‘It’s been a lifesaver!’ Parental and professional reflections on the Mummas Together Group: a South London peer support group for Black mothers

Christina Brown, Michelle Peter

REPORT

Note on language: the term ‘women’ is used throughout, which reflects the terminology used in the wider literature. However, we acknowledge that ‘women’ also includes ‘birthing people’ and want to ensure that all individuals who experience pregnancy and childbirth, regardless of their gender identity, are included.

Executive summary

The transition to motherhood is both life-changing and challenging. For some, these challenges can be significant, and the time during pregnancy and the early period after birth — the perinatal period — can be marred by perinatal mental health (PMH) problems.

PMH problems can affect quality of life both in the short and long term, and can have consequences for the mother, her child, and wider family members. However, both individual and structural barriers can make access to specialist PMH services difficult. Access to these services is especially challenging for women from Black and ethnic minority backgrounds who already face the greatest risk of adverse maternal outcomes and who are among the most likely to experience PMH problems. This issue has been recognised, and the transformation of specialist PMH services within the National Health Service (NHS) is underway. In the meantime, inequity in access to timely and appropriate clinical PMH support remains. The establishment of perinatal peer support services could prove an effective addition to the services offered in routine NHS care.

The Mummas Together Group (MTG) is a South London-based perinatal peer support group that offers peer support sessions aimed at Black mothers. Its unique model is such that sessions are run with input from relevant health care professionals, meaning mothers can receive advice from both their peers and clinicians. The group has been running for one year and, in that time, sessions have been attended by women from all walks of life and at different points in their motherhood journey. The aim of this work was to evaluate the MTG: to understand its impact, to learn what has worked well for mothers, and to gain insight into health care professionals’ experiences of working together with community organisations to support mothers during the perinatal period.

To do this, this evaluation used a combination of survey and focus group data with mothers who have attended the MTG sessions, and semi-structured interviews with health care professionals involved in co-delivering the MTG sessions.

The women who attended the MTG sessions were resoundingly positive about its impact on their lives. They valued meeting other mothers who lived nearby and who had been through similar experiences to themselves, as well as the opportunity to speak

with other women who would take their concerns seriously. They were also grateful to have access to a health care professional who could answer concerns about their mental health. Many of the women who had reported feeling lonely or isolated prior to coming to the sessions described feeling better after attending, and more confident and empowered to speak up about their mental health. Speaking to others had helped many of the women realise that society's depiction of the ideal mother does not exist and had helped them to feel hopeful about their future. Most importantly, the women were thankful for the safe space that had been created to be themselves around other women who looked just like them.

The professionals were also positive about the MTG sessions and were passionate about the psychosocial benefits that peer support can bring. They were emphatic about the continuation of the MTG and for peer support of this type for improving equity of access to PMH support. Collaborating with community leaders to bring local women and health services together was seen as vital.

Through the experiences of women and health care professionals, this evaluation has highlighted the importance of the MTG for the mothers of Bexley and Greenwich, and demonstrated a clear need for perinatal peer support services that are tailored to the requirements of local communities.

Introduction

A time of joy, a time of pain

The experience of bringing a baby into the world is life-changing, and while pregnancy and the early period after birth is a time of excitement and joy for many women, for some, this time — known as the perinatal period — is one that is challenging to both their physical and mental health.

Far from unusual, 10–20 per cent of women are affected by perinatal mental health (PMH) problems (NHS England (n.d.). Perinatal depression (PND) (not to be mistaken with the baby blues which typically passes after two weeks) affects around 11 per cent of women (Woody et al 2017) with symptoms including 'empty' mood, feelings of helplessness, trouble forming an emotional attachment with the baby, and doubts about the ability to care for the baby (National Institute of Mental Health n.d.). At the most severe end, PND can be fatal. Between 2018 and 2020, maternal suicide in the UK accounted for 18 per cent of maternal deaths, making it a leading cause of death in women between six weeks and a year of their pregnancies ending (Knight et al 2023). Often but not always comorbid with PND is perinatal anxiety (PNA). With international prevalence estimated at around 21 per cent (Fawcett et al 2019), symptoms of PNA can include feeling restless or unable to sit still, problems with sleep, rumination (persistent cycling of distressing thoughts), and panic attacks (Mind 2024).

As well as immediate negative consequences on the quality of life for women and their families, PMH problems can have long-lasting adverse impacts. For instance, there are links between PND and the risk of negative long-term outcomes for the child (Netsi et al 2018), and PNA is associated with adverse pregnancy outcomes including preterm birth, low birth weight (Grigoriadis et al 2018), and with prolonged sick leave and increased health care use (Andersson et al 2004). There are also financial costs to society, with an estimated £1.2 billion annually being spent by the NHS and social services on problems related to PMH (Bauer et al 2014). The involvement of specialist mental health services at the earliest opportunity should, therefore, be considered a priority. However, adequate provision and access to appropriate services is often not straightforward and, according to the Centre for Mental Health, 60 per cent of women in the UK have no access to PMH services.

Perinatal mental health: a problem for some more than others

A number of barriers to accessing care for PMH problems has been identified. Some of these are at the individual level. For instance, a woman's perceptions of her struggles as a natural part of motherhood can prevent her from seeking help (Ford et al 2019). Women may also hide their feelings for fear that friends and family may not understand or that they may respond with inappropriate advice (McLeish & Redshaw 2017). Barriers are also caused by structural issues at the organisational level and can lead to delays in accessing PMH services, such as health care professionals lacking training in identifying PMH problems along with extensive waits and referral times (Sambrook et al 2019). Crucially though, the intersection of race and ethnicity with mental health problems more broadly means that we see differential access to PMH services and outcomes for women coming from Black and ethnic minority backgrounds (Prady et al 2016, Jankowic et al 2020).

