. The mothers suggested it might help to look at the family as a whole – including extended family. It is suggested then, that the Dad's group be extended to include any family members who support mothers with PND and who could benefit by further information and support themselves.

Notwithstanding that, it is recognized that families dealing with depression of some kind don't necessarily access groups very easily.

3.1.6.2 Matching Need

Sure Start Question, "How well do the services we actually have match the needs identified before we began?"

3.1.6.2.1 Meeting Aims and Objectives

The aims of the project in the course outline, were 'to facilitate mothers so that they can understand and 'own' their PND and greatly enhance their ability to cope' in a safe environment.

Objectives are stated as:

- To reduce symptoms
- To improve maternal functioning in terms of self-esteem, assertiveness and coping.
- To address relationship difficulties in family and/or partner
- To deal with parent-infant difficulties
- To develop social networks and/or reinforce existing.
- To reframe the experience of PND as an opportunity to learn skills to enable individual to cope
- To lessen the likelihood of PND occurring following another delivery.

"It's about empowering mothers to identify and monitor her own signals, to identify when she is experiencing depression and to differentiate this experience from day to day feelings". Service Provider

The aims and aspirations of the mothers do not necessarily coincide with those of the SPs. When mothers were asked what made them come along in the first place, they agreed unanimously that they recognized they needed help and wanted to see if it

[having PND] was normal. They felt the need to be “*allowed to feel how you’re feeling and you’re not a bad person for feeling like that*”.

Mothers were asked what they hoped to get out of attending the sessions. Replies ranged from “*finding out more about PND*” to “*developing coping strategies.*”

They acknowledged that the course was difficult:

It’s very hard, but worthwhile sticking at it.

Opening your feeling and knowing why you’re feeling the way you’re feeling.

It’s hard to do that.

3.1.6.2.2 Making a difference

Making a difference is a complex thing to try to measure, as there are many ingredients that can affect the performance of a group or course. Mothers’ accounts of the difference the PNDDT course has made are held in articles in the appendices. The measure of the ‘success’ of the project falls into three main areas, which are by no means mutually exclusive:

- Practical coping strategies they learned
- Support as a positive benefit
- Its effects on their lives

3.1.6.2.2.1 Practical coping strategies

When asked how they could measure any difference, one Service Provider commented on the different dynamics within the groups.

“[Some] had quite dire marital relationships. Failed communications, rows. Four like that. Two quiet and withdrawn”. Nevertheless, she maintained they “all came back and said they’d talked to their partners. All without a doubt, did it”.

Mothers were asked to describe a session that stuck in their mind particularly. One mother said the session about relationships was valuable for her:

“I’ve never given myself time to think about it and I think about it when I get home.”

Mothers, particularly from the first course, all said they continued to use coping strategies they had learned when they were doing the PNDDT course.

They also commented:

knowing that you’re not alone

coming away with skills for coping

there are ways to deal with it

3.1.6.2.2.2 Support as a positive benefit

Cards from the mothers to the service providers include these comments:

The course is run within a very welcoming and relaxed environment. It is easy to relate to all the sessions . . . the handouts are useful not only for future reference but to pass on to others.

Though they described different sessions, the significance of the session was that it enabled some kind of breakthrough for them. As one mother said:

Even if a session wasn't a trigger point for you, there was someone else in the group for whom that session was really meaningful That made you feel more positive.

3.1.6.2.2.3 Outcomes - long term effects on their lives

The biggest and best difference described by SPs was the *“difference in appearance of the mothers from beginning of the course and the end”*.

A mother commented in a card sent to the SP's *“I'm beginning to see the funny side of life again now!”*

Comments from other mothers include:

Having the support to get through it has changed my life completely.

Didn't feel isolated.

Lot more patience

Getting to like yourself again

3.1.6.3 Qualitative Assessment of Service Provision

Sure Start question, “Are the services of a high standard?”

3.1.6.3.1 Overall satisfaction

Asked to rate their overall satisfaction with the group and how it was run, within the range from good to indifferent to bad, the mothers overwhelmingly voted it *“excellent”*. When asked what they didn't like or what could be changed to make it better, they all agreed that it *“couldn't be better”*. They said the number of group members was about right (*“not too many”*) and that the absolutely best thing about the service was the staff. The mothers said no change was needed in the existing structure or methods or delivery of the PNDDT course.

SPs were asked how they know if a session is successful. They said they have a verbal 'wash-up' at the end of each session, assessing the mothers and their relationships with each other. They also draw relationship charts to track, week by week, the change in group dynamics. (Evidence shown to evaluator but not included in this report to maintain confidentiality). The SPs recognize the need to formalize this evaluation process, both weekly and at the beginning and end of courses. SPs and evaluator will work together towards this end. (Also see section 3.1.6.4)

3.1.6.3.2 Staff

Sure Start Question: Is the range of professionals and volunteers we employ appropriate to meet the need?

The Service Providers are clear about the boundaries for the course. Their remit is to care for “mild to moderate” cases of PND. Though the SP commented that the course is not based on the skills of the SPs but *“based on enabling these women to get in touch with their own skills sets”*, the intense nature of this course demands that it is run by service providers, at least one of whom will ideally have a very strong mental health background. Here the mental health practitioner said she did not get *“freaked in the way that other less specialized professionals do”*. She feels she can support mothers better in this respect. The Health Visitor, for child development issues, makes this a very effective team of professionals.

The mothers themselves felt the service providers were ‘definitely’ appropriate to meet their needs. They agreed that the SPs “*know their stuff*”. Not only were they excellent individually but also the mothers agreed that the service providers worked “*brilliantly*” as a team.

Just to say a really big thank-you for all your help & support over the last few months, I really think that you are wise and lovely women... Please keep up the good work. (Mother on a card to SPs at the end of a course).

3.1.6.3.3. Gaps

The only gap identified by the mothers in terms of staffing was that if more crèche workers were employed, more mothers could attend. However, as the SPs have indicated, more than 8 mothers on the course, would change the group dynamics and make it too big to manage effectively.

3.1.6.4 Involvement.

Sure Start Question: How successful has been the involvement of parents in the planning and delivery of services?

This is a structured course, based on the academic practice. Although the service providers are flexible, they do need to have this structure to establish coping strategies for the mothers. The amount of involvement from the mothers in constructing the course, therefore, is not high. However, the SP pointed out that if the mothers wanted to repeat a section, they could accommodate this. An evaluation is conducted at the end of each course (starting from the second course). The evaluation will be developed as detailed above (Para 3.1.6.3.1). Since the interviews the SPs have devised, in consultation with the evaluator, a sessional evaluation to pilot on the next course.

3.1.6.5 Suggestions for the Future

Part of the reason for this study is to identify gaps in the service provision. To this end, mothers were asked: What will you do now the course has finished. Do you feel ready and able to go it alone?

3.1.6.5.1 For mothers

One mother, offered extra counselling, declined it as she felt she “*could just go on now*”. Another described brief relapses but said “*everything is there now Don’t need to do the whole course again.*”

One mother expressed a wish to run an interest group (not connected with PND) in the near future at SSS. Most agreed they could still meet up if they wanted to, some using the PNDSS group, and said that support is still there if they want it. One of the mothers (on the first course) had already taken several other courses on offer at SSS. Other mothers indicated their intentions of doing the same.

3.1.6.5.2 Community awareness

Mothers agreed that raising awareness in the community about PND is important and their perception is that it is not done enough. They suggested flyers should be put in Bounty packs so that *pregnant mothers* know about the possibility of PND before hand (without scare-mongering). There is a flyer in the SSS pack when new families

become members, but this is one of many other flyers. An evaluation of the SSS membership packs is due next year, and further consideration should be given to the most effective way to raise awareness. It should be noted that several articles have appeared in the press and publications associated with SSS, copies of which are held in the appendices.

3.2.6.5.3 Mentors

Mothers also spoke about a kind of mentor or minder. There were mixed opinions about this. Some mothers said they had to “*tough it out*” and that attending the group was “*something I had to do for myself*”. Others had been taken along and introduced by their HV and then left there: “*Otherwise I would never have gone*”.

