What’s so special about peer support for mums and dads?

Pregnancy, birth, coping with a small baby – it’s so new that parents can find themselves completely bewildered. They may be full of joy one minute, and overwhelmed by stress the next. They may have many questions, and difficult decisions to make such as on infant feeding, or drinking alcohol.

Who can they turn for support? Ideally, it would be someone who really understands their situation, because they have been there too. Someone who can offer help and information. But this peer support can often be missing. This is why it is so exciting to see how NCT and other organisations are building peer support for new parents. Training of volunteers to support others in their own communities has been a long-standing interest of NCT - see our latest examples, the ‘Maternity Champions’ in Queen’s Park and Old Oak, London, and breastfeeding peer support around the UK.

Mental health is a growing concern and is specifically addressed through peer support programmes including NSPCC’s Pregnancy in Mind, as well as through internet chat forums.

As these examples reveal, it’s important that peer support is rooted in a strong evidence-base. But peer support is not easy to define or to deliver, owing to the complex factors at play. Interpreting the research evidence, therefore, can be very challenging.

There is also new support for NCT practitioners, in the form of group reflective support for sharing and learning from experiences, and the opportunity to undertake NCT doula training to provide direct support to mums (and partners) during birth.

Please let me know your comments and your ideas for future issues.

Julie Clayton, Editor, NCT Perspective
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Next issue: Perinatal mental health – September 2016
Shona Gore, tutor and head of NCT’s New Development team, tells Julie Clayton about her role shaping training at NCT, and the importance of community-based peer support for parents

**How did you get started with NCT?**

I was working as a nurse at St. Thomas’s hospital when I had my first child. But living outside London, the cost of travel etc., meant that I would have no income left if I went back to work. And once I’d had my daughter I didn’t want to go back to work and was a very happy stay-at-home mum. Later I wanted to do something that fitted round family life so trained through my local Ascot NCT branch to work as an antenatal teacher.

In the mid-90s I became co-chair of ‘Teachers’ Panel’, a group of very feisty women, who were overseeing the development and quality of NCT antenatal education panel membership was purely voluntary. Because of my role on Teachers’ Panel I became involved with the development of accredited training for NCT practitioners with the University of Luton (later Bedfordshire). It was unchartered territory for NCT and for a new university who weren’t quite sure how to work with a charity like us. There were many ups and downs which sadly resulted in the development team being reduced to three- Nina Smith, Mary Nolan and I. Not being an academic my task on this team was to maintain a focus on practitioner skills and keeping the new training grounded within NCT ethos. From this work my passion for pioneering and nurturing new ideas was born!
Why did NCT decide to have university accreditation?

NCT practitioner training was honed and polished by some amazing women over the second half of the last century. Many brought learning and skills from education, counselling and varied health professions so that the training offered to our student practitioners was excellent. However it lacked the rigor of consistent and reliable assessment. It seemed unfair for them not to get recognition for their hard work or to be able to demonstrate this on a CV. We weren’t just taking women returners and letting them sit in our sitting rooms for a while before throwing them out to work with parents! We were taking them through a process in a good learning environment, and employing highly recommended adult education techniques.

What is your role with the New Developments team?

The NCT College New Developments team has only existed for three years, but before that I had been involved in developing a lot of new training courses, such as an access course (PEAP) for people wanting to do NCT practitioner training or the NCT degree to prepare people to become Assessors or Tutors. My role is often the strategic planning, design and course writing before handing a new project over to different tutors to implement. I really enjoy looking for something new to develop within NCT, working with other departments at NCT in order to ensure that there is a market for the service and to ensure the quality of the service. This includes supporting really good grassroots ideas from our very creative practitioners.

How did the Birth and Beyond Community Support project come about?

This was a marriage of two things: after publication of the Department of Health’s Birth and Beyond report I joined an expert reference group which was tasked with implementing the report recommendations. The group also included Mary Newburn from NCT Research, and Mary Nolan from the University of Worcester. It was a really rich team of scientists, psychologists, psychiatrists, FNP nurses, health visitors, looking at antenatal and perinatal education, and led to the Preparation for Pregnancy, Birth and Beyond (PBB) toolkit, with evidence-based recommendations for antenatal education. Part of my role was to work with other organisations around the country who were training peer supporters to work in the perinatal period, such as ‘Altogether Better’ in Sheffield, and Parents 1st in Essex, to see how they were applying some of the PBB recommendations. Separately, the NCT breastfeeding counsellors had developed an excellent peer-support training programme that predated PBB. Putting these together, the PBB toolkit and our own breastfeeding peer support training, we knew that we could support people in the transition to parenthood with a community-based peer support programme. This would train peer supporters who would volunteer in the community and give messages that were strongly rooted in research. Our funding bid was successful, and so I co-wrote the training programme for Birth and Beyond.
Community Support (BBCS) training, together with Mary Nolan. Maura Clarke and Kay Cram. The latest example of our BBCS work is the programme running in Queen’s Park and Old Oak, London (see report by Vanita Bhavnani). At this time, NCT also decided to use the PBB themes to develop our PBB Essentials antenatal course, which is a more syllabus-based course, rooted in research, which could be offered to the NHS and children’s centres as well as NCT clients. Essentials is now growing healthily alongside our regular Signature antenatal course. However, NCT currently reaches only around 10% of the population, and so we need to find ways of reaching a bigger demographic.

How did you develop the community-based peer support training?

The idea was to train a group of 16 practitioners who could offer peer support training to cohorts in different areas, each area with a different focus for outreach. We would train women volunteers as peer supporters, to go back into their own communities and attend a playgroup or other gathering and support mothers in the transition to parenthood.

We worked in Huddersfield with refugees and asylum seekers, in Catterick, Yorkshire, with young mums whose husbands were in the services, in Liverpool with the Asian community, and in Birmingham with a mixture of black and ethnic minority groups and some refugees and asylum seekers. These were all start-up projects in which the support was tailored to the needs of the different communities. But these needs were incredibly varied, and it was a steep learning curve for everyone involved. Some volunteers had had very difficult experiences and needed to debrief as parts of the course triggered memories. Some of them had never been educated about their own bodies, or about the processes of birth. Birth happened to them, which for some was horrendous. Some volunteers had had to leave their children in other countries, or had escaped and lost their children in the process. And having arrived in Britain, some were being moved from hostel to hostel - a chaotic lifestyle that made life difficult for them.

Was this the situation for the volunteers as well as for the women you were hoping to help in the different communities?

Yes – the women we wanted to train as peer supporters were ones who could befriend and support other women going through a similar experience, to whom she could offer empathy and friendship.

How useful were the lessons learned from NCT’s own breastfeeding peer support programme?

We definitely drew from the experiences of the breastfeeding peer supporters, especially their training in listening skills, setting of boundaries, and signposting. NCT tutor Maura Clark had been involved in the training of the trainers for the breastfeeding peer support, her input was invaluable.
What were the results of the BBCS pilot programme?

Once our practitioners felt confident in delivering training, and once we’d got things working between the operations side and education side, it began to work really well. Each of the four areas developed its own personality and moved forwards. The Catterick group has since set up a charity in order to continue beyond our pilot programme, while in the other areas we trained a lot of peer supporters who went out to work in their communities. The pilots were a success – there was so much learning. In Birmingham one woman said to me ‘I would never have sat in a room with people from these different places and listened to their stories. I’m just amazed by what they’re going through. This is the most decent thing I’ve ever come across.’

When the pilot ended NCT was unable to fund the programme going forward.

NCT is now once again training community peer supporters in London

I happened to attend a seminar where I met a woman from Queen’s Park, London, who told me about plans to set up training for ‘Maternity Champions’. I described our BBCS training and it turned out that this was exactly what they were looking for. They were looking for accredited training in order to try to get their volunteers into education programmes or work. They obtained funding and commissioned us to train community-based volunteer peer supporters for parents during pregnancy and in the postnatal period (See report in this issue by Vanita Bhavnani). This has now been recommissioned to continue up to October 2016, with a ‘bolt-on’ breastfeeding peer support training. The development of this combined BBCS and BFPS course has been a great step forward in NCT’s peer supporter training programme, thanks to the work of Isabelle Karimov, Sophie Macfadyen and Maria Dowden.

What is the key to success of these programmes?

From the evaluation of the various BBCS pilots (including the pilot in Newcastle) what works best for NCT is to provide the training, and for recruitment and management of peer support volunteers to be done by whoever has commissioned us rather than for us to go in cold. If we work with groups set up by housing associations or possibly councils, for example community champions, we provide training for their maternity champions who can then provide effective support for parents in their area.

What is the broader take-home message from these programmes?

The take-home message is that the core peer supporter training is great! Next we need to consider other themes which will support parents in the First 1,000 Days (for example perinatal mental health), and combine this learning with our basic course. Our next goal will be to make this work on a bigger scale in many communities throughout the UK.

An additional benefit for the peer supporters — and ultimately for their communities — is that NCT’s peer support training enables them to get an OCN Level 2 qualification which helps with job applications, access to
further education, and possibly university. What’s also exciting is that at many meetings I now see people referring back to the PBB research and guidelines. Many charities are following the PBB model. The NSPCC’s Baby Steps course, for example, is absolutely rooted in it, and many health visitors have had PBB training and are offering PBB-type support. The evidence is growing the whole time, and I feel very privileged to be meeting people who are pushing the barriers and working with programmes that are informed by PBB.

PBB is now a piece of research that is embedded in everything we do at NCT.

References


What are doulas and what do they do?

Providing practical and emotional support to both mothers and their partners during the birthing process, doulas often fill a gap in care that arises when midwives and other health professionals have to focus on clinical duties. NCT doula training prepares students to take on this role, according to Cynthia Masters-Waage, Miriam Schofield and Natalie Misaljevich.

Seven years ago, NCT embarked on the training of birth doulas. At the very heart of this programme was the desire to enhance the experience of women and their partners on their journey to parenthood. It was the first NCT course to be offered in partnership with the University of Worcester, and has led to the qualification of over 50 doulas. Anyone who is a trained NCT practitioner or who has attended our Access to NCT training course is eligible to apply. The nine-month course involves four weekend training sessions in Worcester, monthly telephone tutorials, 24-hour midwifery observation, a supervised birth and ongoing support from the NCT.