One contributing factor to these disparities is lack of awareness about mental health. For example, Black Caribbean mothers in the UK were found not to consider themselves depressed because their depressive symptoms were viewed as a reasonable response to the multiple stressors they had faced (Edge et al 2004). Family members may also have limited understanding of PMH problems and therefore fail to encourage women to seek help (McIntosh 1993). Delays in access to appropriate PMH support have also been attributed to lack of knowledge about available services (Watson et al 2019) as well as varying cultural expectations around motherhood and where to seek help. For instance, Bangladeshi women living in East London viewed the role of health care professionals as providing physical

care and not emotional support (Parvin et al 2004). Added to this, is that health care professionals are less likely to ask women from non-white backgrounds about their mental health or to offer them treatment after having their baby (Harrison et al 2023); these systemic biases exacerbate and perpetuate the difficulties in accessing PMH services for women from these communities.

The inequity in access to PMH support is further complicated by the fact that, in the UK, maternal outcomes are already disproportionately worse for women from Black and ethnic minority backgrounds. Not only are there inequalities in Black and Asian women's experiences of maternity care, with reports of negative interactions and racially discriminatory behaviour from health care professionals during pregnancy (Peter & Wheeler 2022, Thomson et al 2022), but there are stark differences in clinical outcomes: Black and Asian women are 3.7 and two times as likely to die as white women during pregnancy, delivery or postpartum, respectively. Stillbirth rates are also twice as high for Black women compared to white women (Muglu et al 2019, Jardine et al 2021, Matthews et al 2022), and Black women are most at risk of having their baby die in the first 28 days after birth (Knight et al 2023) and of being re-admitted to hospital in the six-week postnatal period (Care Quality Commission (CQC) 2021). Notably, bereavement as a result of stillbirth or neonatal death is more likely to lead to mental health problems (Howard et al 2014). Thus, the women least likely to receive adequate or timely PMH support are those among the most at risk of experiencing PMH problems.

The gravity of this issue has been widely recognised by the National Health Service (NHS) and other organisational bodies. The NHS long term plan (NHS 2019) has outlined a commitment to '*transform specialist PMH services across England*'. With £2.3bn of investment in mental health, the UK Government has promised to increase the availability of specialist PMH community services and improve access to evidence-based psychological therapies for women and their partners. The most recent MMBRACE-UK report has also highlighted the need for maternal health staff to be sensitive to some of the factors that might prevent a women from disclosing mental health symptoms such as stigma and fear of child removal (National Institute of Mental Health n.d.).

The need for a joined up and holistic model of care is clear. However, the integration of specialist PMH services into England's health care system is not going to happen overnight. While these services become established, perinatal peer support could play a significant role in bridging this gap.

Perinatal peer support to bridge the gap

Recognised as having benefits for mental health and wellbeing (Sokol & Fisher 2016, Shalaby & Agyapong 2020), peer support groups are a type of psychosocial intervention where individuals with shared lived experience come together to support and learn from one another. Social isolation and the perception of having low social support are risk factors for depression and anxiety during and after pregnancy (Littleton et al 2007). The provision of peer support during the perinatal period can therefore be a valuable resource for women with or at risk of PMH problems.

Within maternal health more broadly, but especially in the perinatal period, peer support can give women the opportunity to talk honestly about their concerns with others who may be facing similar issues (Rice et al 2022). Developing these types of relationships can have psychological benefits such as relieving anxiety, fostering a sense of belonging, and normalising concerns through positive feedback (McLeish & Renshaw 2017). Peer support can also empower individuals to take ownership of and feel more in control of their health and wellbeing.

The Motivational Mums Club (MMC), founded six years ago by maternal health advocate, Christina Brown, was developed to do just this. The MMC provides a safe space for mothers from all backgrounds but targets those from Black and minority ethnic communities because they are among the most impacted by maternal health inequalities.

Peer support is a core component of the MMC and regular 'Mummas Together' sessions are held where women can share their experiences of motherhood in a judgement-free environment. The sessions, which are free of charge, are aimed at Black women and provide them with support during the perinatal period to develop the knowledge, skills, and confidence to maintain their physical health, as well as address other issues that may be impacting their mental health and wellbeing. The Mummas Together Group (MTG) takes place twice weekly and is held in two South London locations: Bexley and Greenwich. Sessions last around two hours and are attended by between five and 12 women and their children. While peer support groups are typically offered in non-clinical contexts and include non-professional advice, the MTG has embedded within it the involvement of health care professionals. Run in conjunction with psychologists and midwives, women who attend the MTG are given the unique opportunity to receive advice from a relevant professional as well as their peers. The sessions so far have covered a range of topics including one delivered by a midwife that focussed on journaling and another on empowerment and mindfulness. Discussions have also focused

on self-advocacy and breaking the cultural stigma around mental health as well as highlighting what services are available locally.

Learning what's good and how to make it better

The MTG sessions have now been running for one year and, in that time have been attended by women from different backgrounds, with different experiences and at different points in their motherhood journey. Now is the time to understand the impact of the MTG, to learn what has worked well for mothers, and to identify where improvement is needed.

This report details the findings of an evaluation of the MTG that aimed to: a) build a picture of how and why mothers utilise the MTG, b) understand the impact of the MTG on mothers' mental health and sense of wellbeing during the perinatal period, c) identify areas of success and where improvements could be made, and d) gain insight into health care professionals' views and experiences of working together with community organisations to support mothers during the perinatal period.