3.1.6.5.4 Expanding involvement of other agencies

Mothers also suggested that midwives could be more conscious of the potential for PND with pregnant mums. Note: SSS HVs are contracted to provide an ante-natal visit. (Please see section 3.3.1 on HVs). A closer working relationship with the midwifery service might be considered.

3.2 POST NATAL DEPRESSION SOCIAL SUPPORT (PNDSS) GROUP

3.2.1 Description of Project.

3.2.1.1 Home-Start Portsmouth.

The Service Provider for this group is Home-Start Portsmouth, a local branch of a national organization. Home-Start is a 'voluntary befriending scheme, which offers personal support and practical help to young families'.²⁰ The volunteers have a comprehensive in-service training programme. Home-Start is also a highly structured organization, efficient and well managed, with well-trained committed staff. Sure Start funding allows the Home-Start support scheme to respond quickly within the Sure Start area. However, outside the Somerstown area there are waiting lists of about six months for families to benefit from Home-Start services. This has inevitably led to criticism about the lack of an 'equitable service'.

3.2.1.2 Home-Start and PND.

Of the families receiving support from Home-Start, 70% were identified as having PND or some other form of depression, though it is difficult to separate this specifically from Isolation which is the main reason families use the Home-Start service. Home-Start's annual report 2001-2002 shows that PND/ Depression is the second highest reason for Health Visitors referring families to them.

Home-Start were asked by the sub-group for Outreach and Home Visiting to establish this support group, as they already work closely with mothers with post natal illness and have established links with Health Visitors. As one of the service providers explained, setting up the PND Support group was a natural progression from the 'at-home, one-to-one' service provided by Home-Start. Although the figures are slightly less than in 1999, "*we have supported several mums this year that have needed some time in hospital.*" (Home-Start Annual Report, p9). Home-Start already had someone in post that was working exclusively for SSS families and she agreed to take on the role of facilitator of this group as well. Both main service providers had personal experience of PND.

3.2.1.3 Post Natal Depression Social Support (PNDSS) group

3.2.1.3.1 General description

The PNDSS group is a 'drop-in' group where mothers who are experiencing PND offer mutual support. It has been running since September 2001, preceding the provision of the PNDT course by about six months. The group runs every Thursday morning at SSS centre, including school vacations, and a crèche is provided. The maximum number of mothers is determined by the maximum number the crèche can accommodate. There is no waiting list. At the time of interview, a PNDT course had just finished. All the mothers from that course now attend the PNDSS group.

There is a library of books and tapes on helpful topics, such as self-esteem and relaxation, as well as aromatherapy oils and candles. All expenses are met by Home-Start, which is commissioned to provide this service by SSS.

²⁰ Home-Start Annual Report 2001-2002.

The group provides a unique opportunity for mothers to get two hours to themselves. Because it is a drop in, different people come in at different stages. *“Those who are further along support the others”*. (SP) And, even *though* the group is a drop in, the majority of the mothers come every single week.

As well as getting together in *“a guilt-free zone,”* as one mother described it, or *“respite”* as another called it, visiting speakers attend and outings are organized. Mothers have the opportunity to do short training sessions on topics like self-esteem, relaxation, play and feeding problems. Perhaps most popular are the pampering sessions, which include aromatherapy and relaxation. The Home-Start worker balances the activities. For example, speakers do not attend the whole session, so the mothers still have time for each other. Also speakers do not attend too often.

If we had a guest speaker in every week it would be taking away their time. So it's every 3 or 4 weeks. By that time they're probably ready for a bit of outside input into the group.

Mothers described a typical session

Come in to building – quite an effort – drop children into crèche and relax. Have coffee and catch up. Recently had speakers in, two sessions on relaxation, sleep problems with babies, aromatherapy. Relax without small ones.

3.2.1.3.2 Outreach

Home-Start volunteers can bring an anxious mother to the group for the first few times. As the service provider explains:

It can really benefit mums, particularly the female confidante role. It also helps them to open up, when they might not tell anyone they're feeling depressed. Once they've disclosed that they don't feel well and are finding it really difficult with the baby, its nice for them to find other mums who feel exactly the same . . . because sometimes you do think that every one's getting on with it and everybody's much better at it than you are. That's a big barrier to get over.

3.2.1.3.3 Getting started:

The support group was a new idea for the area, but the service was slow to take off. On the first session there was one mother with the service provider. As the group has become established it is now well attended. Initially mothers outside the area were invited to the group to help boost numbers. This was beneficial to the group as a whole. The senior organizer has stated at the Home-Start conference (November 2002) that if there should be a conflict of interest, (that is, if a non-SSS mother is being funded instead of a SSS mother) Home-Start will fund the non-SSS mother themselves. However, even though the numbers are now rising, it would be completely unhelpful to ask non-SSS mothers to leave the group as they have helped to form very supportive relationships for the SSS mothers.

3.2.1.3.4 Changing role of Home-Start

Home-Start's role has changed - *“I'm more of an overseer now.”* Now the mothers approach the SP with any problems, such as concerns about crèche. The Home-Start project worker also books all the speakers, and still attends some sessions *“because I*

like to see the mums". She also makes sure the mothers are included in other Home-Start activities, such as an outing to Paulton's Park.

3.2.1.3.5 Evaluation

The service provider carries out evaluation, which has been considered in this study. Home-Start also produces an annual report, the contents of which have also informed this study.

3.2.2 Costs

A full cost-benefit analysis has not been conducted on the projects in the SSS programme to date. It is intended that this will be done during the 2003/2004 financial year. Interested parties should apply to the evaluator or the manager, SSS for further details.

Though a breakdown of actual costs of providing this service are not available to date, (being incorporated as they are with the whole Home-Start service provision for SSS), the annual budget for running this project is £5,250. Annual costs would include:

- The crèche, which is the main expense - £3,500
- Visiting speakers/Rent - £500. (Note, rent is not paid at SSS center, but is paid during the temporary relocation due to refurbishment of building).
- Part staff costs of Home-Start co-ordinator dedicated to SSS. - £1,000
- Administrative support - provided by Home-Start.
- Refreshments - £250
- Volunteer's expenses - provided by Home-Start

It is self-evident that this group is very cost effective to run. The costs that might be incurred by statutory agencies if the group did not run have the potential to be overwhelming. (See comments in section on costs for PNDT course).

3.2.3 Details of Participants

Only those mothers regularly attending the PND Support group were invited to participate in the evaluation study. Six mothers out of a total of nine mothers, who attend regularly, were able to attend the interview. Some mothers are from outside the SSS area. (See next section below).

One mother had been attending since the first week that the group had run. The most recent attendee had been coming to the group only 3 weeks. All the mothers described themselves as White, though one was not British. Three members of this group, at the time of the interview, had attended or were currently attending the PND Treatment course. All the mothers described themselves as having had or as currently receiving 'professional treatment' for PND as well as attending the group. Two mothers had PND after the birth of each of their two children.

3.2.4 Interview Details

3.2.4.1 Identifying Need, (Referrals and Assessments)

Sure Start question: Are we reaching the right people?

3.2.4.1.1 Referrals

Most mothers were referred by their HVs, either direct to the PNDSS group or to Home-Start. However, not all mothers have good relationships with their HVs. One in particular, living outside the SSS area, thought her HV had a dismissive attitude to her illness. It should be noted that HVs working in the SSS area were the first to be trained in PND and other HVs in the city have had to 'catch up'.

Further, the Home-Start assessment tool indicates the area of support required by the family (and the degree to which this support is required) and this can also identify the need to attend the group.

If the referral form says depression I'll ring them up and see if they want to come to the group. (SP).

The nature of the group as a drop-in also means that mothers can self-refer.

3.2.4.1.2 Assessments

Though need is identified, the severity of a mother's PND is not assessed before she comes to the group. Most mothers are or have been on some form of medication, but SPs and mothers attending the group do not consider this places the group at risk. The SP was asked what she would do if she thought it was inappropriate for a particular mother to attend the group.

We did have one mum come along and it was obvious that her depression was more severe than normally recognized as post-natal depression. She came for one week and, though she enjoyed it, she said it was too far for her to come. Fortunately it was mutual. Otherwise I think I would have had to say about it.