The course involves:

- Highly experiential sessions in a mock hospital ward which give participants a chance to look, use, touch, and gain practical hands-on experience
- Support and supervision throughout the programme
- Tutors with many years’ experience of working as NCT antenatal teachers and as birth doulas
- Developing understanding and self-awareness through reflective practice and application of research-based evidence.
Participants view challenging videos of birth, observe the role of the midwife on a labour ward, and discuss and reflect on what a doula can and should be. Tutors and students also take part in role play exercises that model situations and dilemmas that can arise during the perinatal period, and explore practical techniques like massage, rebozo, acupressure, and simply imagining what it feels like to be with someone in labour.

Here, we provide you with our reflections on the role of a doula:

• following the experience of working as a doula and tutoring student doulas (Cynthia Masters-Waage), and
• following recent immersion in the NCT doula training (Miriam Schofield and Natalie Misaljevich).

What do doulas do?
The practical aspects of what a doula does for parents will change with every mother or couple that she supports. But whatever a doula is asked to do, she will in some way be filling the gap left by busy midwives overwhelmed with managing often two or three births at once, or restoring ‘the role of women helpers in the birth experience’.

As birth in this country has moved from home to hospital, and society has become more fragmented with extended family networks no longer the norm, we have lost this vital support for women giving birth by other women whom they know, and who have given birth themselves. Fathers partly fill this gap but cannot replace the calm reassurance of a trusted woman who has been through birth herself, especially if the fathers are alarmed and overwhelmed by seeing birth for the first time.

Why might parents need doula support?
Wherever possible, enabling a woman to be her own advocate is preferable to being an advocate for her, as it gives her strength — she is empowered to deal with issues herself. As Clarke says, the key to a positive birth is not so much what happens, as that women are involved in the decision-making. And corroboration in decision-making leads to improved self-esteem. Doulas can support women to make and act on informed decisions, which is particularly important when maternity care is shaped by a culture of fear that is contagious and passes from worker to worker and on to women.
• before birth
A doula can provide parents with crucial information about the birth, birth options, and possible interventions that may be offered. One first-time mother was told that she would need to have a syntocinon drip, without any discussion about what this was, why it was necessary, any alternatives, or possible risks. However, it is also essential that a doula realises that her own views about another woman’s pregnancy or birth are not the only possible views, nor are they superior to anyone else’s.8

• during birth
A doula can play a key role in reducing maternal anxiety. In one observation, a first-time mother was very anxious and was failing to progress into active labour despite her waters having broken the night before. She needed the emotional ‘holding’ environment which a doula can provide to enable her to relax, letting her body do what she needed it to do.3 Although her midwife was aware of the need for a calm birth environment and the removal of the mother’s anxiety, she was not able really to ‘join with’ the mother, empathising and experiencing the birth with her, as the clinical aspects of the birth had to be her priority.9

• after birth
Doulas understand that how a woman is treated during pregnancy and birth can have a long-lasting and profound impact on the rest of her family life.3 Caring for, protecting and nurturing the women and families in her care, are founding principles guiding a doula’s work. Midwives, particularly, are likely to start out with similar aspirations, but their duties to provide clinical care, and the context and settings in which they work, can impact on their ability to care in this way.10

Women with continuous support from a trained birth companion who is neither a family member nor a friend, and is there solely to provide support, are less likely to use pain relief, and have shorter labours resulting in spontaneous births; their babies are more likely to have good Apgar scores at five minutes after birth. Crucially, these women are also more likely to feel satisfied with their births.11

• with partners
A doula can also enable a birth partner to be more relaxed and involved in a calm, loving way.3 This will increase both the woman’s and her partner’s oxytocin levels, promoting a sense of intimacy and connection between them,12 which may account for the finding that women report better relationships with their partners, and their babies, when they birthed with a doula.11

What is most challenging for a doula?
It is challenging for a doula to hear about and see care that is not woman-centred, and which causes women distress. Sometimes it elicits anger at a system and type of care that fails women and families at such a vulnerable and momentous time in their lives. It may leave us feeling frustrated or impotent — wishing we could do more. And it can remind us of our own distressing experiences and reopen old wounds. These are strong and difficult emotions to deal with.

Natalie Misaljevich
But is the doula approach enough?
To effect change a political context is needed. Midwives — and ergo doulas — can’t do it by themselves. Since at least the time of the Department of Health’s report *Changing Childbirth* the policy drivers for women-centred care have existed. What is needed now is for women and maternity workers to join together and form a ’strategic alliance’. As a doula, I would like to encourage the families I work with to give feedback to their caregivers about their experiences, and to engage with initiatives like the Positive Birth Movement, which is successfully uniting women, challenging the culture of fear, and raising expectations. I shall also continue to relay families’ voices, and work for change through MSLCs, and by building relationships with maternity professionals.

It is important that a doula has realistic expectations of herself and others, understands and respects the differences in roles and responsibilities, and works within their boundaries. Indeed, ’A doula’s success depends on her ability to get along with a diverse group of hospital staff members.’ Stepping over boundaries is likely to bring conflict into the birth room and may be detrimental to the woman’s birth. Simkin says that ’sometimes the best interests of the mother are served by avoiding conflict rather than by resolving it’. This means influencing what we can control, letting go of what we can’t, accepting the constraints of the situation and focussing on helping the woman deal with the here and now. These are also raised as important coping strategies for birth companions themselves.

Partners need support too!
A doula’s job is first and foremost to support the mother, but she is also there to support the partner. A doula is often the person in the room who has the experience and knowledge readily available to help the partner be more involved and less anxious. She can help make sure that all the good ideas planned beforehand actually get tried!

Here are some tips for working with the partners of pregnant women.

<table>
<thead>
<tr>
<th>Ten do’s</th>
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<tbody>
<tr>
<td>1. Ask if there are specific ways the couple would like you to support the partner.</td>
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<tr>
<td>2. Explain specifically when you will be on call and what that means. Are there events in the diary that are causing anxiety?</td>
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<tr>
<td>3. Explore what preparations have been made, where support and information are coming from, and the partner’s expectations.</td>
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<tr>
<td>4. Explain that in order to get into a rhythm of working well together, why it’s helpful to meet at home first during labour.</td>
</tr>
<tr>
<td>5. Plan how you will work with the partner, eg. check details around cord cutting, fears, health needs, dreams, family experiences, and around specific tasks such as loading car, making play lists, sorting the car park and bags.</td>
</tr>
<tr>
<td>6. Prepare in case of boredom, hunger, grumpiness or fear (it’s a bit like mothering!).</td>
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</table>
A doula should watch her manners, boundaries and innuendos.

'The doula ate my chocolate and flirted with my husband!' 'Would have been better if she’d facilitated my husband’s involvement – but that’s the precise opposite of what she did!'

7. Appreciate that partners do not always want to hold the baby straight away. Help to protect their need to adjust to the wonder of what has just happened.

8. Prompt sharing of the news when the baby arrives and help to take photos suitable for mass distribution. Babies aren’t weighed straight away, to allow mother and baby time together skin to skin. Offer suggestions of what else to share, such as ‘she’s cuddled up with her mummy,’ or, ‘I got to put his first nappy on and when she goes for her shower I will dress him.’

9. Talk to the couple after the birth about whether there is food and drink in the fridge for the lone arrival home?

10. Listen to both stories of the birth at the postnatal visit. They may be quite different and often the partner’s experience is overlooked. Talking and sharing can make everyone feel positive.

Three don’ts
1. Don’t ‘take over’. This is their birth, their baby, their relationship.
2. Don’t assume the partner wants the best birth experience ever.
3. Don’t make the partner feel uninvolved and anxious for it all to be over.

Don’t forget the laughter
One of the joys of working with partners is sharing the humour of the labour room:

A man to his partner labouring in the pool, ‘What can I do to help?’ he asks. ‘Get in here and do this,’ she replies. He chuckles, I smile, she shouts at us, ‘You think I’m joking!’ He and I are suitably chastened but we still smile and I then encourage him to get on with pouring water gently over her back.

Cynthia Masters-Waage

This article includes extracts of reflective essays by NCT doula students Miriam Schofield and Natalie Misaljevich, on ‘The dimensions of the role of a doula’.

References


The role of peer support in perinatal anxiety and depression

There is a growing evidence-base for the use of peer support with a wide-range of populations during pregnancy and the early years. This article gives an overview of peer support approaches in parents experiencing anxiety and depression in the perinatal period, drawing on current research and models of best practice.

Background
The NSPCC explored the role of peer support in perinatal mental health when we developed our new Pregnancy in Mind programme. The programme aims both to minimise the impact of anxiety and depression directly on parents, and support them in their relationship with their babies. It was developed in recognition of the lack of services for mothers and fathers who experience anxiety and depression in pregnancy, particularly those with mild or moderate...
problems. We were concerned about recent research showing that 60% of cases of perinatal anxiety and depression go undetected, and many of those that are detected fail to receive evidence-based forms of treatment.\(^1\) NSPCC commissioned a literature review of the most effective interventions for mild to moderate anxiety and depression in the perinatal period, from which the following five themes were found to have the most promising evidence-base:

- Mindfulness
- Active relaxation
- Psychoeducation and cognitive behavioural coping skills
- Mind-mindedness parent-infant approaches
- Peer-support

Each of these themes was built into the two core elements of Pregnancy in Mind:

- an **antenatal group intervention** of up to eight sessions delivered by professionals during pregnancy;
- monthly **peer support drop-in groups** delivered by a team of volunteers, from point of referral up until the end of the postnatal year.

### Common structure for Pregnancy in Mind Groups

- **'Coming into the room'** exercise
- **Welcome and ground rules**
- **Active relaxation or mindfulness activity**
- **Check-in** - This follows the active relaxation and mindfulness activity, to reduce arousal and enable participants to access and process their feelings well.
- **Short break**
- **'Coming into the room'** exercise
- **Learning activity** - A chance for parents to build their knowledge about pregnancy, parenting and mental health and how to promote wellbeing.
- **Reflections and take-home message**
- **Informal peer support time** – An informal but no less important moment for parents to talk to one another and do a relaxing craft activity. Many parents can find it easier to talk if they are also focusing on another activity.

All group sessions were designed to be two hours long. There is no prescriptive session-by-session programme, but instead practitioners and peer supporters use a toolbox of exercises based on the programme’s themes of mindfulness, active relaxation (controlled breathing, yoga-informed stretch and massage), psychoeducation, cognitive behavioural coping skills, and parent-infant relationships. This framework creates a consistent, containing structure that parents come to expect, and allows practitioners and peer supporters to be flexible and meet the needs of the parents and their babies in the room.
It was also very important to decide the vision, purpose and ethos for involving volunteers in Pregnancy in Mind. Was it to be a professionally-led service delivery model with predefined and prescriptive volunteer roles? Or would it be a model of citizen involvement that enables members of the community to work together, share ideas and support each other to achieve a shared outcome?