Methods

Study design

This evaluation used a combination of survey and focus group data from mothers who have attended the MTG sessions, and semi-structured interviews with health care professionals involved in co-delivering the MTG sessions.

Participants and data collection

Surveys and focus groups with parents: parents who attend the MTG sessions at either Bexley or Greenwich were invited to complete a survey or to take part in a focus group exploring their views and experiences of the sessions. Survey items included closed and open-text items and assessed respondents' demographic information, their views on the importance and impact of the MTG sessions, whether they would recommend the group to others, and suggested areas of improvement. Focus group questions covered similar topics. The survey was open from 6 February 2024 until 4 May 2024.

Interviews with professionals: health care professionals who support the delivery of the MTG sessions were invited to take part in an interview to explore their views and experiences of delivering support to mothers during the perinatal period via a community-based group.

Data analysis

Surveys: descriptive statistics using frequencies and proportions were calculated. Qualitative responses were coded and then organised thematically.

Focus groups and interviews: focus groups with mothers were audio-recorded and transcribed verbatim. The interviewer took notes during the interviews with health care professionals. A summary of the interview was produced immediately once the interview was complete to ensure content was recorded accurately.

Results

The themes identified in the survey and focus group data overlapped significantly and so these findings are presented together. Seventy-two people took part in the evaluation: 52 of these completed a survey, and 20 took part in two focus groups, one held for mothers who attend the Bexley MTG (*n*=9) and one for mothers who attended the Greenwich MTG (*n*=11). The majority of survey respondents identified as coming from a Black African or Black Caribbean background. Most (44 per cent; *n*=23) had only one child, and just under half (46 per cent; *n*=24) had been attending the sessions for between one and three months. A similar pattern was observed among those who took part in the focus groups, with most identifying as Black African or Black Caribbean, and having only one child (Bexley: 67 per cent; *n*=6), Greenwich: 64 per cent, *n*=7). Participant characteristics can be seen in Table 1.

Survey and focus group findings

1. Motivations for attending the Mummas Together Group (MTG)

A chance to connect with 'other mums facing similar things'

Overwhelmingly, women described the need for connection with likeminded individuals as their main reason for attending the MTG sessions. Speaking to others who have '*gone through your current challenges*' could help women to normalise their own situation. The importance of locality was evident as many of the women reported that they wanted to get to know '*other local mums*': '*I can meet other mums and it's nice to get out of the house — after the school run, I'm just literally at home until it's time to pick up baby.*'

Many of the women wanted the opportunity to 'share motherhood experiences' and to do so freely:

'*It's a supportive community of mothers whose experiences I can relate to, share tips, and offer advice on navigating the challenges of motherhood, especially after such a long gap between children.*'

Finding new friends and someone they could relate to was important, as was the chance to build a new network as was the case for one woman who reported that she '*loved the idea of extra support and meeting new mums*'.

Table 1. Survey and focus group participant characteristics

N (%)			
	Survey respondents	Focus group participants	
		Greenwich	Bexley
	n=52	*n*=11	*n*=9
Ethnicity			
Black African	33 (63)	7 (64)	5 (56)
Black Caribbean	12 (23)	3 (27)	3 (33)
Black British	2 (4)	0 (0)	0 (0)
White and Black Caribbean	2 (4)	1 (9)	1 (11)
White and Black African	1 (2)	0 (0)	0 (0)
Asian and Black Caribbean	1 (2)	0 (0)	0 (0)
Asian Mauritius	1 (2)	0 (0)	0 (0)
Number of children			
1	23 (44)	7 (64)	6 (67)
2	16 (31)	3 (27)	3 (33)
3	11 (21)	0 (0)	0 (0)
4	1 (2)	0 (0)	0 (0)
Currently pregnant, no other children	1 (2)	1 (9)	0 (0)
How long attending the MTG			
Less than a month	13 (25)	–	–
1–3 months	24 (46)	–	–
4–6 months	13 (25)	–	–
6–12 months	2 (4)	–	–

Positive reviews from friends and professionals

Word of mouth was a common way that many of the women had heard about the MTG sessions. Some had been recommended by a friend who had already attended the sessions and who had spoken about it positively. For instance, one mother described how testimonies from other mothers had encouraged her to join while another had '*heard amazing reviews*'. Seeing the benefits of the group sessions first-hand had spurred on one mother to attend: '*I saw the great impact the group had on a friend who attends. I knew this was special based on that.*'

Others had joined the sessions because they thought they '*sounded really different*' or had been told by someone else '*it's an interesting group*'. Referrals to the group also came via health care professionals — predominantly midwives but sometimes other clinicians such as social workers or via primary care services: '*I've followed Motivational Mums Club for a while and I saw the group's poster in my GP in Bexleyheath…*'.

Advertisement through social media posts or flyers in community health settings, such as children's centres, were also ways in which women had been made aware of the group.

A safe space for Black mothers

A number of the women were driven to join the MTG sessions because of the opportunity to share their experiences with women whose cultural and social identity reflected their own. Keen to '*meet other Black mums*', women described needing '*a space to belong*' and wanting to '*be around other women like me': 'It's a space where I can connect with others who understand the unique joys and concerns that come with being a Black mother — with absolutely no judgement*'.

The idea of trust and the need to feel safe was important. In particular, women were motivated to join the MTG sessions because they felt it would be an environment in which they could be themselves:

'*I wanted to connect with fellow Black mums in a supportive environment where I can freely discuss my journey through pregnancy and motherhood without feeling the need to censor myself or explain cultural/racial nuances.*'

A chance to address mental health and wellbeing

The MTG was seen as an environment that would support those concerned about their mental health. The opportunity to get advice from health care professionals and to speak to other mothers who had experienced similar issues and overcome them was a motivator. One woman described how, after having her baby, she had found it '*really tough*' and that this had encouraged to reach out to the MTG: '*While I was struggling, I went to the centre and was introduced to this group of amazing ladies!!*'

Another woman who had suffered with poor mental after experiencing a traumatic birth described how she had attended the MTG because she wanted to feel '*safe, heard and seen*'.