The mothers, when asked the same question, were confident that the back up was there from the Home-Start SPs.

3.2.4.1.3 Outreach

Mothers also said they needed a lot of support actually attending the group

My Health Visitor dragged me along. When you're so down, you need that shove to do it.

The first time I was petrified.

Home-Start has said that they accompany mothers to the group, as part of their Home-Start service if requested or if they perceive the need. However, self-referrers or mothers not associated with Home-Start may be unaware of this. Higher profile should be given to this service.

3.2.4.1.4 Gaps in identifying or addressing PND

Partners or Dad's support.

Again some mothers suggested that a Dad's group would be really helpful. They agreed that their partners didn't understand about PND and that meant they couldn't talk together about it. One woman said her husband would have benefited:

I was having all the help. He would have liked someone himself to talk to. An informal thing.

One mother commented that her partner only started to understand about PND when it was “officially labelled”. Other mothers commented:

He just thought I was a miserable old cow.

My husband wondered what on earth had happened to me.

Suggestions from the mothers for a partners’ group included an information-giving or awareness-raising exercise, like the one-off attempted by the PNDT group was intended to be. Another suggestion was a more general partners’ group run a couple of evenings a month where partners and mothers come together, with a crèche available.

3.2.4.2 Matching needs

Sure Start Question: How well do the services we actually have match the needs identified before we began?

3.2.4.2.1 Aims

Home-Start’s initial project proposal, dated 25 January 2001, identified the purpose of the project as providing ‘a social support group for Mum’s suffering from Post Natal Illness’. (SSS Funding Pro Forma EYC0018 August 2000). At this stage Home-Start identified the suggestion that parents would eventually facilitate the group for themselves and the possibility that they would be self-financing.

The SP describes their aims and objectives as:

To provide an environment and the facilitation so that mothers with post natal depression of varying degrees can offer mutual support to each other. And for this support to extend beyond the boundaries of the 2 hour session.

It is about enabling the mums and making them feel good about themselves.

(SP)

The original aims of the SP can be categorised as:

- To facilitate a mutual social support group for mothers with PND.
- To provide a safe environment
- To enable the support to work outside the parameters of the group
- For the group to become self-governing

Support. Mothers overwhelmingly identified ‘support’ as key to the success of the group. Not only did they get support from each other - “*a chance to make friends with other mum’s who have all suffered similar PNI symptoms.*” (Mother in Service Provider’s evaluation from) - but it should not be forgotten that some of the mothers come from difficult family circumstances. One mother also commented “*It is the only time I really express myself as I don’t find it easy to talk to family.*”

Though Home-Start’s involvement might be considered hands-off, the achievement of the aim of facilitating mutual support was brought home with emphasis by the mothers themselves:

I started the Treatment group as well as coming here, but it was too hard. It was only her [another member of the support group, who had attended the first Treatment course] who made me go.

One of the mothers, who had been on medication and had been in hospital and clinics for her depression, found that with the help of her Home-Start volunteer and the PND Support group she was able to cope again.

Gradually my confidence returned and I was back in the swing of things.

Not only did she no longer need a volunteer, but, after training, is now a Home-Start volunteer herself, and also runs the PND Support group. (This example is cited with her permission).

The PNDSS group fulfils a need that other groups, such as Parent and Toddler groups cannot meet.

Parent and Toddler groups are great but it can take quite a lot for you to say I don't really like my child that much and I'm not bonding with them. I feel awful and I find it hard to cope. Whereas in that group, they all can say that. Because they all know everyone else is experiencing exactly the same thing. (SP)

A 'safe' environment. Mothers in interview recognized this factor as allowing them to be themselves without recrimination or judgement. This is closely tied to the support aim:

The most important thing is talking to other people who've been through a similar experience.

Isolation is a key factor. It helps to see other people who feel like that."

A chance to relax for a couple of hours, chat and offload any current anxieties about motherhood

Nice to get some 'Me' time

The mothers also recognized the importance of respecting each other's confidences.

We didn't speak at all about what happens in the group.

Part of the appeal is that the group is a drop-in. However, though the mothers do not have to attend, most come every week. They agreed that it was much less intense than the PNDT course, they felt more relaxed and "*feel lost if you don't come.*" They agreed it gave them a break from the children but they knew they were safe in the crèche.

Extending the support outside the group parameters. Another aspiration identified by the SP was to put the support 'out there'. This achievement is demonstrated by the mothers meeting at each others' houses, taking other courses together and doing activities outside the confines of Thursday mornings, many taking up other projects and services offered by SSS. Mothers' comments included:

One of the mums cooked a meal for the other mothers and their partners. It was like a group of friends.

We've all got each others' phone numbers, so we can phone in the week if we want.

It's gone beyond just being a group on a Thursday morning.

Empowerment and Self-governing. The group also has achieved the self-governing factor that was identified at the start. (See section on Involvement, below)

3.2.4.2.2 Making a difference

Perhaps the overarching aim, as for all SS projects is ‘making a difference’. Mothers were asked about the impact the support group had had on the lives of themselves and their families. Evidence is best demonstrated quite simply, as the SP said, “*Because they come*”. Mothers made a real effort to attend the group, especially in winter months. One mum struggles with twins but attends regularly. “*They make the effort because they think it’s worth it*”. (SP)

A mum joined recently and was welcomed and quite enjoyed it and she came to Paulton’s Park with H-S and she said it was the first time she’d been out of the city.

She said she’s really happy with the group. It’s made her feel that everybody in Portsmouth isn’t horrible and there are people out there that she can get on with. I suppose if you’re feeling down, you sit in your home and you think ‘I’m never going to meet anyone,’ so I was really pleased. And she came with another mum who’d only been once.

There are some mums I can see visible differences in since it started - and they still come. They tend to take on that welcoming role.

One mother’s comment in the Home-Start report: “*It has made me confident in myself*”.

3.2.4.3 Qualitative Assessment of Service Provision

Sure Start Question: Are the services of a high standard?

3.2.4.3.1 Overall satisfaction

Asked to rate the standard of service provision in the group all six unanimously voted it ‘*Excellent*’. All the mothers looked forward to attending the group each week. One mother described the high priority she gave the group:

There’s loads of times when I’ve had appointments and I’ve said No, I’m busy that day.

When asked what she considered to be the best or most successful thing about the PND support group, the SP said,

to see how they’ve come on. They’re confidences and the confidence of their children too, through the crèche.

The mothers were invited to comment about what they didn’t like about the group. They all agreed they would like it to run more often. All said they would come to it if it ran another day as well. All thought that the impending refurbishment of SSS could improve the relaxed environment in the long term, though disruptive in the shorter term. Some said more outings could make the group even better.

The SP was asked, “How do you know when a session has been successful?”

Evaluation forms are filled in regularly, once a term, and the mothers are frequently asked what they want.

They’ve not come back to me with any negatives – because it’s so open to learning, they want to feel like a human being again and get a bit of knowledge. I ask them what they’d like and stick to that. And they come.

3.2.4.3.2 *Balance of activities.*

Mothers described some of the things they did in the group and agreed that there was a good balance between chat and support, outside speakers, such as a Health Visitor talking about sleep and babies, and some pampering sessions. They were asked what they liked best about being in the Support group. They generally agreed that, as well as the mutual support, they valued the opportunity to relax ‘*without the kids.*’

3.2.4.3.3 *Crèche.*

The crèche is recognized as being really good by mothers and SPs. “*Mums are happy in the knowledge that children are well cared for close by*”. Some mothers thought that having the free crèche was one of the most useful things about the group. They said their children enjoyed attending it. This experience had a beneficial long-term effect, which not only de-stressed the mothers, but enabled the children to get some positive benefit from mixing with each other as well.

3.2.4.3.4 *Staff*

Sure Start Question: Is the range of professionals and volunteers we employ appropriate to meet the need?

The mothers in the group thought it was important that the SPs had personal experience of PND.

“*You can’t know what PND is if you’re reading it out of a book.*”

Though the SP has attended a one-day course, she has not had any in-depth specialised training. She considered that it is not really necessary for running this type of group, commenting that they mothers wanted “*not a specialist just someone who can hopefully empathize and be there*”.