The latter model aims to mobilise citizens through social action volunteering, and owing to compelling evidence for its benefits, was proposed for Pregnancy in Mind. Whilst volunteers keep within agreed role boundaries, they act as informal advocates and intermediaries and are actively encouraged to contribute new ideas in response to the strengths and needs of their communities. This article will discuss the peer support aspect in more detail.

**What is the evidence-base for peer support in perinatal mental health?**

Meeting and making friends with other new parents is the main reason why many parents attend antenatal programmes. Social support is important for parents’ emotional wellbeing, and protects against poor mental health. Its importance across the perinatal period has led to more research and practice around the effectiveness of peer support programmes, for example, the giving of assistance and encouragement by an individual considered equal. Peer support programmes are based on the premise that information is better received when given by a peer, or someone whom you feel has personal experience of similar difficulties to yourself. According to research evaluation, peer support programmes can protect against developing postnatal depression, reduce symptoms of stress, and relieve loneliness and isolation.

**What is the best way to set up a high-quality peer support programme?**

In order to answer this question, Parents 1st conducted a literature review that focused on programme organisation and implementation. Previous literature reviews have largely focused on whether or not a programme works rather than on how; one of the few examples identifying what aspects can make a difference is Moran et al. The Parents 1st review is therefore based on a somewhat patchy literature base, drawing on reviews and studies that focus at least in some part on implementation and good practice examples of peer support for people with mental health difficulties, for parents, or breast-feeding mothers. We did not find any studies of programmes focusing in particular on peer support for new parents who are vulnerable to mental health difficulties, and we found no rigorous studies that examine the link between programme implementation and outcomes.

The following components were identified as being important to ensuring high-quality implementation of peer support programmes.

1. **An operational hub**

Programmes appear to benefit from having a well-resourced, professionally staffed ’operational hub’ which manages all aspects of the programme e.g. volunteer recruitment, training, deployment and supervision; liaising with local health professionals; marketing, evaluation and quality monitoring. Ideally this would include a paid professional, with relevant expertise, plus
administrative support. Other models include a specialist providing ongoing support while day-to-day responsibility rests with a programme coordinator.\textsuperscript{7} This central team can be supported further by having a physical space in which to host the programme. Programmes embedded within other services, such as Children’s Centres, benefit from having access to the physical and administrative infrastructure of the service e.g. crèches and venues, as well as from clear referral routes between services and the programme. The physical space also helps peer supporters to develop relationships between themselves and with professionals in the same location.\textsuperscript{8}

2. Recruiting and selecting volunteers
Recruitment requires consideration of the skills and attributes of an effective peer supporter and whether these skills and attributes are a prerequisite for recruitment or can be enhanced through training.\textsuperscript{10} Overall, it appears that the capacities and attributes of peer workers are more important than personal experience, or being ‘from the area’, although the importance of these should not be underestimated.

Individuals may be deterred from volunteering by lack of confidence, fear of losing welfare benefits, and recruitment processes that are too formal, bureaucratic or disproportionate to the role.\textsuperscript{8,11} Anecdotally, the most successful recruitment methods appear to involve word of mouth, such as community networking activities or presenting to local community groups.\textsuperscript{11,12,13}

3. Training and development
Appropriate training is essential for an effective programme. One consideration is the importance of developing the personal and relational skills that are the cornerstone of effective peer support,\textsuperscript{8} as well programme specific knowledge, for example, around content or code of conduct, safeguarding, and boundaries.

Informal learning approaches may be helpful in overcoming anxieties arising from negative experiences of formal education for some volunteers. Learning can be enhanced by hands-on and experiential approaches, such as role-play, the opportunity to share experiences, and interactive or arts-based methods. Running training in tandem with ‘on the job’ experience can be helpful for peer supporters as it provides a forum in which to reflect on issues encountered while providing support.\textsuperscript{8,11,14} A staged, or ‘chunked’ approach to training can also be useful as those who leave before training ends can still take away discrete learning, while those who wish to can progress to more advanced levels.\textsuperscript{15}

Continuous development of peer supporters is vital in order to maintain programme quality, motivate ongoing engagement, develop skills, and provide support.\textsuperscript{8,11,16} Training events may also be an opportunity for peers to share experiences and enjoy mutual support.\textsuperscript{15} Different development models include shadowing, buddying or regular training sessions.

Training can also offer a progression pathway into more formal education for some peer supporters, or into a paid role.\textsuperscript{11,12} Progression pathways may also facilitate retention of peer supporters on the programme.
4. Supervision
Supervision is another facet of continuous development as well as an important means of managing risks, providing support, clarifying roles, expectations and boundaries, and identifying areas for development. Lack of effective supervision and support can lead to demoralisation among volunteers and departure from the programme. Programmes vary in their approach to supervision e.g. one-to-one, group, peer-to-peer, or a combination. Supervision is also particularly important in peer mental health programmes in enabling peer supporters to stay well.

5. High quality day-to-day delivery
There is some debate as to the extent to which peer support services should follow a structured programme or be more flexible in responding to the individual needs of the parent. Overall, there needs to be a balance between the two, with a structured approach, including materials for parents, which a skilled peer supporter can use flexibly and confidently in response to need. Wherever the balance lies, relationship building is central. Indeed, the relationship between peer supporter and parent is key to achieving positive outcomes. Important attributes for the peer supporter to have therefore include: social and communication skills, empathy, commitment, openness to learn, self-regulation and coping skills.

Managing boundaries can be complex for some peer supporters, for example, mental health peer supporters who are former service users and alongside those they are now supporting. Guidance is therefore needed on how to maintain boundaries, manage distinctions between peer support and social relationships, and handle risk and confidentiality.

Managing relationships with local health professionals can also be complex and challenging. Issues can include, lack of acceptance by health professionals and managers, lack of professional support for peer workers, lack of understanding of the programme or concerns about its quality, and reluctance to refer to the programme.

6. Ensuring retention of peer supporters
High turnover of peer supporters represents a loss of expertise, and may affect the programme’s quality and resources, for example, diverting resources to the recruitment and training of new peer supporters. Retention strategies include: regular supervision and informal support and mentoring, free training, reimbursement for expenses, social events, and progression opportunities. Some programmes also offer peer supporters financial remuneration. Payment, however, requires careful consideration as it raises a number of issues such as impact on the programme ethos and peer–client relationship, implications for peer supporters on benefits, equality between peer supporters, and costs.

6. Monitoring and evaluation
To illustrate the impact of peer support programmes requires a clear evaluation strategy which takes into account the programme’s ethos, aims and time frame. The evaluation should not, for example, intrude upon or upset the relationship between peer supporter and parent; it should include appropriate measurements such as long-term social outcomes, and secure the co-operation of peer supporters in, for example, completing relevant forms. Evaluation should also involve suitable expertise and resources.
Pregnancy in Mind: an example of high quality peer support

In Pregnancy in Mind, peer supporters maintain social networks developed within the antenatal practitioner-led group by facilitating contact between group members in the postnatal period. We hope that peer supporters will help to engage and provide better support for vulnerable parents-to-be who might otherwise have reservations about joining the group and talking about their mental health. They also help to sustain the positive impact of the programme and embed it within local communities.

1. An operational hub

A volunteer manager will oversee the peer support element including recruitment, training and management of peer supporters. They will also play a key role in managing any cases where safeguarding concerns are raised, and be an advocate for the service. Peer supporters will be part of the wider Pregnancy in Mind team and based at a service centre.

2. Recruiting and selecting volunteers

Rather than having a particular professional skill or background, peer supporters will need a range of skills and qualities which enable them to engage effectively with parents and communicate compassionately. The staged recruitment process will involve informal conversations, reference and DBS checks and a personal values-based interview.

3. Training and development

During recruitment, volunteers will complete a pre-training e-learning course on safeguarding. Subsequent training is designed to be delivered over a series of 15 x two hour sessions, but could be divided into two or three full weekends. Social activities are included for team cohesion.

4. Supervision

Peer supporters receive face-to-face supervision with their volunteer manager every four weeks and have the opportunity to attend their own peer support volunteers’ coffee mornings every eight weeks.

5. High quality day-to-day delivery

Peer supporters receive their own toolbox of activities to use with parents in informal postnatal ‘meet-ups’. These are designed to encourage and build further parents’ own ability to ‘tune in’ to their infant’s thoughts and feelings.

6. Ensuring retention of peer supporters

Peer supporters are not paid, however, they do receive regular supervision, mentoring, free training, reimbursement for expenses, social events, and progression opportunities.

7. Monitoring and evaluation

We are evaluating the impact of the programme through assessing volunteer satisfaction, changes in self-esteem, and moves to paid employment.

For more information go to: www.nspcc.org.uk/pregnancyinmind

Summary

There is a growing evidence-base for the use of peer support with parents experiencing perinatal mental health difficulties. However to ensure the best outcomes for both the peer supporters themselves and the families they are working with, close consideration needs to be given to how such programmes are set up and delivered.
References


Championing peer support

In London’s Queen’s Park and Old Oak areas, ‘Maternity Champion’ volunteers are supporting local families, helped by NCT’s Birth and Beyond Community Peer Support training. It is not only the parents who benefit — the volunteers have also experienced very positive outcomes, reports Vanita Bhavnani, Senior Research and Evaluation Officer.

The Queen’s Park and Old Oak areas of London are among the capital’s most deprived wards, with more than 50% social housing. They have a concentration of social problems, for example child poverty and domestic abuse, particularly around the Mozart Estate in Queen’s Park. And both areas have a large number of immigrant residents, mostly from Africa (including Somalia and Eritrea), the Middle East (including Syria) and South Asia (including Bangladesh).1,2 A consultation with local residents highlighted, among other issues, the need for guided support for parents, many of whom felt isolated or had experienced difficulties with accessing maternity and other services due to language barriers, lack of knowledge or unfamiliarity with the healthcare system.

‘There are a lot of cultural and language barriers. A lot of people are not aware of what the best advice is, so the work of the Maternity Champions is to raise awareness about maternity services, eating, exercise, dental health.’