2. Value of the MTG

Feelings about the importance of the MTG were overwhelmingly positive: 88 per cent (*n*=46) of survey respondents stated that the MTG was 'Very important', and 12 per cent (*n*=6) felt it was 'Somewhat important'. No one described it as being 'Not important at all' and 100 per cent (*n*=52) said that they would recommend the MTG to others. These sentiments were further corroborated by the qualitative statements in the survey and by those who took part in the focus groups. Findings naturally fell into two distinct but interrelated concepts: the knowledge that had been gained from the MTG and the impact of the MTG on women's mental health and wellbeing.

Knowledge gained from the MTG

Almost all of the women described the knowledge they had gained in terms of psychosocial benefits of attending the MTG. Several felt that the group had helped them come to the realisation that '*other mothers feel the same*' and that '*we are not alone in our experiences*'. For many, the group sessions had given them confidence where they had had little. Sometimes, this related to confidence in feeling able to just be themselves in front of others: '*I have a space where I can not be strong in front of the system. I can be vulnerable without any judgement. And it's given me my power back in knowing I'm a good mum*'.

In other cases, women described developing the confidence to speak up about their concerns and to '*reach out and ask for help*' rather than trying to '*do it alone*'. For one women whose native language was not English, this new-found confidence had empowered her for future appointments: '*For my next pregnancy I can get a translator to help me with understanding what midwife is saying*'.

The opportunity to speak to a health care professional was valued and a number of women spoke of the benefits of being able to get answers to their questions about their physical and mental health problems:

'*I had a C-section and I didn't get a lot of guidance on the healing process. I didn't know what was normal or not normal. Having a space where there is a midwife on site, I was able to raise concerns when I wasn't able to get a GP appointment.*'

The presence of health care professionals provided the added opportunity to gain knowledge on parenting and typical child development such as normal sleep for babies, guidance on nutrition, and signs that a child may require additional support:

'*My child doesn't talk and hardly looks at anyone in the eyes. My in-laws have told me that he is fine, but since going to Mummas Together, it made me realise that seeking help is fine and will only support my child to get the right support*'.

Worryingly, there was evidence that some women were relying on access to health care professionals via the MTG because of gaps or limitations in local service provision:

'*Obesity runs in my family and we have pre-existing mental health conditions. I was able to learn more about managing my weight and to look after my mental health. My current appointments are short and there isn't enough time for me to ask questions about my concerns.*'

On a more practical level, the groups had improved women's awareness of '*what's happening locally*' and the services they could access in the surrounding area.

Impact of the MTG on mental health and wellbeing

The building of a trusted support network had had positive impacts on the perinatal mental health of many of the women. When asked if the MTG sessions had made changes to their mental health, 96 per cent (n=50) of survey respondents said that it had. Making friends and sharing experiences was greatly valued and was a common reason that women came back to the sessions week after week:

'*Just knowing that I can run through the door here and have a moment to debrief and just say how I feel and have a bit of wisdom from people with different backgrounds coming to share what they're going through and uplift and encourage me… it actually helps.*'

One focus group member described the group as '*a blessing*' and that she always left '*feeling light*'. Another explained that before attending the MTG she had felt '*quite lonely*' but after weeks of joining the sessions she knew that she had '*something to look forward to*'. Echoing this experience, a number of women who had reported feeling low or isolated prior to coming to the MTG described alleviation of these feelings after attending the sessions:

'*When I first attended, I was in a shambles to be fair… trying to navigate motherhood and understand my new role. But coming here, it gave me a space to kind of get used to it as well and now I feel more in control of myself. I feel like it's easier to navigate and be around the other mothers, so yeah … I'm much better.*'

The benefits of the MTG were especially pronounced for women with limited English and who had little social support. Talking about joining the MTG for the first time, one women explained:

'*The kindness that was shown to me was overwhelming. I don't have no time to do anything for me. I arrived on my first day with my baby in her pram and I cried because I felt so alone… I didn't how to get help because my C-section experience was horrible. The hospital was not patient with me. My English is not good and my husband is in Nigeria.*'

Opening the doors to '*a whole new community*' of mothers was a sentiment shared by many of the women. Notably, the MTG was viewed by some as having special status and was felt to be distinct from other parent groups: '*It's different from the library group where you meet other mums. Here, we really connect. It's nice to hear other people's stories*'.

The unique dynamic of the MTG was echoed by another woman who explained that she had found it difficult to fit in at other parent groups but felt immediately at home at the MTG:

'*I'm much older than when I had my first born. I had a good birthing experience but when I attended other groups in the children centre, I couldn't connect*

with other mums… I didn't feel safe to talk about my mental health and lacked confidence. When I came to the Motivational Mums Club, I felt safe instantly. I felt light and shocked myself when I said I need help.'

It was clear that the act of listening to others' experiences had helped women to normalise their own, and that the MTG had provided a space in which women who were often vulnerable, self-critical, and anxious could flourish into confident, happier individuals who were unafraid of bringing their feelings to light:

'*Before, I held back on sharing my story because I didn't want to seem like a Black angry mother. Since coming to the group, I've engaged with midwives in the group to improve on my mental health, met great ladies and my experience reflects other Black women's experiences*.'