The emphasis of training seems to be focussed at the assessment end of the service provision and this is conducted by trained Health Professionals, mostly Health Visitors. Some concerns were expressed by Health Visitors about the lack of training of SPs for this group but this is probably due to the HVs being poorly informed about the nature of the group (see section on Health Visitors).

The group is now run by a Home-Start trained volunteer, who has herself been ‘through the mill’ and attended this group. However, all the women are involved in the development of the group. They all felt confident that, they could approach the SP if they had ideas for speakers or events. They demonstrated huge confidence in Home-Start as an organization and the workers associated with the group in particular.

3.2.4.4 *Involvement*

Sure Start Question: How successful has been the involvement of parents in the planning and delivery of services?

This need was identified in the initial stages of setting up the project, but this need was not identified by the mothers themselves. However, they have quickly become empowered and now run the group themselves. The facilitator for this group is a mother who was first of all a participant. She describes her experience in the Home-Start annual report 2001-2002. The most powerful comments come, appropriately, from the mothers themselves:

*Don't feel like it's being done for us.
It's our group.*

All the mothers felt confident to facilitate the group and help other people. Suggestions from the mothers have been implemented. These include: running the group through the holidays, topics they would like covered in the group, watching a video, a mini training session. A request for a speaker to address the group about various forms of anti-depressant medication was the only outstanding item on the evaluation forms. As the mothers concerned have now attended the PNDDT course, where this is addressed, this request has been overtaken by events

The mothers are wholly committed to the project, and the confidence that has been empowered by attending the group has resulted in them speaking at the Home-Start conference 4 November 2002, and writing articles for the SSS Newsletter. (See appendix).

In short, the mothers' ownership of this project is exemplary.

3.2.4.5 Suggestions for the Future.

The size of the group is determined by the capacity of the crèche. The room size at the moment restricts the number of children to 10. Another reason why it is important that the existing group does not get too big is because

the mums really bond with each other as well. 8 – 10 mums would be enough. Just because you lose the intimacy. It would become like a formal meeting – waiting for everyone to speak. As it's quite small it does work really well.

There is some concern, then, about what will happen to the existing members of the group if numbers grow and new members want to attend. As one of the SPs pointed out, PND is not something that "just stops".

The service provider recognized that the mothers come to the group not only because they need it but also because they like it (though these are not mutually exclusive). When asked how she would tackle that situation of moving people on, she replied:

Like with a family receiving Home-Start support when they're ready to do without their volunteer. Outline to them how well they've done, that they can move on.

Some suggestions for the future include:

- A new (parallel) PNDDSS group (with the possibility of another crèche)
- Other SSS courses and activities (Two of the women had gone on to do an IT course, also run through SSS)
- New activities or courses, such as the Are You Listening course.
- Working with other agencies (such as Children's Fund) to expand service for mothers with PND
- Promotion of work being done, raising awareness of PND by mums for whom funds like SSS are not available.

3.3 OTHER SERVICES THAT SUPPORT HOW SSS ADDRESSES PND

3.3.1 Health Visitors. (HVs)

3.3.1.1 HVs and SSS

3.3.1.1.1 Description of Service

SSS is the envy of other Sure Start Initiatives in having the equivalent of two full-time HVs dedicated to the families in the area. In real terms this takes the form of four HVs and a junior member of the team. There were some huge problems initially due to a national shortage of HVs, and, consequently posts at SSS were not filled for some time. Further the case-loads in SSS have now risen above all expectation.

This squeeze on resources has obviously had an effect on the quality of service provided and compromises have had to be made. Some results are that number of Health Visiting contacts proposed in the original Delivery Plan, May 2000, particularly the ante-natal visits (See Delivery Plan page 66) and the 3 months and 8 month post natal visits to assess PND (page 67), are not being done.

Nevertheless, the 6 week check *is* done and the identification and assessment of PND *at an early stage* is now much more likely – certainly in SSS and probably across the city. Though this has not been reflected in the perceptions of the experiences reported by the mothers interviewed for this report, it is hoped that a watching brief will ensure that evidence of the rewards of this early intervention is gathered.

3.3.1.1.2 Training

Most of the HV team at SSS have undertaken a 4-day in-depth training course in PND, plus one follow-up day. They rated the training highly. They were the first in the city to benefit from PND training, though this has now been rolled out across the city and is given routinely. The implication that training in various aspects of PND is being given a higher priority is, however, rather belied by the comment of one member of the team that she had been waiting a long time for training to occur. The reasons for this were not investigated further.

The Health Visitors also commented that a one-day basic awareness training day is in the pipeline for all SSS staff. This will be run by one of the facilitators for the PND Treatment group. They felt this training would be sufficient for staff who worked closely with HVs, but who did not have their range of responsibilities.

3.3.1.2 Identifying need.

The HVs are key in identifying PND. They are the main referrers to the PNDDT course. Referrals are not needed for the PNDDSS group as it is a drop-in group, but referrals *are still sometimes* made to Home-Start generally and to the PNDDSS group specifically.

The HVs are in a privileged position because they can assess people at home. They provide, then, the first post-natal contact with parents of a new baby, (excluding the midwifery service) where they talk about HV role and services in broad terms and how the (new) parents feel about having a baby. At this stage they raise awareness of PND. The whole team stress the importance of identifying signs of PND as soon as possible.

3.3.1.1.1 Edinburgh Postnatal Depression Scale (EPDS) reissued as the Feeling and Moods Motherhood (FMM) assessment.

Description

Women are asked to read, or have read out to them, each of the 10 statements and the responses that best fit how they had been feeling over the previous seven days are noted. The assessment rates the severity of some symptoms of depression and anxiety. (Copy held in appendix). However, The HVs emphasized that the FMM assessment tool is not a diagnostic tool: “[It] doesn’t mention depression but asks questions around sleeping, crying.” This particular tool has been criticised in recent Professional Health Practitioner circles.²¹

If the HVs feel concern for their mother, they discuss different options available for the mother to enable her to make an informed decision. They agreed the FMM assessment tool is useful to “give a snapshot of mood” but emphasise it is

not to diagnose but to pick up indicators. It’s helpful to indicate areas of stress” – then refer for support. Talk about options, which may include GP, drug. Ask mum how she feels about that. The choice is the mothers. [Drugs give a breathing space]. Important GP is kept in picture. PNDDT and PNDDSS groups are not the only answer.

Frequency of use

Health Visitors said that an FMM assessment is now used in all cases at the six-week post natal check. This visit is described as being “for the mother rather than the baby”. (HV). However, this formal assessment has only been conducted since August 2002 when a vacant HV post was filled. Before this time, HVs relied on their experience to identify women who had a higher need because of PND.

The summary flow chart for the detection and management of Post natal Depression (at appendix) indicates that this process should be repeated at 10-16 weeks and at 8 months, but the second and third assessment are not done as HV staff are already working to their maximum output. (see comments para 3.3.1.1 above)

Home visit observing use of FMM assessment tool

At a home visit observed by the author of this report, the HV made the process very non-threatening and non-judgemental. Though she explained what she was doing, she gently incorporated the questions into general topics for discussion, for example sleeplessness, crying. The mother was told what her score was, but was not informed of its significance. In discussion after the family visit, the HV considered this would be a ‘slow process’ with this particular client. She had, however, already been in contact with the Service Provider for the PNDDT group. The mother was also encouraged to attend the SSS drop-in group and has since spoken with the SP for the PNDDT course there.

Overall the HVs considered that “the referral system is excellent”, but stressed that

²¹ See Strengths and Limitations of the Edinburgh Postnatal Depression Scale on website www.PNDtraining.co.uk. Further discussion in this area is outside the scope of this report.

it is important that this assessment is carried out by Health professional as other factors could cloud the issue.

3.3.1.2 Costs

Because assessments have to be done against *all* live births (the issue of still births outside the scope of this study), this process is a necessary expense of addressing PND, and needs to be conducted, whether treatment or support is facilitated by SSS or by the statutory agencies. Costs for this process have not been cited. However, SSS funds two full time HV equivalents and funds training.