Ted Flanagan, PDT Senior Manager for Community Programmes
In response to the consultation, the Paddington Development Trust (PDT) and Old Oak Community and Children’s Centre began a joint two-year pilot trial of a group of Maternity Champion volunteers, with the aim of providing guided peer-to-peer support: signposting to antenatal and postnatal services and creating opportunities for local parents to meet and bond so that they felt less isolated. The pilot was funded by Tri-borough Public Health (a partnership between Westminster City Council, Hammersmith and Fulham Borough Council and Kensington and Chelsea Borough Council), as part of their commitment to early intervention and supporting ‘the best start in life’.

NCT Birth and Beyond Community Support (BBCS) training

The NCT BBCS training and model of service delivery was developed during a large-scale pilot in four areas of England in 2011-2014 and was specifically designed to engage with, and support, families who are vulnerable or who are from communities that experience exclusion. The 30-hour course, facilitated by a NCT practitioner-trainer, leads to a Level 2 award from the Open College Network and trains volunteers to offer empathy and encouragement to parents. Volunteers also learn about local support services to which they can signpost parents confidently. They develop listening skills and focus on the importance of maintaining confidentiality and boundaries when providing support.

PDT was keen to develop a skilled cohort of Maternity Champion volunteers specialising in providing peer support for pregnant and new parents during the perinatal period, and saw that NCT BBCS training suited well their vision and wider aim of focusing on early intervention as a means of tackling health inequalities. According to Ted Flanagan, PDT Senior Manager for Community Programmes, PDT had the team of Maternity Champions on the ground, and links with Children’s Centres, but no expertise on maternity support. He reported, ‘the fit with BBCS training was perfect.’

Training of Maternity Champions

Eleven Maternity Champions completed the NCT training. All were mothers themselves living in the Queen’s Park and Old Oak communities. They were between 27 and 56 years of age and came from a variety of ethnic backgrounds: Black or Black British, Arab, Asian and White British. Carmella Obinyan, the Coordinator for Maternity Champions in Old Oak, describes many of the Maternity Champions as having come from ‘hard-to-reach’ communities.

There was no specific training package. We would bring in experts to give talks for example on postnatal depression, weaning… but we needed something bespoke around working with parents.

Emma Sweeney, PDT Project Coordinator

‘Maternity Champions come from the community. Some of them are hard-to-reach women themselves. We define them as women who did not finish their education, isolated or young mums who don’t have a lot of confidence. Some have had social services involvement around their children and some are living at home with their parents because they don’t have access to housing.’

Carmella Obinyan
Impact of the training

The Maternity Champions were highly motivated and wanted to undergo the training in order to help parents in their community and help themselves to progress to further study or paid employment. All Maternity Champions described their training as either good or excellent. They valued the interactive nature of the course and the skills of NCT trainer Isabelle Karimov. One said, ‘I really enjoyed the course. I felt engaged and switched on. It was very enlightening on many levels. The trainer was good, patient and supportive.’

This comment reflects the tone and content of most other feedback; there was very little negative feedback. Some Maternity Champions did, however, say that they would have liked the training to last longer, and found the task of completing OCN workbooks to be repetitive and onerous.

The BBCS training has also resulted in a number of positive benefits for the Maternity Champions, both in being able to support parents more effectively and personal development.

Understanding the peer support role

NCT’s evaluation showed that the BBCS training has made a big difference to the Maternity Champions’ understanding of the peer support role, and their knowledge and skills. In particular, all eleven Maternity Champions said that they understood better the need to listen and not talk about their own experiences, the importance of providing information rather than advice, how to maintain boundaries during support, and the importance of building trust through confidentiality.

Confidence in supporting parents

The key impact of the BBCS training has been to raise the Maternity Champions’ confidence in supporting parents. All felt more ready and confident to provide support. Several commented on how the training has helped them relate better to parents and to feel more confident in extending support to dads and other family members.

‘Learning the knowledge makes you feel better about everything as it covered not just the mum but the father and extended family.’

‘We learnt so much that was new... instead of giving advice we gave information.’

Maternity Champion

‘I have learned techniques to be able to be openly attentive whilst listening e.g. friendly nodding gestures to acknowledge what is being said, good eye contact, attention to detail, showing mindfulness, empathy, using supportive language and all the time reassuring and giving comfort and information. I learnt that we can encourage trust through confidentiality.’

Maternity Champion

‘Watching the girls, I can see a big difference, the way they interact with people now... they approach women with empathy, listening and not feeling they have to have all the answers. They are more confident.’

Emma Sweeney – PDT Project Coordinator at Queens Park
Personal development
Maternity Champions have also progressed in other ways: three have won places on access-to-midwifery courses; four have undertaken NCT Breastfeeding Peer Support training and are supporting mothers on postnatal wards at Queen Charlotte’s Hospital and St Mary’s Hospital, London; another six are on the waiting list for this training; one Maternity Champion is now in paid employment at a Queen’s Park Children’s Centre. For others, the training has motivated them to think about future training.

‘It’s given me the incentive to think about what I want to do for myself. It’s opened more doors, so I could consider midwifery or nursing and more studying. It has given me a vision about what you can do for yourself.’

Impact on parents
Parents have benefited considerably in both Queen’s Park and Old Oak. Maternity Champions have supported parents at a postnatal drop-in group and a baby weighing clinic, and informally as part of their daily lives. More support activities are planned in order to reach a larger number of pregnant parents.

It is too early to know the full impact that the support of Maternity Champions has achieved but 26 parents, including mothers and fathers attending a Queen’s Park drop-in group supported by Maternity Champions, have given positive feedback, with indications that parents enjoy the group and having contact with the Maternity Champions. The majority 92% (n=24) report that they have benefited from contact with the Maternity Champions, that they were good at listening (96%) and understanding (91%). They feel more confident and reassured about parenting, less isolated and more positive (85%). A large proportion of parents (80%) also reported that the Maternity Champions have helped them to access relevant local services. Several comments made by parents include:

‘All the Maternity Champions are good. When you come here they know your name and are really welcoming. They offer you tea and coffee and we’ve not had that before anywhere else. This is the most attended compared to other places locally.’

Dad
'I feel a lot more confident and a better parent because [of hearing] different points of views from other people. Obviously the Maternity Champions are trained, so I get more information.'

'I was lonely and low but once I started coming here, it made a difference. At first it was hard to come here because [the baby] wasn’t sleeping. I didn’t know anyone in the area, I had just moved and now because of this group and talking other mums and the Maternity Champions, I make sure I come. They recognise you and take an interest in you and the baby, and you can talk and get help.’

’Here, no one is going to judge you and now I feel confident about being a parent. When I first had my son, the professionals made all the decisions and I was being told how to feed my baby but when I came here, they said to do what’s best for you and your child and you feel like you have the leading role and I feel I have a say as a parent.’

’When I was concerned about breastfeeding, [the Maternity Champions] gave me leaflets and encouraged me to keep going.’

PDT and the Old Oak Community and Children’s Centre hope that further funding will be obtained so as to continue this valuable service beyond 2016.

Acknowledgements
The commissioned NCT Birth and Beyond Community Support training was evaluated by the NCT Research and Quality Team. NCT would like to thank the Maternity Champions, project coordinators from Queen’s Park and Old Oak, local parents, NCT staff and the PDT Community Programmes Manager for taking part in the evaluation.

References
Coming to a hospital or community centre near you!

Jon Down, formerly NCT Grants and Bids Manager, and Anna Maddox, Head of NCT Healthcare Business Department, give the low-down on what’s available

Looking for breastfeeding peer support, antenatal classes or a Baby Café? NCT’s Commissioned Services could provide just the right thing. Our goal in the Commissioned Services Team is to provide support to the most vulnerable parents across the UK by persuading public health providers to buy NCT services. It might be a Scottish Health Board, it might be a Clinical Commissioning Group (CCG) or, as is increasingly the case, it might be a Public Health Team at a local authority. The landscape is ever changing – all the more so as responsibilities for health outcomes continue to move out of the NHS. Sometimes we achieve commissions through discussions and negotiations but increasingly we undertake the often complex, process of competitive tendering.

Although we sell a comparatively small range of products the permutations are many and varied. Sometimes the buyer has something very specific in mind and knows precisely what they are looking for, sometimes we can be more creative in what we propose. It all depends on the requirements of the person charged with spending the authority’s money – the Commissioner.
For example, a commissioner may wish to establish a Breastfeeding Peer Support programme, which we can deliver either on the ward or in the community. Alongside this they may also be looking for a programme of antenatal classes, perhaps some Baby Cafés and maybe a Breastfeeding Welcome Scheme too. If it’s for the Department of Health’s Preparation for Birth and Beyond (PBB) programme then the focus might be on a particular locality and a particular priority group, such as young parents or parents from a black or ethnic minority. There may be a local issue to consider, such as the emotional resilience of parents.

However, what is common to all our services is a focus on vulnerable parents and marginalised communities. In Leicester, for example, we are running a breastfeeding peer support project in areas where breastfeeding initiation rates are as low as 37% (compared to the UK average of 81%)\(^1\) and where prevalence at six to eight weeks is only 19% (UK average, 55%).\(^1\) We are tasked with supporting young mothers (under 20 years old) in particular, for whom drop-off rates are almost three times those of mothers over the age of 35.

Likewise, initiation rates in the most deprived communities in Glasgow are as low as 16% - some of the lowest in the UK. Mothers here are three times less likely to breastfeed than mothers from Scotland’s wealthiest areas.\(^2\) Here we are delivering peer support programmes and Baby Cafés in three of the most deprived districts in the west of Scotland. We’ve also trained volunteers to support mothers of babies at the Yorkhill Hospital neonatal unit, both on the ward and afterwards in the community, and we’ve been running a peer supporter-led Mother’s Milk Club at Glasgow’s Princess Royal Maternity Hospital, Royal Alexandra Hospital and Southern General Hospital.

Peer supporters report that what mothers value most from them is their ability to listen, be approachable and offer practical and emotional support.\(^3\) For example, at the Queen Elizabeth University Hospital (formerly known as the Southern General Hospital), one peer supporter described supporting new mums in getting their babies to latch on: ‘I have] never had a mum who didn’t want me there. Think I have a good approach… showing the laid back/biological position.’