One women reported, '*I've truly come out of my shell*' and another said that she always felt '*a lot better after attending*'. Notably, women welcomed the MTG as a space for mothers to focus on themselves rather than their children and viewed the time as an important opportunity for self-care where women can be '*more than just a mum*':

'*I was anxious about attending groups particularly where there would be open discussion. So much so that it took lots of encouragement from my partner for me to attend my first couple sessions, but it's honestly been refreshing meeting with other mums in a group that is centred on us and not the kids. These sessions have alleviated my sense of isolation by providing a platform to both listen to and share experiences*.'

Overall, the MTG was viewed as '*a lifesaver*', and an important factor in supporting and improving women's mental health and wellbeing during the perinatal period:

'*The group has definitely helped with my mental health. I had a near death experience … I would experience flashbacks when I least expected it in public which made me stay at home. I saw the group being advertised … I was nervous going and felt immediately comfortable with how warm and loving the group was, filled with mums who look like me and just laughter*.'

3. Ambitions for future MTG sessions

When asked about how to improve the MTG sessions, several women were positive about the group, feeling that '*it runs really well already*' and '*it all seems good so far*'. However, common themes emerged from both survey respondents' and focus group members' suggestions regarding potential changes in the future. Their suggestions have been grouped into these themes and are presented in Table 2.

Table 2. Suggestions for improvements to the MTG sessions.

Theme	Illustrative quote
Timing and frequency of sessions	*'It would be amazing if there was a session in the evening or on the weekend, even if it was only monthly, so that mums can still access the support when they return to work.'* *'The only criticism I'd give is the length of time; I wish it lasted longer!'*
Reach and location of sessions	*'I wish I can attend more often but the journey at times can be difficult. I attended the Bexley group and Christmas party and it was magical. It would be great to see the group in Southwark. ALOT of Black mums will 100% benefit from the group there'.* *'Mothers would benefit from this group in Lewisham. I have told a large amount of mums about it and my friends and relatives who are mothers would like to see it expand there.'*
Scope of the sessions	*'Something I'm struggling with at the moment is returning to work. So maybe discussions or seminars specifically focused on supporting mothers with transitioning back to work after maternity leave.'* *'I suggest they introduce some kind of skill acquisition program/training to help the mums.'* *'Organise more programs to help relieve mamas from stress e.g. hangouts, Spa time, coffee time, etc.'*
Focused sessions	*'We could organise sessions to learn more about taking care of our babies. Do some more fun activities to improve our mental health.'* *'Weekly topics to discuss.'*
Introducing new members	*'I noticed new mums attend every week, I think it will be good to introduce ourselves and start with the program or talk of the day.'* *'A few things to help group mix together especially when new, maybe game or quiz.'*
Raising awareness about the sessions early in pregnancy	*'Black mothers need to know about these groups during their pregnancy period. Try and get the group leaflets in folders given to us by our midwife.'* *'I like the idea of being introduced to the group before you're pregnant. It can help you to build up a local community who can check in on you. It should be standard for HCPs to know about these groups.'*
Bringing in more health care professionals	*'We also need more professionals to come in various roles.'* *'It's important that perinatal services come into the group and speak to us. It should be extended to community midwives and GPs.'*

Interview findings: health care professionals

Interviews were conducted with health care professionals who support delivery of the MTG sessions and whose specialisms are in counselling psychology and midwifery.

The power of women together

Just like the women who were surveyed and who took part in the focus groups, professionals were also passionate about the need for a space in which women at different points in their motherhood journey can come together. Providing a space where women can '*feel safe*' and '*build their village*' was highlighted by all of the professionals, as was the recognition that '*there was nothing like this*' in the area. In addition, the chance for women to learn from their peers and get advice from professionals in one dedicated space was seen as unique and a model that should be rolled out more widely:

'*I really feel groups like this, where women and birthing people can come together and share their stories and concerns and have access to a health care professional should they need to is priceless*.' (Midwife)

The idea of supporting those who may have had a negative pregnancy experience and the opportunity to be '*a listening ear*' had encouraged one professional to actively reach out to the MMC. Another professional praised the MTG sessions and the value they could add to women trying to manage the challenges of motherhood: '*It is so hard juggling parenthood and health, keeping that important social interaction, and this group is brilliant for all of this*' (Midwife).

Perceived gaps in health care service provision during what can be '*such a vulnerable time*' had driven one professional to become involved in the MTG sessions:

'*I wanted to be a bridge for new parents who needed a connection but were left waiting for months on NHS/private lists. The perinatal period is such a vulnerable time in a person's life, with lots of change and constant new trials to face*.' (Counselling psychologist)

Equitable access to support in the perinatal period is vital

All of the professionals acknowledged the disproportionality in maternal health outcomes for Black women and talked about the value of the MTG sessions for addressing these issues. Described as '*a ground-breaking initiative*', the MTG was praised for breaking down cultural stigmas around mental health in Black communities and for opening up avenues to PMH support:

'*Traditional support groups and mental health services often do not cater specifically to the needs of Black and Brown mothers… the Mummas Together Group helps build trust and foster a sense of community. This can significantly enhance participants' willingness to seek and accept support*.' (Midwife)

In line with the survey findings, professionals viewed access to a health care professional as beneficial for women who were sometimes unaware of their entitlements or how to self-advocate:

'*I attended this group a few times where women did not know what a consultant midwife was, how to organise a debrief or have their birth options discussed. We need to ensure equity of access and provision, even more so for our Black women and birthing people who have poor outcomes*.' (Midwife)