3.3.1.3 Gaps

3.3.1.3.1 Ethnic Minorities

Concern was expressed about people not being identified at all. It was commented, for example, that the FMM assessment tool is hard to translate into Bangla for Bangladeshi (Bengali) families. Further, depression is expressed differently in different cultures. (For example, in West Indian culture it is expressed physically as stomach ache).

In Bengali there is no word for depression. They use the word mad.

Difficulty in getting accurate answers due to interference (deliberate or unwitting) of interpreter.

Another factor that may contribute to depression, that British counterparts don't have to contend with, is the idea of "*keeping going till they have a boy*" and thus gaining family approval, such as "*gold earrings from the mother in law*".

It should be recognized that services SSS offers to address PND may be culturally inappropriate to these families. A suggestion was made that something could be offered by, or in collaboration with Bengali services, though it is recognized that they may not place the same importance on it if they think it is madness, willfulness or self-indulgence. Perhaps liaising with EMAS or the local Mosques might identify a requirement for a development of existing services to this specific target group. However the initial difficulty of identification and assessment needs to be overcome as well.

3.3.1.4.2 Mothers not wishing to access groups

Though stretched, the HVs said they would like to offer Cognitive Behaviour Therapy (CBT) at home, time and training permitting. CBT is included in the PNDT course but it could be offered to women one-to-one who feel uncomfortable in a group setting. If it is offered by HVs on home visits, there should be some liaison with the PNDT course.

3.3.1.4.3 Outreach

Getting people over the threshold was recognized as a difficulty.

Difficult for mothers to present there – to walk into the centre and say at the front desk what they've come for.

The HVs suggested a meeter/greeter, so that a mother could just ask for them. The Home-Start volunteer fulfils this role for the PNDSS group if required. If a need

was identified for this service to be available to mothers attending the PNDT course, it could be addressed by

- a volunteer or a dedicated mentor from a parent-to-parent scheme (Parents Forum, currently being developed at SSS).
- a member of the HV team, who has expressed an interest in expanding her training in PND
- Home Start, who already provide this service for the PNDSS group

3.3.2 Family Support Workers(FSWs)

The team of Family Support Workers, working to the Social Services Statutory Agency, provide support for families in need. They emphasised that they support the whole family. Those at the SSS centre are dedicated to working with SS families, though they have some core work as well. Some of the families they see may need help as a result of PND, though this is unlikely to be the sole factor.

Families are most often referred to FSWs by HVs or Social Workers. FSWs commented that, if a mother had PND, *“if a HV refers a family to us, they’ve probably already referred it to PNDT course or PNDSS group anyway”*.

3.3.2.1 Identifying need

The team emphasised that they do not usually identify PND, though they would recognize if a parent were depressed. They said the need they identified was *“about mum’s childcare, not specifically PND, for example if the mother needed extra support or was particularly isolated”*. (FSW). They would also see a family if a need had been identified by a social worker. *“But PND is one of many things”*.

The team recognized that if a need is not identified, if the family is not accessing any services, they would not see that family. A new way of working with six-week packages, however, means that families may self-refer or the FSWs could be working with a family and then the problems become apparent.

3.3.2.2 Interrelation with PNDT course and PNDSS group

Some members of the team said they didn’t know there were two groups addressing PND at SSS. Some said they knew little about the Treatment course, except it was a closed group. They knew who the Service Providers were for both groups and knew that Home-Start were currently looking at ways of *“moving people on”*, as the issue had been raised in a sub-group meeting. However, they all agreed that it was not relevant for them to know more about the groups as they are not the “first port of call” and don’t identify PND. Nevertheless, they all agreed that if an occasion did occur they would feel confident about approaching the Service Providers.

FSWs agreed that the PNDT course and PNDSS group were other resources they could use for families if they needed to. They could also foresee that they might need to use the resource – *“Just because we haven’t, doesn’t mean that we won’t.”* The consensus was that the two groups addressing PND at SSS work well together.

FSWs also recognized that the courses and/or groups are not appropriate for everyone. One FSW reported a mother who said she

didn't want to go to a group where everyone was talking about their problems. She'd rather go to a group where they're talking about something completely different.

Members of the FSW team thought the idea of mothers running the PNDSS group themselves was "Great". But they added that there should still be a member of staff overseeing things.

In my experience, if you hand things over to parents completely, unless you've got very, very committed parents, things fall down very quickly.

They acknowledged that running groups is a skill in itself and agreed that if parents were paid on a sessional basis to run groups, they would legitimately take on the responsibility for it.

3.3.2.3 Gaps

Dad's group

FSWs' holistic approach, working with the whole family, made them aware that

Dad's need a lot of support, especially if they're going to work and frightened to leave mum at home with the baby.

They were sure there was scope for a supporter's group.

3.4 HOW SERVICES THAT SUPPORT PND INTERRELATE.

3.4.1 Introduction

One might think it would be a natural progression for a mother with PND to do the PND Treatment course and then attend the PNDSS group. However, in practice, whether by accident or design, this has not happened. Talking to the mothers, it transpires that it doesn't really matter what order things are done in, as long as they are available. At the time of the interviews 3 mothers were attending both groups concurrently and thought it worked well.

In the Treatment group, we're learning skills. In the support group, we have a break. It's more relaxed.

It's nice to have both sides.

As there was some overlap in the groups, some of the same mothers attended both focus group interviews. However *all* the mothers were well informed about both the PNDT course and the PNDSS group. They recognized that both groups worked in different ways and thought having an intensive structured course *and* a casual drop-in was a really good idea.

It is important to recognize the support process actually working. One mother said she had started to attend the PNDT course and was finding it very hard going. However she was positively encouraged by another member of the PNDSS group, who had attended the first PNDT course.

I went to PNDT group and said I don't know if I can do that again and "Plum" made me go. I'm glad she did.

3.4.2 PNDT course

The PNDT course is hugely indebted to the Health Visiting service who, in the main, makes the referrals. However, none of the HV team had seen a schedule of PND Treatment course, so did not know too much about the detail of the course. They said they would be interested to know, but were not unhappy that they had not seen it. They *did* know it was run by Health Professionals and, being Health Professionals themselves, felt this was appropriate.

The service providers for the PNDT course were asked what they knew about PND support group. One SP initially commented that she didn't really know what they do, or even if they are run by professionals. *"My background is very 'profession' oriented"*. This had led to some reluctance on her part to recommend the PNDSS group to the mothers attending her treatment group. This SP has since changed her opinions - *"After we talked I realized I should find out about them, so I did."* She now recommends the mothers in her group to try the PNDSS group.

The reputation of the very dynamic SPs who run the Treatment course has spread across the city and they are in demand to give talks and advice. One of the SPs particularly would like to do more information and awareness raising about PND throughout the city. SPs also suggested a network of interested professionals could help roll out the programme across the city sharing information and best practice.

3.4.3 PNDSS Group

The mothers attending the PNDSS group knew a lot about the PNDT course.

In the beginning there was a conflict. The Treatment group got all the publicity, and Support group got none. (PNDSS mother)

It's important having the two running together. The Treatment group is very hard-hitting and having the support group the next day gives a balance.

Post Natal Depression Treatment group is so intense, you almost need the support more.

The HVs commented that the “PNDSS leaflet is very sketchy”. One of the HVs had been a visiting speaker to the PND Support group. She is the HV for two of the mothers who attend the group regularly and who have told her the group is good. One of the other HVs knew “very little” about the group. Generally they understood that the group had a good facilitator and selection of resources. However they expressed concern that mothers would not have the confidence to attend the groups and suggested a need for someone to ring mothers or arrange to accompany them to the first session, maybe sit with their child and so allay feelings of anxiety at leaving child with stranger. There is the interest and the will, funding allowing, for a junior member of the Health Visiting team to “develop her skills in this area”. This would further integrate the different agencies addressing the issue of PND in SSS.

Some of the HV team expressed concerns that the facilitator for the PND Support group is not trained in PND especially in how to make a referral. They made the point that some of the mothers, who could attend what is, in effect ‘open’ sessions, had the potential to be ‘very unwell’.

Some things might come out in the group about self-harm and harming the baby that the facilitator may not know how to deal with.