**‘We had a wee baby two weeks ago born at 39 weeks, really small for her age. She was one day-old when I saw her. Went back two weeks later and can’t believe how well she is doing - I thought that she might not make it. When I first met [the mother] she hadn’t expressed. I took her to the postnatal ward, showed her the expressing kit, how to set it up and what to expect - not much milk at first. I went back two weeks later and she was there doing skin-to-skin and her baby, although still wee, was doing really well. She was really thankful for all my support - so good to see her doing so well.’**

**Glasgow neonatal unit peer supporter**

Initial contact between supporters and mothers may be by telephone or online. One peer supporter at a Glasgow Baby Café recalled how she initially made contact with a mum via Facebook. ‘She was worried that she didn’t have enough milk and I encouraged her to come along to the group and said that I would meet her there. Her baby is four months old now; she is still...”
breastfeeding and still comes to the group and has made friends. She said to me the other day that she doesn’t know if she would have continued if I hadn’t encouraged her to come to the group.’

It is often critical that we recruit and train volunteer peer supporters who share the life experiences and concerns of women in these communities. They are genuine peers who can truly connect with local mothers and make a real difference to their breastfeeding journeys. It’s vital too that we provide practical and emotional support for the peer supporters — many are vulnerable mothers themselves.

Typical of some of our service users is a 15-year-old new mum on our Preparation for Birth and Beyond course in Hampshire. Frequently subjected to domestic abuse from her on/off partner (who is well-known to the police for a variety of reasons) in recent years she had rarely attended school. Her own mother was a young mum and went on to have a large family.

We introduced the 15-year-old to a mentor who was also a young mum (aged 19) and who had previously attended one of our PBB courses. They met at the first session, clicked instantly and contact one another regularly through Facebook. The 15-year-old tells us that the support has been invaluable.

Some commissioners are very interested in something called Social Value. The 2012 Social Value Act requires ‘public authorities to have regard to economic, social and environmental well-being in connection with public services contracts’. Commissioners define this in different ways but those interested in the economic and social well-being of volunteers (especially those from marginalised communities) score our services particularly highly. A peer supporter, for instance, can train at NCT College as a breastfeeding counsellor. We regularly see peer supporters who have earned Open College Network (OCN) credits through our peer support training course gain further qualifications or paid work, including as midwives or other health professionals.

One peer support volunteer whose first language was not English struggled so much with the written part of the training course (accredited to the OCN) that she wanted to stop. After receiving further support from her trainer, and additional time to complete the course, she has proceeded to become one of our most effective volunteers.

NCT volunteers also experience broader benefits. In a recent peer support training programme 83% reported having made new friends, 74% said they had improved self-confidence and self-worth, and almost half felt they had better job prospects after volunteering for NCT.

In Peterborough, Michelle Hoard gained confidence from her training to become a breastfeeding peer supporter: ‘The biggest challenge for me was learning how to listen. I thought I was quite a good listener, until we started doing all the role plays. The hardest thing was trying not to solve every problem. As a peer supporter, we are there to listen, provide signposting and empower the mother to find her own solution… That’s a big mind-shift for me. I’ve spent most of my career in media and marketing where you are positively encouraged to solve problems and come up with ideas.’
Over the years the relationship with a commissioner can become more of a partnership. In Peterborough we first worked together with the Primary Care Trust in 2007 on an NHS-funded pilot to train breastfeeding peer supporters. Since 2008 we've supported work towards the UNICEF Baby Friendly Initiative (BFI) accreditation both in the community and Peterborough and Stamford Hospitals. We oversee the recruitment, training, placement and reflective practice of peer supporters across the city.

NCT also facilitates one of the four Baby Cafés in the city - the others are led by health visiting teams and community nursery nurses. The Baby Cafés are spread across Peterborough in Children’s Centres, a school and a shopping centre. Working together we ensure that the Baby Cafés operate on different days throughout the week so that breastfeeding mums can choose a time that most suits them and have the option to take part in more than one a week.

As Henrietta Ewart, Interim Director of Public Health, says ‘Our local breastfeeding rates in Peterborough at six to eight weeks have continued to increase in recent years and are being sustained and improved through the approach we have adopted with NCT and local partners.’

Of course, it’s unwise to attribute directly increases in breastfeeding initiation and prevalence rates to any single intervention. What we can do, though, is look at the intensity of our programmes. In a two year period in East Lancashire, for example, we recruited, trained and supported 110 volunteers who carried out over 1500 support interactions. Or, to put it another way, in a recent quarter 25 volunteers donated a total of 270 hours supporting some 500 mothers.

We can look, too, at the impact of a programme on individual mothers. Within two months of deployment of twelve peer supporters in Glasgow we had supported over 100 mothers. 75% of babies were seen by a peer supporter when they were under two days old, with a quarter of mothers helped by a peer supporter on the day of the birth. All except two mothers reported that they were happy with the support that they had received and 97% said it had made a real difference in their breastfeeding journey.

We know also about the impact, course by course, service by service. Figures from a PBB service in Walsall, one of the most deprived areas of the West Midlands show:

- 94% of parents starting a PBB course complete it;
- 86% of parents report courses as ‘excellent’, 12% as ‘good’;
- By the end of a course 96% of parents report feeling either confident or very confident about labour, birth, caring for and feeding baby and becoming a parent;
- The percentage of parents attending one course reporting that they knew about how to improve their own or their partners’ physical and mental health rose from 27% (before the course) to 96% (by the end of the course);
- 91% of parents attending now know a lot about the importance of a father or another caring adult being involved with the baby.
What really counts for us in the Commissioned Services team is the difference we make with parents in communities up and down the country. While our day-to-day work is all about competitive tendering, expressions of interests and service specifications, and while our time is taken up with percentages, budgets and measuring social value, what drives us is the need to secure funding to enable NCT to reach more vulnerable parents.

NCT Commissioned Services is a small team working on opportunities across the UK so we’re always on the lookout for anyone who can help give us that extra edge, that competitive advantage. Maybe you’ve got some powerful stories that show how NCT turns things around for individual families. You might have that crucial piece of local intelligence that will convince the Commissioner that NCT has the best solution. Perhaps you can link us into the key networks in your local area so that we talk to the right people. If you think you can help us next time there is an opportunity in your area we’d love to hear from you. Get in touch with anna.maddox@nct.org.uk.

References
Spotlight on research

The impact of epigenetics in pregnancy – low birth weight, stress and salutogenesis

Mary Newburn, intrepid lay person, attempts to find out something about epigenetics

Epigenetics for the uninitiated! Prompted by a meeting organised by the Royal Society of Medicine’s (RSM’s) Maternity and Newborn Forum*, I rashly offered to write this piece. I have very limited knowledge on this subject, but the forum is multidisciplinary so I figured presentations should be understandable to an intelligent lay person with a reasonable grasp of midwifery. I generously thought I could pass on a beginners’ guide to NCT colleagues. I fear that others would be much better placed than I am to do this, as I came away feeling a bit overwhelmed. But, undaunted, and with Google at my fingertips, this is my introduction to the subject.


Epigenetics and low birth weight

The study of epigenetics is being used to try to explain, or better understand, the causes of conditions such as obesity, coronary artery disease, hypertension, and type II diabetes; diseases that are becoming increasingly common, and which tend to affect people in middle age and beyond.

The theory of evolution is fundamental to epigenetics. We know that species are successful when they adapt to dramatic changes in their environmental conditions. In particular, it is essential for the developing fetus and newborn infant to be able to survive and thrive, and for young to stay alive long enough to reproduce and protect their offspring until they can function independently.

Evolution over time has led to a rich variety in the genome (an organism’s complete set of DNA, including all of its genes) and flexibility of the programming of genes. These forces operate to support reproduction and life into adulthood, with adaptions being made to reduce exposure to risk and to promote life. But the survival of the species is not dependent on health beyond thirty or forty years of age. Indeed, some of the changes and processes that support successful survival in infancy or youth may be detrimental as we age.
The Barker hypothesis refers to a seminal British epidemiological study of coronary artery disease in 100,000 men and women born from 1911–1930. Men with the lowest weights at birth and at one year had the highest death rates from ischaemic heart disease. It seems that the body adapts to its environment, setting up fundamental changes to metabolism. Thus, if there is a switch from pre- and postnatal malnutrition to a later abundance of calories, this could be harmful to a person who was programmed to a low nutrient or low calorie diet at a young age. In addition to heart disease, low birth weight is associated with adult-onset hypertension and type II diabetes.

What is epigenetics?

The term epigenetics refers to heritable changes in gene expression (active versus inactive genes) that does not involve changes to the underlying DNA sequence; a change in phenotype without a change in genotype. This in turn affects how cells read the genes. Epigenetic change is a regular and natural occurrence but can also be influenced by several factors including age, the environment/lifestyle, and disease state. Epigenetic modifications can manifest as commonly as the manner in which cells terminally differentiate to end up as skin cells, liver cells, brain cells, etc. Or, epigenetic change can have more damaging effects that can result in diseases like cancer. At least three systems including DNA methylation, histone modification and non-coding RNA (ncRNA)-associated gene silencing are currently considered to initiate and sustain epigenetic change. New and ongoing research is continuously uncovering the role of epigenetics in a variety of human disorders and fatal diseases.

Source: [http://www.whatisepigenetics.com/fundamentals/](http://www.whatisepigenetics.com/fundamentals/)

Epigenetics and prenatal stress

Vivette Glover, Professor of Perinatal Psychobiology, who spoke at the RSM meeting has studied the impact of maternal stress during pregnancy on children. She emphasises how significant the prenatal period is for babies’ brain development and suggests that exposure to stress and anxiety, family discord, wartime conflict or acute disasters may have a long-term impact. Following Barker, Glover argues that ‘fetal programming’ takes place in utero, a process in which epigenetic changes occur. These are functionally relevant modifications to the genome which change expressions of the genes. This process, known as methylation, occurs through the addition of a methyl group to a DNA strand, which turns particular genes on or off but does not affect the underlying DNA structure.