As was highlighted by those completing the survey and taking part in the focus groups, the dynamic of the MTG was observed to be unique; one professional remarked that women attending the sessions have reported that they '*do not feel welcome*' in some other parent group spaces. The need for a group that offers '*culturally relevant support*' and understanding of the '*specific mental health challenges these communities face*' was seen as necessary for putting women at ease and improving equity of access to appropriate and timely PMH support:

'*I think that the sessions are a great first step for women to process what they are going through and what it is that they need. Often, acknowledging that you need support is the most difficult step*.' (Psychologist)

The devastating consequences when this is not put in place were described, further highlighting the need for accessible support for the women most at risk of PMH problems:

'*If a mother isn't appropriately supported and given space during this time, they have the potential to lose themselves. As a consequence, their mental health can decline and often these negative changes can happen very quickly*.' (Psychologist)

Working together to benefit all

Integrating the type of peer support offered by the MTG into perinatal health services more widely was seen as essential. Professionals felt that adopting a holistic approach into clinical care settings, in which the value of peer support groups is recognised, would be an important next step. Offering peer support in conjunction with support via clinical services was proposed:

'*We cannot improve maternity services by waiting for women to come to us to tell us… we are not given the space outside of our clinics and day-to-day to build this relationship and trust. I really feel it would be so powerful to have a group alongside a postnatal clinic, where midwives could see women for 1-2-1, but there would also be a group running at the same time to build friendships*.' (Midwife)

There was acknowledgement, however, that this integration of services would not be possible without the support of key trusted advocates within local communities to drive it forward and that this process would take time: '*Building relationships with community leaders like the Mummas Together Group requires effort and commitment, but it is a feasible and rewarding endeavour*' (Midwife).

One professional noted that building rapport with local community leaders requires genuine engagement from health care professionals whereby they '*actively participate in community events*' and develop trust through '*consistent and reliable actions*'. Community leaders were seen as instrumental in bringing health care professionals and local mothers together and their unique position of understanding the cultural nuances of their community was recognised as making them an ideal mediator:

'*Women are more likely to communicate openly and honestly with health care providers who trusted community leaders endorse and community leaders can identify issues early on and direct individuals to appropriate health care services, leading to timely interventions*.' (Midwife)

Conclusion

The aim of this evaluation was to examine the impact of the MTG sessions for mothers and to understand health care professionals' perspectives on working together with community groups to support women's health in the perinatal period.

Undeniably, the MTG sessions have contributed towards a more positive outlook for all of the women who shared their views and experiences. Women frequently described the value of meeting other mothers who lived nearby and who had been through similar experiences to themselves. They welcomed the opportunity to speak with other women who they felt were non-judgmental and who would take their concerns seriously. Crucially, a huge part of women's motivation to sign up to the MTG sessions was the chance to be around other women who shared their ethnic and cultural identity. This was a significant driver in their continued attendance.

Importantly, there was evidence of psychological benefits from attending the MTG sessions: many of the women who had reported feeling lonely or isolated prior to coming to the sessions described feeling better after attending. Consistent with other research (McLeish & Redshaw 2017), appraisal and validation of their experiences from others attending the MTG had helped women to normalise their concerns and had built their confidence in parenting and in advocating for themselves. Speaking to others had helped many of the women realise that society's depiction of the ideal mother does not exist and that there is no one standard they should strive to live up to. The sessions also helped women feel safe to share thoughts they may not have disclosed outside of the group and, as has been shown elsewhere (Mauthner 1997), meeting others who had recovered from their problems, helped women to feel hopeful about their future.

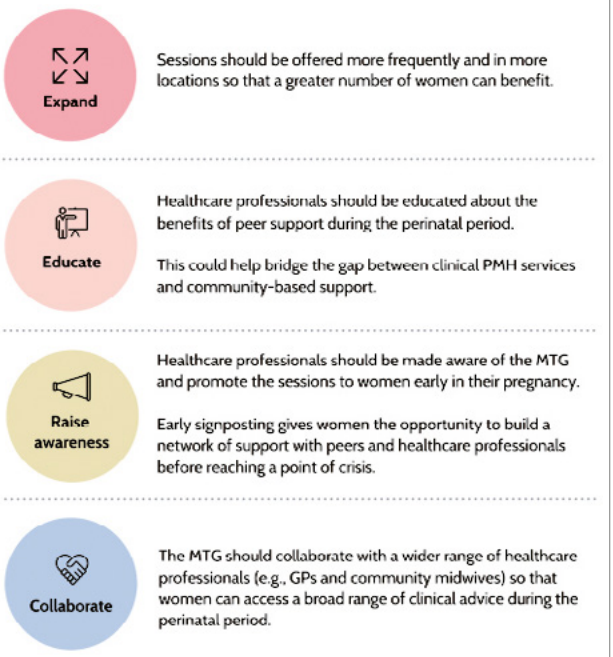
Research has revealed that a woman's perceived close relationship with health care professionals can help them understand their PMH problem (Wrobleski & Tallon 2004) and can be an important facilitator in seeking treatment (Amankwaa 2003). In this evaluation, women felt more confident to speak up about their mental health concerns after speaking to a health care professional at the MTG sessions. They were grateful to be able to get professional advice and several requested this happen more frequently with professionals from a wider range of specialisms.

The professionals who took part in this evaluation were emphatic about the continuation of the MTG and for peer support of this type for improving equity of access to PMH support. Driven to support women during what they felt to be a vulnerable time, these professionals had translated their passion into offering professional guidance to women, many of whom could not obtain health information elsewhere. Further, they acknowledged the importance of collaborating with community leaders to bring local women and health services together. Feeling strongly that peer support services should be tailored to the requirements of local communities and should complement the work of clinical perinatal mental health services, the professionals in this evaluation epitomise what it means to act as a change agent for the improvement of equity in maternal health care.