Though (and because) it is a therapeutic group, ‘it has the potential to be dangerous’. This concern had also been expressed, initially, by one of the Service Providers for the PNDT group. (This issue has been addressed elsewhere in this report). The service provider for the PNDSS group was asked for her response to these concerns. She said:

There haven't been any traumas but most of the mums in the group have been through the treatment group now and I think that is where the deep-seated traumas come out. One girl said I didn't even know that that still affected me and though she cried her eyes out at the treatment group, she could talk about it at this group. It's good when the two run together.

3.4.4 Working in the SSS environment

An inter-agency study currently being conducted for SSS by Social Service Research and Information Unit (SSRIU), University of Portsmouth is investigating this in greater detail and interested parties should consult this document when it becomes available. It is currently in draft form.

3.4.4.1 PNDDT course

Service Providers were asked if working in the SSS environment helped or hindered the delivery of their service. They said that “*communication is difficult*”, citing lack of “*proper administrative support*” and said that inconsistencies in the administrative infrastructure were frustrating. Some examples included messages not being passed on or being passed on after the effective date.

SPs felt they had to be very proactive so as not to be excluded from “*the loop*” and were still unsure what would happen to the group during the SSS building refurbishment.

Nevertheless, on the whole they applauded SSS, because it gave them the opportunity to do something they feel very passionate about

Sure Start gives us the opportunity to do it.

Other advantages are that the building is ‘normal’, so clients are not stigmatised and the immediacy of being able to talk to people.

The drop-in works really well.

As this is a closed course, it could be rather isolated from other SSS projects. However, the SPs attend the drop in and staff meetings when time allows.

3.4.4.2 PNDSS group

One of the milestones outlined on the project application form is to network with other agencies to provide a holistic package of support. The SP’s assessment that this has been achieved (Quarterly return 8 April 2002) is born out by the evidence. The group have invited speakers from other projects running within the SSS programme, such as Speech and Language Development, Home Economy project, and Health Visitors. They also feed into other activities outside PND, and two of the mothers have attended an IT course commissioned by the SSS programme.

Due to Home-Start’s presence within Sure Start Somerstown it has enabled us to support more families within a reduced waiting list and also gives us the opportunity to locate other projects within the programme that may be of benefit to them. The families have the option of being offered a choice of resources to support them and their children. (Organizer’s report, H-S report – p14)

Like the HVs, the Home-Start worker is dedicated to SSS families to deliver an enhanced service. Service Providers were asked whether working in the SSS environment was helpful or problematic. One of the service providers described the building itself as being a barrier to the effectiveness of the group. Two years ago the centre (previously a Family Centre with Social Services connotations) was seen to be filled with professionals and “*people weren’t welcome*”. Now SSS Health Visitors are in post, “*things are better*”.

Mums moan about having no sofas. Meeting room is not ideal – but after refurbishment – who knows?

As well as these geographical constraints, the difficulties of working in an interagency setting, were described as a ‘nightmare’ at the beginning, though things “*have improved*”. Now the SP acknowledges that working in SS environment helps her in her job.

Overall it’s nice to work in SSS because there’s so much to offer a family. Really nice to be able to draw on all the other resources that SSS provides, especially a lot of free things, that aren’t free elsewhere. (Home-Start Service Provider)

However there is a tension perceived in the SS centre and feeling part of the team is very much down to individuals to make a proactive effort.

Identify with Sure Start? – yes, I feel part of the team and know everyone and try to make an effort to know people and form relationships with them. Monitoring forms – they’re fine.

Home-Start themselves have responded to the inter-agency working environment by being more flexible – for example their project worker attends the SSS drop in and SSS staff meetings.

During the refurbishment of the SSS centre, the group will carry on, with Home-Start arranging its venue. It was acknowledged that over such a long period of time (6 months without access to the building) people would get fed up and that it would be a disruption to something quite successful. But the SP did not think it would affect this group because they are all keen to continue attending. All mothers are well informed about aspects of the refurbishment, and are particularly keen on the community café. All saw themselves having lunch together.

SECTION FOUR: CONCLUSIONS

4.1 INTRODUCTION

The two groups addressing Post Natal Depression (PND) in Sure Start Somerstown (SSS), the Post Natal Depression Treatment (PNDT) course and the Post Natal Depression Social Support (PNDSS) group, are entirely different and serve completely different aspects of supporting mothers with PND. However, together, with support from HV team and FSW team they provide a comprehensive package of support.

Mothers interviewed validated the service facilitated by SSS hugely, particularly around quality of service provision and appropriateness of staff. However some gaps were identified by both mothers and service providers.

This conclusion summarizes the findings from the interviews, more details of which are held in the appropriate sections.

4.2 IDENTIFYING NEED

4.2.1 Are we reaching the right people?

4.2.1.1. Identification and Referrals

- Assessments to identify PND are not carried out at three post natal stages, (and the ante-natal visit is not done, or not done consistently) because enormous HV case-loads do not allow enough time.
- As case loads cannot be reduced, connected as they are with the Somerstown catchment area, extra staffing or resources should be found to fulfill this part of the HV function at SSS. Alternatively the service level agreement may need revision.

4.2.1.2 Assessment

- Rigorous assessment is conducted by the PNDT Course SP. Commitment to attend the course is gained and there have been no drop-outs. This is good practice, which should be migrated to other PNDT courses as they arise.
- No formal assessment in PND is considered necessary for the PNDSS group. Home-Start might like to reassure themselves that their facilitators are confident in dealing with crises, should they arise, and that this procedure is documented.

4.2.1.3 Tracking support

- It has been almost impossible to track figures of women currently identified with PND and receiving 'appropriate support'. Closer monitoring of these mothers probably *is* being done by Health Professionals, but this is not transparent. In short, tracking what happens to these mothers needs to be *seen* to be done and be more easily accessible, in accordance with the Data Protection Act. The following could be held on the monitoring database:
 - snapshot of exactly how many mothers currently residing in SSS have been identified as having PND
 - What course of action these mothers have opted to take as support (or state none if mother has declined support).

Alternatively a separate database could be designed for the Health Visitors to record this information and capture it more easily.

4.2.1.4 Outreach

- The absence of mothers from ethnic minorities in either of the groups is a complicated issue that needs further investigation. Liaising with the Ethnic Minority Achievement Service (EMAS) or the local Mosques might identify a requirement for a development of existing services to this specific target group. However the initial difficulty of identification and assessment needs to be overcome as well.

4.2.1.5 Raising profile/awareness

- The statistics suggest that 11 of the 23 mothers identified with PND are supported outside the PNDDT course and/or PNDSS group. While groups are not appropriate for everyone, a higher profile should be given to the support available. These are some suggestions to ensure that mothers are aware of PND and the support available:
 - Flyers could be put in Bounty Packs given out by midwives to pregnant women
 - Support and co-operation from midwifery services and GPs surgeries should be sought actively so that they are fully informed and can pass on this information.
- There is no provision for supporting mothers with PND who do not wish to attend a course or group. HVs said they could offer one-to-one Cognitive Behaviour Therapy (CBT) at the mother's home, time and training permitting. A feasibility study should be conducted. If CBT is offered by HVs on home visits, there should be some liaison with the PNDDT course.
- Professionals throughout the city should also be more aware of the groups and good practice should be shared. A road-show, giving information to different groups should be considered.
- Sure Start Staff should be better informed about the groups. This is in discussion and should go ahead.

4.3 QUALITY AND DELIVERY OF SERVICE

4.3.1 Are the services of a high standard?

- Mothers *overwhelmingly validate* the services being provided .
- Both groups can be seen as positively contributing to how SSS addresses the issue of PND in the area and in contributing to meeting government targets.
- Though gaps were identified, the quality of the service of both groups is reported as "*excellent*".
- Groups were slow to start. This was due, in part, to a lack of Health Visitors. This situation has now been resolved as SSS is functioning with a full complement.

4.3.1.2 PND Treatment course

- Though the course was 'very tough' for many of the mothers, they *all* reported that they reaped enormous benefit – 'had a breakthrough' - from it, though at different points in the course.
- Three main areas, unique to how the course runs at SSS, contribute significantly to the success of the project.