Glover argues that epigenetics can help to explain the finding that the 15% most anxious women in the Avon Longitudinal Study of Parents and Children (ALSPAC), had children with a 10-15% increase in behavioural problems and poorer IQ scores at 17 months. She says that exposure to additional cortisol (stress hormone) triggers cortisol receptors and disruption to gene expression. However, she argues, these changes are modifiable by maternal behaviour in the postnatal period. Children with sensitive mothering and
better attachment are protected, and those with (persistent) insensitive mothering, who experience increased fearfulness show increasingly disrupted behaviour, so there are strong reasons to back social policies and community activities that generate psycho-social support for mothers. There is some research that links learning from experimental animal studies with human studies, such as one that has examined brain changes post-mortem following deaths by suicide, comparing the genetic expressions of those with a known history of child abuse with those of people without a known traumatic childhood. Glover’s team of researchers present epigenetics for a lay audience at http://www.beginbeforebirth.org/the-science/epigenetics

**Epigenetics and salutogenesis**

The last and most engaging speaker of the evening was midwife researcher, Professor Soo Downe. Downe is interested in salutogenesis, or the factors that enable people to stay healthy and promote well-being, rather than factors that cause disease. Downe is part of an international, interdisciplinary research collaboration looking at the epigenetic impact of childbirth (EPIIC). They hypothesise that events during the intrapartum period - specifically the use of synthetic oxytocin, antibiotics, and caesarean section - affect the epigenetic remodelling processes and subsequent health of the mother and offspring. There is some evidence that vaginal labour and birth may programme babies to respond differently to stress experienced later in life, and protect against onset of type I diabetes, multiple sclerosis and obesity. Can science do more than show an association? Can the correlations be explained causally? Well, potentially. Downe cites laboratory studies showing differences in DNA methylation in the cells of infants born vaginally compared with those born by caesarean, suggesting that labour, and indeed a long labour, may cause more (protective) methylation, the switching on (or off) effect. However, results are mixed.

Downe emphasised, *We know that the physiological process of labour matters*, but was refreshingly candid about the current limited state of knowledge. Indeed, the key message of the evening from all speakers was that there was a need to go on building the evidence. My own summing-up would be: if epigenetics doesn’t give you fatal brain ache, it is really very interesting. Also, as you will appreciate if you tackle the definition in the box above, it helps enormously to have a good grounding in biology and chemistry.

**Key points**

- Epigenetics is a relatively new area of scientific knowledge and there are many unanswered questions.
- Many of the experimental studies have been performed using animals, often rats or mice, and the impact of epigenetics for humans is still not well understood. Nevertheless, epigenetics is considered fundamental to understanding the development of environment-sensitive diseases, and indeed protection from conditions as diverse as asthma, diabetes and cancer.
References


Mary Newburn is a consultant, health researcher and public & parent involvement (PPI) lead for Maternity theme, King’s College London, CLAHRC South London. Follow Mary on Twitter @marynewburn1
Online peer support for perinatal mental health

Donna Moore discusses how visiting online forums may help women deal with the stigma of perinatal mental illness and disclose to health professionals

This article considers some of the ways many women with perinatal mental illness use internet resources for peer support. It provides an overview of internet resources available for perinatal mental illness support and examines in more depth online peer support, particularly the role of online forums, which has important implications for recovery. I explore the potential of online forums for challenging stigma and encouraging disclosure to healthcare professionals in the context of my PhD research.

The internet and perinatal mental health

Mental illness during pregnancy and after childbirth (perinatal) is a global health concern. Perinatal mental illness includes affective disorders such as depression, anxiety, post-traumatic stress, obsessive compulsive disorder and postpartum psychosis. Approximately 10-15% of pregnant women and new mothers are diagnosed with perinatal mental illness, which has well-documented negative consequences if left untreated. While this article focuses on women, perinatal mental illness can also occur in new fathers, and can be detrimental to the whole family. Unfortunately, many women with
this illness do not get the help they need despite its availability, one reason being stigma. The internet could be a useful tool in helping women to access the help they need anonymously, thus circumventing any possible negative outcomes associated with stigma. Indeed, it might be the first place some women look for information and support when experiencing distress.

A Google search on ‘postnatal depression’ will yield over 2 million results.

There has been a rapid growth in online forums for peer support in recent years, allowing individuals to receive, as well as offer, support from others who are in, or have been in, a similar situation. I initially reviewed 114 websites on postnatal mental illness for quality and content, after searching via the four main search engines. I included websites that were exclusively dedicated to postnatal mental illness or had substantial information on postnatal mental illness. Rating scales were developed with a senior researcher, forum users and using high quality information including DSM-IV-TR. Scales measured information (symptoms, risk factors and impact on the family), resources for women (self-help tools and online support) and website quality (for example, presentation and navigation). My results led to identification of the five high-scoring websites providing information for healthcare professionals, and five top sites healthcare professionals could recommend to women looking for online resources.

When I started my PhD in 2009, websites for antenatal mental illness were largely absent, but now there is a multitude of antenatal resources available. Internet resources are also beginning to emerge for men with perinatal mental illness, as well as for men supporting women with the illness. My second project was an interview-based study with women who used the internet to assist their recovery from postnatal mental illness, including for peer support, which led to my interest in online forums.

What is online peer support for perinatal mental illness?

Online peer support is like face-to-face peer support except that women contact others through computers, or other electronic devices, and can interact virtually. As they do not have to leave their home in order to get support, there are obvious advantages for pregnant women and new mothers. Online peer support for parents has similar benefits to face-to-face support, and is available through forums (also known as message boards or online support groups), online chat rooms, personal messaging, email and various social media sites, such as Facebook and Twitter. These online communities allow people with similar health concerns to connect with each other. They can be quite general, for example ‘antenatal and postnatal mental illness’, or more specific, for example ‘birth trauma’.

How does online peer support work?

Women can read forum posts and start and/or contribute to existing conversations, or threads. Visitors sometimes have to sign up to become a member, but this rarely involves more than creating a password, supplying an email account (normally not visible to others) and agreeing to the forum
terms and conditions. Twitter supports online communities such as one run by Rosey, a survivor of perinatal mental illness. Women can access each other’s posts, or ‘tweets’ by creating a Twitter account and either including the tag #PNDChat in their posts or by replying to others’ posts. Contributors vary from current sufferers to recovered women, and healthcare professionals often participate. There is a weekly topic regarding perinatal mental illness every Wednesday between 8pm and 9pm. This can be found by searching #PNDHour, #PNDChat or following @PNDandMe.

‘The Birth Trauma Association is a closed group, posts are not visible to non-members, and it is a safe space for women to express feelings and fears they may feel they cannot share with friends and family. Women can find our closed group simply by searching Facebook for Birth Trauma Association and requesting permission to join the group.’

Gwyneth Eanor — group administrator

What makes this online peer support popular?
Forums offer support day and night and are easy to access through a wide range of technology, such as computers, mobile phones and tablets. Some women find it valuable to have access exactly when they need to, for example, while out, or in the middle of the night when other forms of peer support may not be available. This is particularly important if there are no available resources in the local community or if they are waiting for professional help.

‘Often women are left waiting for formal support/therapy such as counselling etc so having access to online peer support can really help bridge that gap and offer hope for recovery.’

Rosey @PNDandMe

My interview study revealed that women felt supported even if they did not post online. In fact, several women said they benefited from just knowing others were there should they wish to ask for support. One of the most commonly cited advantages was that they could access information and support from others without being identified. Unfortunately, many women with mental illness feel stigmatised, so anonymity was valued as a way to overcome this barrier to seeking peer support.

‘Peer support and advice are just a few clicks away. I can honestly say that peer support via #PNDChat has been such a huge factor during my recovery.’

Anonymous #PNDChat

The stigma of mental illness
Mental illness has long been associated with negative beliefs, such as an affected person being dangerous.9 Although many campaigns exist to reduce stigma (some with exceptional online coverage, for example Time to Change) many people feel that the general public still hold stigmatised
attitudes towards individuals with a mental illness. This is often termed external stigma. Conversely, internal stigma occurs when an individual takes on this stigmatised belief and applies it to themselves. This can happen even if they do not necessarily agree with the external stigma. Both types of stigma can have negative consequences for an individual such as social exclusion, lowered self-esteem and avoidance of disclosure.\textsuperscript{10,11}

**The stigma of perinatal mental illness**

For women and families the issue can be more complicated, as women not only have the stigma of mental illness, but also of being a mother with a mental illness. This can lead to debilitating feelings of inadequacy as a mother, and guilt about failing their child. It can exacerbate symptoms and lead them to conceal their illness because they do not want to be seen as, or feel like, a ‘bad mother’.\textsuperscript{12} This ‘bad mother’ idea is common in the literature that explores women’s feelings of perinatal mental illness stigma.\textsuperscript{13}

With this in mind, my colleagues and I conducted a deductive systematic thematic analysis of posts on an online forum for antenatal/postnatal depression on Mumsnet.\textsuperscript{14,15} We found that many women posted in order to get advice from others about their symptoms, and asked if they should tell a healthcare professional. Many women struggled with stigma and described feeling like a ‘bad’ or ‘failed’ mother and had concerns about being stigmatised should they disclose to a healthcare professional. The vast majority of replies encouraged women to disclose, seek help and take treatment. Many replied that they had overcome the stigma and taken this advice. The forum discourse presented an alternative ideology of perinatal mental illness as compatible with being a mother, especially if the woman sought professional help and adhered to treatment.

‘It gave me the courage to speak out and realise that suffering in silence wasn’t good for me, speaking to these like-minded people saved me.’

*Anonymous #PNDHour*

Whilst there are scales that measure stigma associated with mental illness in general and specific illnesses (e.g. depression), research suggests that perinatal mental illness stigma is distinct from stigma attached to solely depression or anxiety.\textsuperscript{12} However, there is no known scale that measures perinatal mental illness-related stigma. I developed a 30-item draft scale from a literature review to measure this unique form of stigma and tested it with 279 women with perinatal mental illness.\textsuperscript{16} The final 15-item City Mental Illness Stigma Scale (City MISS) had a three-factor structure: perceived external stigma, internal stigma and disclosure stigma. The scale appeared to be a valid measure that could serve as a useful tool for clinical practice and research. I have used this scale to investigate the role that online forums may play in reducing stigma and, in turn, increasing disclosure to healthcare professionals.\textsuperscript{17} It is vital to continue research on interventions to reduce stigma and promote disclosure to healthcare professionals, which is often the first step in women’s recovery.
Forums may promote the idea that you can be a good mother and have perinatal mental illness. This way of thinking may challenge stigma and enable help-seeking behaviour in some women.

Disclosure to healthcare professionals
My research suggests that online forums have the potential to increase disclosure by helping women to recognise stigma and challenge it.\textsuperscript{14,17} Within forums, women may describe positive experiences with healthcare professionals; they can test out disclosing their illness on the forum; they can learn how to describe their symptoms to others; and can be encouraged by other members to talk to their healthcare providers. Nonetheless, there are some concerns about using forums. Moderators can promote members welfare and ensure members’ safety by viewing posts and removing any harmful or inaccurate messages. They can also caution and remove members who do not adhere to the forum policy, and lock conversations if they become hostile. Policies and moderators vary from site to site and may not always be reliable. Some forums are un-moderated, meaning that potentially harmful posts and/or members are not controlled, which could have serious consequences for already vulnerable adults.\textsuperscript{18} However, healthcare professionals may recommend quality and moderated forums and social media groups to interested clients.