Recommendations and next steps

Taken together, the findings from this evaluation have highlighted two key points. First, they provide a prime example of what good looks like when it comes to perinatal peer support. The MTG aligns fully with the Perinatal Peer Support Principles (Maternal Mental Health Alliance 2019) and has provided a safe, inclusive environment for women — particularly those among the most at risk of PMH problems. Second, they demonstrate the need for an integrated perinatal service in which access to high quality and culturally appropriate peer support of the type offered by the MTG is routinely offered alongside clinical PMH services. The following next steps could help ensure the future success of the MTG in supporting women in the perinatal period (Figure 1).

Figure 1. Recommendations and next steps



Authors

Christina Brown, Founder and CEO, The Motivational Mums Club, www.motivationalmumsclub.co.uk. Chrissy has been recognised by the Prince and Princess of Wales for her work within the community to support Black mothers with their mental health through her peer support group, Mummas Together Group.

Dr Michelle Peter, social scientist and research fellow with experience spanning over a decade. Co-author of the largest study on Black women's experiences of UK maternity care, she is committed to working on projects that address and aim to improve racial health inequalities, particularly within maternal health. She is an advocate for equity across academic spaces and in health care services, and is keen to highlight the importance of inclusive research practices for allowing the voices of underrepresented communities to be heard.

For more information on this topic see MIC database Search Packs: P198 Perinatal mental health; MS75 Culturally sensitive maternity care; P30 Social support in pregnancy; PN157 Social support in the postnatal period.

References

Amankwaa LC (2003). Postpartum depression among African-American women. *Issues in Mental Health Nursing* 24(3):297-316.

Andersson L, Sundström-Poromaa I, Wulff M, Aström M, Bixo M (2004). Implications of antenatal depression and anxiety for obstetric outcome. *Obstetrics and Gynecology* 104(3):467-76.

Bauer A, Parsonage M, Knapp M, Iemmi V, Adelaja B (2014). *The costs of perinatal mental health problems – report summary*. London: Centre for Mental Health, LSE Personal Social Services Research Unit. https://www.centreformentalhealth.org.uk/wp-content/uploads/2018/09/costsofperinatalsummary.pdf [Accessed 16 December 2024].

Care Quality Commission (CQC). *Safety, equity and engagement in maternity services*. https://www.cqc.org.uk/publications/themes-care/safety-equity-engagement-maternity-services#intro [Accessed on 7 April 2022].

Edge D, Baker D, Rogers A (2004). Perinatal depression among black Caribbean women. *Health and Social Care in the Community* 12(5):430-8.

Fawcett EJ, Fairbrother N, Cox ML, White IR, Fawcett JM (2019). The prevalence of anxiety disorders during pregnancy and the postpartum period: a multivariate Bayesian meta-analysis. *Journal of Clinical Psychiatry* 80(4):18r12527.

Ford E, Roomi H, Hugh H, van Marwijk H (2019). Understanding barriers to women seeking and receiving help for perinatal mental health problems in UK general practice: development of a questionnaire. *Primary Health Care Research & Development* 20:e156.

Grigoriadis S, Graves L, Peer M, Mamisashvili L, Tomlinson G, Vigod SN, Dennis CL, Steiner M, Brown C, Cheung A, Dawson H, Rector NA, Guenette M, Richter M (2018). Maternal anxiety during pregnancy and the association with adverse perinatal outcomes: systematic review and meta-analysis. *Journal of Clinical Psychiatry* 79(5):17r12011.

Harrison S, Pilkington V, Li Y, Quigley MA, Alderdice F (2023). Disparities in who is asked about their perinatal mental health: an analysis of cross-sectional data from consecutive national maternity surveys. *BMC Pregnancy & Childbirth* 23:263. https://doi.org/10.1186/s12884-023-05518-4 [Accessed 9 November 2024].

Howard LM, Molyneaux E, Dennis CL, Rochat T, Stein A, Milgrom J (2014). Non-psychotic mental disorders in the perinatal period. *Lancet* 384(9956):1775-88.

Jankovic J, Parsons J, Jovanović N, Berrisford G, Copello A, Fazil Q, Priebe S (2020). Differences in access and utilisation of mental health services in the perinatal period for women from ethnic minorities—a population-based study. *BMC Medicine* 18:245. https://doi.org/10.1186/s12916-020-01711-w [Accessed 9 November 2024].

Jardine J, Walker K, Gurol-Urganci I, Webster K, Muller P, Hawdon J, Khalil A, Harris T, van der Meulen J on behalf of the National Maternity and Perinatal Audit Project Team (2021). Adverse pregnancy outcomes attributable to socioeconomic and ethnic inequalities in England: a national cohort study. *Lancet* 398(10314):1905-12.

Knight M, Bunch K, Felker A, Patel R, Kotnis R, Kenyon S, Kurinczuk JJ (*eds*.) on behalf of MBRRACE-UK (2023). *Saving Lives, Improving Mothers' Care Core Report - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2019-21*. Oxford: National Perinatal Epidemiology Unit, University of Oxford. https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2023/MBRRACE-UK_Maternal_Compiled_Report_2023.pdf [Accessed 9 December 2024].

Littleton HL, Breitkopf CR, Berenson AB (2007). Correlates of anxiety symptoms during pregnancy and association with perinatal outcomes: a meta-analysis. *American Journal of Obstetric Gynecology* 196(5):424-32.

McIntosh J (1993). Postpartum depression: women's help-seeking behaviour and perceptions of cause. *Journal of Advanced Nursing* 18(2):178-84.