- Rigorous pre-course assessments, conducted by the SP. It means commitment to the course is secured at an early stage.
- Parallel 'out of group' one-to-one support by the SP.
- Past members of the course contacting upcoming members of the course to talk about their experience, a kind of parent-to-parent contact.

4.3.1.3 PND Support group

- Very well administered project that absolutely fulfils its brief, facilitating support within and outside the group.
- Sure Start funding allows the Home-Start scheme to respond quickly within the Sure Start area. This has inevitably led to criticism about the lack of an 'equitable service'. The infrastructure is already in place to roll out similar support groups following this model. Therefore approaches to other initiatives, such as On Track (presently being considered) or Portsmouth Networks (formerly Early Years and Childcare Service) and to the Statutory Agencies should be strongly considered.
- There is the potential for this group to become a victim of its own success. Mothers feel a genuine loyalty to the group and are reluctant to leave it. Though they do attend other groups, they still gravitate back to this one. Some mothers might need to be moved on to a more general parent and toddler group or another counselling/skills/personal development type course that can be made available through SSS and free up some capacity for new mothers. There is the potential that another course for basic counselling skills called *Are You Listening*, also available through the SSS programme, might be an appropriate next step for these mothers

4.3.2 Is the range of professionals and volunteers we employ appropriate to meet the need?

- The nature of people who undertake to deliver these kinds of services is that they perform 'over and above the call of duty'. However this not only distorts the costs of projects, but is a false economy. It is a practice that, with management support, should be discouraged.
- Mothers with PND sometimes find it difficult to make themselves attend groups and courses. A named 'meeter-greeter', based at reception for the duration of the session, might encourage mothers. The PNDSS group, run by Home-Start provides Home-Start volunteers for this purpose if required. Management should discuss further with SPs to identify whether such a requirement does, in fact, exist. If so, it could be addressed by
 - a volunteer or a dedicated mentor from a parent-to-parent scheme (Parents Forum, currently being developed at SSS).
 - a member of the HV team, who has expressed an interest in expanding her training in PND
 - Home-Start, who already provide this service for the PNDSS group

4.3.2.1 PNDT Course

- SPs were highly trained and experienced in PND – a necessity for this kind of course.
- Mothers said SPs were not only 'excellent' individually but also 'worked brilliantly as a team'. However, projects can become 'personality dependent'

and this tendency should be monitored. This dependency carries the obvious risk that losing staff associated with the projects could seriously impair the effectiveness of service provision. Robust structures to maintain the standard of delivery should be consolidated so that new staff can follow procedures and practices that obviously work well.

- Experience of the SPs should be shared as best practice to any other agencies interested in running this kind of course. A network of interested professionals, as suggested by the SP, should be encouraged. SSS could take the lead on this.

4.3.2.2 PNDSS group

- There were some concerns that there was a potential for dangerous situations to occur that the facilitator was not trained to handle. However, mothers felt confident that the back-up resources were in place through Home-Start. A better understanding of the objectives of this particular group might give the assurance that it is not necessary or even appropriate that Health Professionals run the group. (see 4.2.1.5 Raising Profile/Awareness, above) Further training in PND should be given to the facilitator if required.
- The group has been ‘taken over’ by the parents themselves, with Home-Start playing an important but hands-off role. SSS parental involvement and empowerment strategy is working appropriately and successfully here.
- Mothers expressed an interest in becoming Home-Start volunteers at the appropriate time for them. The training given by Home-Start could, perhaps, be integrated into SSS’s current drive to provide training to parents and interested members of the community. This training would include a variety of courses concerned with community development, (though it is anticipated the needs will be family led).

4.3.2.3 Health Visitors

- Training sometimes takes a long time to occur and this causes some frustration. It should be given a much higher priority as delays at this stage have a huge knock-on effect on projects.
- Further training of a junior member of the team would allow more involvement in projects.

4.4 MATCHING NEEDS

4.4.1 How well do the services we actually have match the needs identified before we began?

4.4.1.1 Making a difference

- Mothers overwhelmingly endorse the projects and testify to the difference made to their lives, not only in terms of outputs but also in terms of outcomes.
- ‘Making a difference’ was demonstrated most effectively at the Home-Start Conference (November 2002) when mothers, who had previously been too depressed or anxious to step outside their front door, talked confidently about their PND experiences to the audience at the Portsmouth Guildhall

4.4.1.2 Gaps identified/Future suggestions

- As projects develop gaps in service provision are identified and suggestions for future development include:
 - An information/support group for partners and families.

- There may also be a requirement for some structured sessions to construct coping strategies for the families also affected by the mothers' PND. Perhaps the SP could poll the mothers past and present of their courses and groups to establish potential requirement.

4.5 INVOLVEMENT

4.5.1 How successful has been the involvement of parents in the planning and delivery of services?

- Generally, parents are involved in the management of SSS, being on the Partnership Board. Further a parents' forum is in the process of being formed to date. Both these bodies can influence strategy.
- Specifically, mothers are fully involved in running the PNDSS group and their requests are acted upon by Home-Start, the service provider.
- Evaluations are conducted for both groups and the comments appear to be acted upon.
- As the PNDT course is structured, the opportunity for parental involvement is limited. However, mothers are consulted within the framework of the course and their suggestions or requirements are acted upon. The SPs are best placed to decide whether it is appropriate for parents to become more involved in the planning and delivery of the course.

4.6 HOW AGENCIES WORK TOGETHER

4.6.1 SSS

- Despite some gaps, and after some initial apprehension, the two groups now complement each other, providing a comprehensive package of support.
- The support by other services addressing the issue of PND in Sure Start Somerstown (SSS) is recognized but the degree to which they integrate with these two key groups is varied. Information and awareness-raising sessions with staff and other project workers within SSS is highly recommended. (as 4.2.1.5 Raising Profile/awareness above).
- Some administrative work does not need the particular specialist expertise currently involved. A system of administrative support should be properly organized – perhaps by booking time required from a team of administrative support within the SSS Centre

4.6.2 SSS partners

- The PNDSS group in particular draws on the experience of its service provider, Home-Start, and interacts with many other agencies in a way that is exemplary.
- A lack of detailed paperwork, distinguishing between PNDT course and other Health provision caused many investigative difficulties. SSS should detail the project aims and costs more specifically and should closely monitor the underlying administrative systems to maintain this standard.

4.6.3 Portsmouth City

- The lack of provision for PND across the city of Portsmouth has meant that non-SSS mothers have attended the groups intended for SSS (but to no detriment to the SSS mothers). Now numbers of SSS mothers have risen, the non-SSS mothers will have to get support elsewhere. This could be addressed if PND support across the city took the form of:

- Running groups in partnership with other agencies across the city, with a greater degree of flexibility, (drawing from a larger pool of participants),
- Providing free transport (and crèches).
- A network of interested professionals, sharing information and skills, could help roll out the programme across the city and ensure projects are not isolated. SSS could consider taking the initiative, but should certainly be involved with this.
- SSS's best practice in these areas should be offered to the new wave Sure Start (Sure Start ABC)²² and to statutory agencies and other initiatives city wide.

4.7 SURE START PRINCIPLES:

4.7.1 Co-ordinate, streamline and add value to existing services in the Sure Start Area

- There was no provision for PND in Portsmouth City when these initiatives were started.
- SSS projects have trail-blazed PND treatment and support with
 - These two specific projects
 - High standard of training of HVs in assessment
 - How different service providers integrate to provide support
- These add value particularly to the service provided by Portsmouth Primary Care Trust (PCT) in terms of identification, assessment, treatment and support.
- These projects are now in a position to migrate working practices to inform future groups throughout the city.

4.7.2 Involve parents, grandparents and other carers

- These groups are run for a specific group of mothers. They are involved as comments above. (Section 4.5).
- Families and partners can be involved in a partners' group. (See 4.4.1.2).

4.7.3 Avoid stigma by ensuring that all local families are able to use Sure Start services

- This principle not appropriate for these projects, as they are restricted to mothers identified with PND.
- But the services are available to all local mothers so identified. (They can self-refer).

4.7.4 Ensure lasting support by linking to services for older children

- The new initiative by On Track, funded by Children's Fund, is already in consultation with SPs addressing PND at SSS and with evaluator for SSS.
- Hopefully the success of these projects will encourage other agencies to address and support PND.