‘Forums may promote the idea that you can be a good mother and have perinatal mental illness. This way of thinking may challenge stigma and enable help-seeking behaviour in some women.’

The above research projects have worked towards testing theories of perinatal mental illness stigma, generated from qualitative investigations, and finish with a quantitative online survey to measure the role this has in mediating between forum use and disclosure to healthcare professionals.\textsuperscript{17} My final results (unpublished) suggest that women can explore their feelings by using forums and therefore become more aware of their internal stigma and become empowered to express these feelings to healthcare professionals. Further work needs to be done to consider different forums and test how easily these findings can be generalised to other populations. Future studies could consider the direction of causality: it may be that the women who disclosed were more likely to visit forums rather than forum use itself increasing disclosure behaviour. Overall, these findings have the potential to inform online peer support interventions and I hope to see these theories developed in future in order to help women and their families get the help they need.

Key points
• An increasing number of women are using the internet for peer support.
• Some women may find online forums to be a valuable source of peer support, providing similar benefits to traditional peer support.
• Perinatal mental illness stigma is complex and presents a prominent barrier to disclosure for many women.
• My research shows potential positive outcomes when women engage in an empowering online dialogue that challenges perinatal mental illness stigma.
Peer support through online forums may encourage disclosure to healthcare professionals by promoting the idea that women with perinatal mental illness can still be a good mother, and increase their recognition of internal stigma.

Forums differ in safeguarding practices, so it is worthwhile checking if a group has safeguarding policies and an active and reliable moderator/s.

Healthcare professionals could recommend quality and moderated forums and social media groups to interested clients.

References
7. Moore D, Ayers S. Virtual voices: social support and stigma in postnatal mental illness Internet forums. Submitted for publication.
16. Moore D, Ayers S, Drey N. (under review). The City MISS: development of a scale to measure stigma of perinatal mental illness. Submitted for publication
Online peer support links

**Action on Postpartum Psychosis (APP)**
https://healthunlocked.com/app-network

A network of people who have experienced puerperal psychosis and professionals with an interest in the illness, offering a forum for those affected by puerperal psychosis.

**Birth Trauma Association (BTA) Facebook group**
www.facebook.com/groups/TheBTA/?ref=br tf

A closed Facebook group to support people traumatised by childbirth.

**Mumsnet**
www.mumsnet.com/Talk/antenatal_postnatal_depression

A forum for antenatal and postnatal mental illness support hosted by Mumsnet.

**PANDAS Facebook group**
www.facebook.com/PANDASFoundation/?fref=ts&ref=br tf

A well-established and popular closed Facebook group offering peer support.

**Post Natal Illness (PNI.org)**
www.pniorguk.proboards.com

A long-running and popular forum offering peer support for all types of perinatal mental illness with sections for issues such as symptoms, recovery and parenting advice. It enables members to create an online diary on which others can comment. There is also a chat room where members can send private instant messages to each other.

**Twitter @PNDandMe**

Follow Rosey on Twitter to get updates and encouragement. Search #PNDhour and #PNDChat to access peer support and see conversations regarding many aspects of perinatal mental illness.

Donna Moore is a PhD student at City University, London. She has been researching perinatal mental illness and internet forum use for the last seven years and has presented her findings at several international conferences. Donna’s background is in counselling and she looks forward to finishing her doctorate this summer.
Peer support: how do we know what works?

Heather Trickey, NCT Senior Researcher and Research Associate at DECIPHer, Cardiff University, considers challenges to interpreting the evidence base

What is the idea behind peer support?

Peer support interventions engage people who have had personal experience of an emotional, social or health issue to provide non-professional help to others who are facing a similar issue (see box). Peer support interventions recognise that some forms of help are more acceptable and/or more effective when the relationship is not a professional one. They also recognise that not everyone can find the informal help they need from within their existing networks and that sometimes there is a need to bridge the gap between support from family and friends and the health service.

The idea of enabling ordinary people to feel confident to help one another, drawing on their own experience, has been applied across health care settings and underlies the core work of many voluntary organisations, including NCT. Dennis'1 talks about a spectrum of peer support from para-professionals (lay workers with extensive training) to natural peers (existing friends and family). This breadth is reflected in the work of NCT.1 Antenatal teachers, breastfeeding counsellors, and postnatal leaders are selected for extensive training partly on the basis of their own experience. NCT also provides shorter peer support training courses to enable a greater number...
of parents to help others with respect to specific issues. At the other end of the ‘training’ spectrum, NCT promotes the creation of informal parent-to-parent networks via classes, volunteer groups, shared-experience registers, a national volunteer network and via social media.

### What is peer support?

‘The provision of emotional, appraisal, and informational assistance by a created social network member who possesses experiential knowledge of a specific characteristic or stressor and similar characteristics as the target population’.¹

Commissioners responsible for perinatal and public health increasingly recognise the potential of peer support to improve health outcomes. Currently, NCT is commissioned (i) to provide peer support interventions to help parents from more vulnerable backgrounds (for example refugees and asylum seekers, younger parents, and those who have experienced abuse) along the transition to parenthood, (ii) to provide help focused on feeding a baby and (iii) to improve women’s mental health around the time of pregnancy.

### Bringing the evidence together

Anyone involved in receiving, delivering, designing or commissioning peer support will have an interest in the evidence base, in understanding ‘what works’. A range of approaches to evidence synthesis have been applied to studies of peer support interventions.

**Syntheses of experimental evidence** compare outcomes across studies of people who have been randomly allocated to intervention or to study control groups. The aim is to determine an independent intervention ‘effect’ on pre-specified outcomes. Syntheses can be narrative, or can include statistical combination methods. A finding across several studies that intervention X is (or is not) associated with outcome Y will help to build a picture of intervention strength and generalisability. Researchers will look across studies to explore whether an intervention tends to be more successful when it has particular components (e.g. frequent contacts) or when delivered in particular contexts (e.g. within UK populations), though it is difficult to break down statistical analysis beyond a few categories without losing power. Broadly, experimental studies ask ‘did it work?’ and, on the face of it, this is the question we most want answered.

**Syntheses of qualitative and process studies** draw on interview, focus group, or observational data, perhaps combined with survey data or monitoring information to tell us about the experience of those affected by peer support and to identify factors that help or hinder delivery. They can help to build theory about how peer support is actually working. Qualitative studies may not be linked to a specific peer support intervention. Alternatively, they may be used as the main method of evaluating an intervention, or carried out alongside an experimental study as part of a process evaluation to help researchers interpret experimental findings. Findings from qualitative studies can be systematically combined through review. Qualitative studies and process studies often ask ‘how was the intervention experienced?’ and look at implementation, take-up, idiosyncrasies and unintended effects, to ask ‘what happened in practice?’
**Realist synthesis** is based on the belief that it is nonsense to try to separate out complex interventions, such as peer support, from their delivery context. Realists do not combine studies to look at overall strength of effect, but seek to understand what the underlying processes of change actually are in any given context and why they are triggered in some circumstances and not in others. Realists look to identify changes in the thinking of the people touched by an intervention – the ‘generative mechanisms’ – that cause them to act in ways that they would not otherwise have done, thereby changing the context and so leading to different outcomes. Evidence synthesis occurs through realist review, which incorporates studies of all methodological types in order to develop and test theories about the mechanisms that tend to be triggered in certain contexts. Rather than questioning ‘what works?’ realists ask: ‘how did the intervention work in this context, with this population and in relation to these observed outcomes?’ and ‘what are the transferrable lessons?’

Different approaches to evidence synthesis have their own quality standards and can contribute to our understanding in many ways. An illustration of the various insights that can be drawn from applying different lenses to the peer support evidence base is given in Table 1.

**Table 1. The varied sorts of insights arising from different forms of evidence synthesis around peer support and infant feeding**

<table>
<thead>
<tr>
<th>Review</th>
<th>Purpose and scope</th>
<th>Key insights for peer support delivered in a UK context</th>
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| **Renfrew et al, 2012**<sup>2</sup>  
An international systematic (Cochrane) review of experimental and quasi-experimental studies of all ‘additional support’ for breastfeeding. | To examine the impact of ‘extra support’ on breastfeeding duration and exclusivity compared to ‘usual maternity care’. | Combined lay and professional breastfeeding support can improve outcomes. However, findings were not broken down to country-level. Other insights: face-to-face and ongoing and predictable contacts may be more effective; reactive interventions may not work; tailoring to local needs may help. |
| **Jolly et al, 2012**<sup>3</sup>  
An international systematic review and meta-regression analysis of experimental studies of peer support for breastfeeding. | To examine the effect of intensity (frequency of contacts), timing (antenatal or postnatal) and country-level setting on peer support for breastfeeding. | The findings primarily relate to studies of peer support delivered to individual mothers on a one-to-one basis. Breastfeeding peer support interventions of low intensity (fewer than five contacts) tend not to be effective. Peer support with a postnatal component tended to be more effective. Five experimental studies in the UK have failed to demonstrate positive findings for breastfeeding peer support (at least three were low intensity). |
| **Schmeid et al, 2011**<sup>4</sup>  
An international meta-synthesis of qualitative and survey studies to explore perceptions and experience of professional and peer support for breastfeeding. | To examine women’s perceptions and experiences of breastfeeding support, either professional or peer, to illuminate the components of support that they deemed ‘supportive’. | The type of support perceived to be most effective was that characterised by an ‘authentic presence’ – a trusting relationship and rapport between the woman and her caregiver – and with a ‘facilitative style’ – enabling people to draw on a range of information and experience and learn for themselves. |
**Review**

**Purpose and scope**

**Key insights for peer support delivered in a UK context**

**Dykes, 2005**

A UK-based review of process evaluations of community-based peer support interventions in low-income settings.

To synthesise common themes across peer support projects, highlight innovative ways of delivering services, develop best practice, and illustrate issues related to sustainability.

Primarily relating to group-based peer support, the results indicate that projects will be more successful if they are: aligned to local culture and facilitate local networking; address the needs of health professionals and make time for co-ordination; have clear guidelines for selection, training and supervision of peers and provide training on a rolling basis; market the peer support well and have multiple access points for mothers; embed evaluation; work towards a sustainable funding basis.

**Harris et al, 2015**

A primarily UK-based realist review of community engagement models of peer support to improve health literacy across a range of health topics (including breastfeeding).