McLeish J, Redshaw M (2017). Mothers' accounts of the impact on emotional wellbeing of organised peer support in pregnancy and early parenthood: a qualitative study. *BMC Pregnancy & Childbirth* 17:28. https://doi.org/10.1186/s12884-017-1220-0 [Accessed 16 December 2024].

Maternal Mental Health Alliance (2019). *Five principles of perinatal peer support: what does good look like?* https://maternalmentalhealthalliance.org/media/filer_public/14/07/1407d3ad-148a-4f8b-b2fc-320946761396/mind-mcpin-perinatal-peer-support-principles-full-mmha-web.pdf [Accessed 12 November 2024].

Matthews RJ, Draper ES, Manktelow BN, Kurinczuk JJ, Fenton AC, Dunkley-Bent J, Gallimore I, Smith LK (2022). MBRRACE-UK Collaboration. Understanding ethnic inequalities in stillbirth rates: a UK population-based cohort study. *BMJ* Open12(2):e057412. https://doi.org/10.1136/bmjopen-2021-057412 [Accessed 16 December 2024].

Mind (2024). *Perinatal anxiety*. https://www.mind.org.uk/information-support/types-of-mental-health-problems/postnatal-depression-and-perinatal-mental-health/perinatal-anxiety/ [Accessed 15 June 2024].

Muglu J, Rather H, Arroyo-Manzano D, Bhattacharya S, Balchin I, Khalil A, Thilaganathan B, Khan KS, Zamora J, Thangaratinam S (2019). Risks of stillbirth and neonatal death with advancing gestation at term: a systematic review and meta-analysis of cohort studies of 15 million pregnancies. *PLoS Medicine* 16(7):e1002838. https://doi.org/10.1371/journal.pmed.1002838 [Accessed 16 December 2024].

Mauthner NS (1997). Postnatal depression: how can midwives help? *Midwifery* 13(4):163-71.

National Institute of Mental Health (no date). *Perinatal Depression*. https://www.nimh.nih.gov/health/publications/perinatal-depression# [Accessed 15 June 2024].

Netsi E, Pearson R, Murray L, Cooper P, Craske M, Stein A (2018). Association of persistent and severe postnatal depression with child outcomes. *JAMA Psychiatry* 75(3):247-53. https://doi.org/10.1001/jamapsychiatry.2017.4363 [Accessed 16 December 2024].

NHS (2019). *The NHS long term plan*. v1.2. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf [Accessed 15 June 2024].

NHS England (no date). *Perinatal mental health*. https://www.england.nhs.uk/mental-health/perinatal/. [Accessed 25 June 2024].

Parvin A, Jones CE, Hull SA (2004). Experiences and understandings of social and emotional distress in the postnatal period among Bangladeshi women living in Tower Hamlets. *Family Practice* 21(3):254-60.

Peter M, Wheeler R (2022). The Black maternity experiences report: a nationwide study of Black women's experiences of maternity services in the United Kingdom. *Five x More* www.nhsbmenetwork.org.uk/wp-content/uploads/2022/05/TheBlackMaternityExperienceReport.pdf [Accessed 9 November 2024].

Prady SL, Pickett KE, Gilbody S, Petherick ES, Mason D, Sheldon TA, Wright J (2016). Variation and ethnic inequalities in treatment of common mental disorders before, during and after pregnancy: combined analysis of routine and research data in the Born in Bradford cohort. *BMC Psychiatry* 16(99). https://doi.org/10.1186/s12888-016-0805-x [Accessed 9 November 2024].

Rice C, Ingram E, O'Mahen H (2022). A qualitative study of the impact of peer support on women's mental health treatment experiences during the perinatal period. *BMC Pregnancy and Childbirth* 22(689). https://doi.org/10.1186/s12884-022-04959-7 [Accessed 12 December 2024].

Sambrook Smith M, Lawrence V, Sadler E, Easter A (2019). Barriers to accessing mental health services for women with perinatal mental illness: systematic review and meta-synthesis of qualitative studies in the UK. *BMJ Open* 9(1):e024803. https://doi.org/10.1136/bmjopen-2018-024803 [Accessed 16 December 2024].

Shalaby RAH, Agyapong VIO (2020). Peer support in mental health: literature review. *Journal of Medical Internet Research Mental Health* 7(6):e15572. https://doi.org/10.2196/15572 [Accessed 16 December 2024].

Sokol R, Fisher E (2016). Peer support for the hardly reached: a systematic review. *American Journal of Public Health* 106(7):e1-8.

Thomson G, Cook J, Crossland N, Balaam MC, Byrom A, Jassat R, Gerrard S (2022). Minoritised ethnic women's experiences of inequities and discrimination in maternity services in North-West England: a mixed-methods study. *BMC Pregnancy and Childbirth* 22(958). https://doi.org/10.1186/s12884-022-05279-6 [Accessed 16 December 2024].

Watson H, Harrop D, Walton E, Young A, Soltani H (2019). A systematic review of ethnic minority women's experiences of perinatal mental health conditions and services in Europe. *PLoSOne* 14(1):e0210587. https://doi.org/10.1371/journal.pone.0210587 [Accessed 9 November 2024].

Woody C, Ferrari A, Siskind D, Whiteford H, Harris H (2017). A systematic review and meta-regression of the prevalence and incidence of perinatal depression. *Journal of Affective Disorders* 219:86-92.

Wroblewski M, Tallon D (2004). Implementing a comprehensive postpartum depression support program. *AWHONN Lifelines* 8(3):248-52.

Brown C, Peter M (2024). MIDIRS Midwifery Digest, vol 35, no 1, March 2025, pp 8–18.

© 2024 Motivational Mums Club.