4.7.5 Be culturally appropriate and sensitive to particular needs.

- Two mothers with special needs were members of the groups. Their needs were taken into account in the group dynamics.
- No mothers from ethnic minority groups attended and this is a complicated issue that needs further investigation. (See 4.2.1.4).

²² Home-Start are already involved with Sure Start ABC.

4.7.6 Promote the participation of all local families in the design and working of the programme.

- This principle not appropriate for these projects

4.8 FINAL COMMENTS

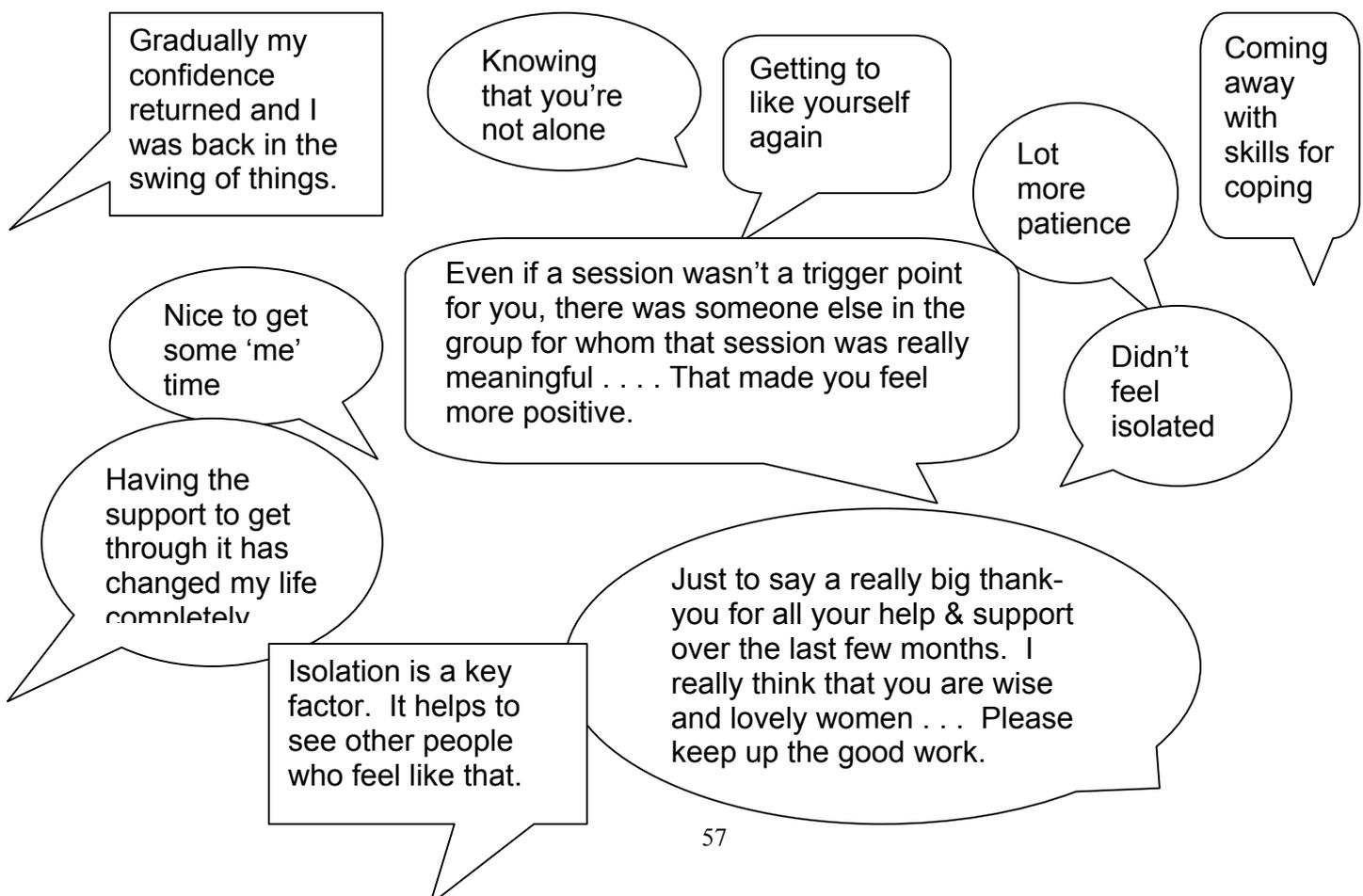
The Post Natal Depression Treatment course and Post Natal Depression Social Support group, together with support from Health Visiting team and Family Support Workers team, provide a comprehensive package of support for mothers identified with PND.

All concerned with Sure Start Somerstown – management, staff and families - should be justifiably proud of this achievement.

The process of setting up and running these projects has not been without difficulties, but these difficulties have, in the main, been overcome. As projects have developed, aims and aspirations have also developed – an organic process that is to be applauded.

This research was not conducted in a void, and during its course, as issues and topics were discussed, service providers were proactive in addressing those areas identified for improvement. Thus many of the gaps and suggestions for the future have already been dealt with to some extent.

The mothers, who were interviewed, validated the service facilitated by SSS without reservation. The final words should come from them.



APPENDICES

Appendix A – Feeling and Moods Motherhood Assessment (previously Edinburgh Scale)

Appendix B – Summary Flow chart for the detection and management of Post natal Depression.

Appendix C – Print of Sure Start Form M5 (Annual Monitoring Form).

Appendix D – SSS Referral Form

Appendix E – structure of focus group interview – mothers - Post Natal Depression Treatment Group

Appendix F – interview questions – Service Providers - Post Natal Depression Treatment Group

Appendix G – Letter to practice manager

Appendix H – Display poster for PNDT Group.

Appendix I – structure of focus group interview - Post Natal Depression Social Support Group

Appendix J – interview questions – Service Providers - Post Natal Depression Social Support Group

Appendix K - structure of focus group interview – Health Visitors

Appendix L - - structure of focus group interview – Family Support Workers

Appendix M – Articles

APPENDIX N - Sure Start principles

- Co-ordinate, streamline and add value to existing services in the Sure Start Area
- Involve parents, grandparents and other carers
- Avoid stigma by ensuring that all local families are able to use Sure Start services
- Ensure lasting support by linking to services for older children
- Be culturally appropriate and sensitive to particular needs.
- Promote the participation of all local families in the design and working of the programme.

(Guidance on Local Evaluation August 2000)

BIBLIOGRAPHY

Dawson, G., Ashman, S. B., Carver, L. J., 2000. 'The role of early experience in shaping behavioural and brain developments and its implications for social policy' *Developmental Psychopathology* 2000, Autumn; 12 (4): 695-712.

Shonkoff, J. P. and Phillips, D. A., eds. (2000) *Neurons to Neighbourhoods*, Committee on Integrating the Science of Early Childhood Development, Board on Children, Youth and families, Natinal Research Council and Institute of Medicine, National Academy Press, Washington DC.

Websites:

INSTITUTE OR PSYCHIATRY: 'Impact of maternal postnatal depression on infant development'. Institute of Psychiatry website. <http://www.iop.kcl.ac.uk/iop/Departments/PsychMed/PeriNatl/childdev.stm>.

LEE, Dr Howard , 'PND – don't suffer in silence', <http://www.ivillage.co.uk/pregnancyandbaby/parent/postnatal/articles/>

NATIONAL CHILDBIRTH TRUST. <http://www.nctpregnancyandbabycare.com>

NESS: Henderson, Juliet, Wilkins, Katrina & Barnes, Jacqueline, 'Getting Started with a Local Sure Start Programme Evaluation', National Evaluation of Sure Start (NESS) <http://www.ness.bbk.ac.uk>

ROYAL COLLEGE OF PSYCHIATRISTS. <http://www.rcpsych.ac.uk>.

TELEGRAPH: 'Majority of depressed mothers go untreated' by Sarah Womack, Social Affairs Correspondent, Filed 27/08/2002. <http://www.telegraph.co.uk/news/>

'Strengths and Limitations of the Edinburgh Postnatal Depression Scale' on website: www.PNDtraining.co.uk.