To understand the potential of community-based peer support in order to help people understand and act on health information.

Peer support is more effective when local people are involved in design and peers use their autonomy to deliver culturally-tailored support. Peers should have ongoing supervision. Peer support works better to promote health literacy when peers have something in common with participants, get participants involved in social networks to discuss problems, and allow participants to discuss a range of topics, not just health.

**Challenges to interpretation of evidence syntheses**

Interpretation challenges arise because peer support is (i) loosely defined; (ii) complicated, because it involves myriad design decisions; and (iii) complex, because by touching so many people the peer support intervention itself can change the wider context in which it is embedded. The latter may occur, for example, through the incidental up-skilling of relatives and health professionals, or a change in the facilities or focus of an existing organisation due to increased funding. The failure to take these changes into account, and an over-reliance on ‘headline’ findings from reviews, can lead to premature conclusions as to whether peer support can be expected to ‘work’.

**Who is a peer?** The commonly used definition provided by Dennis leaves plenty of room for interpretation. The use of peer support implies that similarities between supporter and supportee matter, as these will help a trusting relationship to form. But what exactly is meant by ‘similar characteristics’? Do we mean social group, local area, age, education, or sense of humour? What sort of length or extent of ‘experiential knowledge’ is necessary? Does a mother supporting another with a perinatal mental health issue need to have experienced the same mental health problem? And does it matter how long ago? How much and what type of training will be necessary to integrate and augment experience? Interventions vary in the emphasis they place on ‘matching’ peers and the extent to which ‘peerness’ is considered an active ingredient in the intervention.

**One-to-one or group-based?** Most experimental studies of peer support are of support delivered by peer supporters to individual mothers on a one-to-one basis. In contrast, much of the perinatal peer support currently delivered
across the UK (some of which has been subject to qualitative and process evaluation) is group-based. At least some element of mutual support is intended to take place between participants who have had no special training but who have been deliberately brought together on the basis of their common and ongoing experiences. These different forms of peer support are likely to work in very different ways and to be subject to different challenges. They will probably require different approaches to evaluation and be associated with different sorts of outcomes. Therefore, we should be cautious in transferring findings from one form of support to another.

**A thousand design differences.** Design decisions are based on many factors: the requirements of commissioners, the literature on effectiveness, hunches and experience of stakeholders about what is valued, and practical and financial constraints. Who should the intervention reach - all the parents living in an area, those experiencing severe problems, mothers in poverty, young mothers? When should the peer make contact with the mother, and how - face-to-face, over the telephone, by text? Should she be proactive or wait for the mother to call, or to turn up at a group? How frequently should the contacts be? And when? Should the peer support training have an explicit underlying philosophy (e.g. person-centred counselling)? Or is there an underpinning conversational approach (e.g. motivational interviewing)? All this variation complicates attempts to bring together findings from experimental studies. Crude stratification according to a small number of design criteria fails to incorporate the full complexity.  

**Context matters.** A peer support intervention will only ever be part of a package of influences that work in favour or against a desired health goal. If we imagine a community-level change in a health behaviour as being like depending on a number of cogs all working together, it will be important to know what other parts of the machine need to be in place before the peer support cog can be turned to produce a change in outcomes. For example, existing high background rates of breastfeeding may be a pre-condition allowing ‘additional support’ to achieve improved rates in the short term.  

It may be that in areas with lower background rates the primary function of peer support is to contribute to a change in the context (such as beliefs, attitudes or resources) that will eventually allow another part of the system to make a sustained difference. Or, it may be that without the right context a peer support intervention will fail to gain traction. Non-experimental studies can help identify the components of context that matter (e.g. existing services, organisational buy-in, local leadership, a legislative framework). The ways in which these components interact that will allow peer support to make a difference.

**Unsuccessful implementation.** Well-conducted experimental studies of peer support are evaluated on the basis of ‘intention-to-treat’, in other words they test whether there was a difference between the intervention study population and the control population, regardless of whether the intervention population actually received peer support as intended. This analytical approach is important because (i) it allows evaluators to understand effectiveness in the real world where implementation challenges have to be overcome; and (ii) it retains randomness of allocation in the analysis, thus comparing like-for-like populations. Several UK experimental
studies of breastfeeding peer support have demonstrated problems with implementation (poor take-up, or insufficient peer-mother contacts) and some have raised questions of ‘contamination’ (the control group receiving some of the intervention) or ‘displacement’ (existing services over-compensating with more support for the control group). When interpreting the evidence from experimental studies it is important to be aware of these problems because they suggest that this intervention may have been difficult to deliver (at least under study conditions) and also that a ‘fair trial’ of the underlying theory of the intended intervention may not have taken place. We can’t know what might have happened if participants had received the intervention as intended.

**Lack of theory of change.** Often reports of peer support interventions do not set out an explicit theory about how the intervention is supposed to work, but will have various hunches, ideas and beliefs. Perhaps the key ingredient is expected to arise directly from the relationship between parent and peer, causing a mother to feel better able to cope with her individual circumstances. If so, how? And why? Alternatively (or additionally), peer support is perhaps expected to lead to better inter-disciplinary working, mutual-problem solving across groups of mothers, raised awareness of an issue within a social network, and wider cultural change. How will we know if the processes we expect are happening in practice? How do we expect different sorts of intermediate outcomes to contribute to end goals? What timescales are appropriate for measuring different outcomes? Absence of a clear intervention theory and poor inclusion of expected intermediate outcomes can lead to a lack of congruence between peer support design, implementation and evaluation in individual studies. It may also lead to very different interventions being inappropriately grouped together for the purposes of review. This can be deeply frustrating for stakeholders who may be left feeling that an evaluation, or review of evidence, has failed to consider all the relevant outcomes, or has drawn an inappropriate conclusion.

**Towards better interpretation**

Evidence to inform the design and delivery of peer support interventions can be garnered from a range of methodological approaches, which can be combined through different forms of evidence synthesis. Findings from experimental studies alone cannot tell us what we need to know about whether peer support will ‘work’. Indeed, given the variety of peer support approaches, trying to answer the simple question ‘does it work?’ may be unhelpful without further specifying what ‘it’ is. Although experimental studies can help us to know whether a certain form of peer support was effective in a given context, difficulties in transferring lessons learned arise from the heterogeneity in intervention design, the complex relationship between peer support and context, common problems with implementation, and lack of theory underpinning the intervention design.

There is a need to break the cycle of under-specification. Commissioners should ensure that descriptions of peer support indicate how the intervention is intended to work and the range of intermediate and longer-term changes that are expected to result in the given context. Interpretation of individual studies will be improved by inclusion of a detailed description of the components of a given intervention and of the usual care context in
which it is embedded, as well as the theories of change that underpin the intervention. The latter should be shared by all stakeholders involved in the giving and receiving of peer support. Ideally local stakeholders should participate in the intervention design, and theories of change reviewed as the intervention becomes embedded. Evaluation should seek to capture intended and unintended processes and outcomes.

**References**


Heather Trickey is a PhD student and Research Associate at DECIPHer, University of Cardiff, and a research manager for NCT. Her research interests relate to the effectiveness, experience and ethics of interventions to improve public health outcomes in pregnancy, birth and early parenthood. Her PhD research explores the theory underpinning community-based interventions which aim to support breastfeeding and other forms of infant feeding.
Alcohol and pregnancy

Helen Castledine reviews the guidance and evidence on what impact alcohol has on the health of women and their babies before and during pregnancy and during breastfeeding. She also considers the impact of guidance, the effectiveness of interventions to reduce alcohol consumption, and the role of NCT practitioners.

UK government guidance on alcohol consumption

On 8th January 2016, UK government guidelines on alcohol consumption changed, following a review, to provide clarity and reflect the current evidence-base. The Chief Medical Officers for England now recommend that as a precaution, pregnant women, or women planning to become pregnant, should consume no alcohol, thereby minimising the risk to the unborn child. The more alcohol consumed the greater the risk. However, the guidance also stresses that the risk is likely to be low for women who have consumed small amounts of alcohol before they knew they were pregnant, or during pregnancy (see box: How many units is low intake?).
The new guidance is in line with international consensus, and replaces previously conflicting and confusing advice on alcohol consumption during pregnancy. Previous NICE guidance stressed no alcohol consumption during the first three months because of the increased risk of miscarriage, and low consumption for the rest of the pregnancy. RCOG guidance had stated that there was no evidence that consuming small amounts of alcohol was harmful, and paradoxically, Department of Health advice had advocated alcohol avoidance during pregnancy but recommended a safe limit of up to four units a week for pregnant women.

The health impact of alcohol consumption

Alcohol is the third biggest risk factor for death and disability, after smoking and obesity, and women are at more risk than men to the harmful health impacts of alcohol consumption, even if drinking at lower levels than men. Moderate and excessive alcohol consumption is associated with poorer health outcomes and increased risk of certain illnesses. These include cancers of the mouth, throat, oesophagus, bowel, stomach, liver and breast cancers (the risk of breast cancer increases with increasing alcohol consumption), liver disease, cirrhosis and other alcohol-related liver diseases, memory loss and shrinkage of the brain, heart disease and damage to the heart muscle.

There is also a greater risk associated with alcohol consumption amongst lower socio-economic groups. The reasons for this increased susceptibility are not known, but these groups may be predisposed to the harmful effects of alcohol due to other lifestyle factors such as diet and increased prevalence of smoking.

Alcohol consumption pre-pregnancy, during pregnancy and whilst breastfeeding

There are short- and long-term risks to the health of babies of women who consume alcohol during pregnancy, as well as their own long-term health. There is an increased risk of miscarriage in first trimester, and placental abruption and birth defects in babies. Anderson et al found that in the first trimester, women who reported consuming two to three-and-a-half drinks per week were 1.66 times more time likely to miscarry than women who abstained. Women who reported consuming four or more drinks per week were 2.82 times more likely to miscarry. Between weeks 13-16, women who reported consuming two to three-and-a-half drinks per week were 1.57 times more likely to miscarry. And women who consumed more than four drinks were 1.73 times more likely to miscarry compared with women who abstained. The study found there was no increased risk of miscarriage after 16 weeks of pregnancy.

Excessive alcohol consumption during pregnancy is associated with foetal alcohol syndrome, which can cause facial abnormalities and long-term learning and behavioural disorders, some of which can be permanent. Moderate drinking and binge drinking are associated with foetal alcohol spectrum disorders, which affect children’s development (see box: How many units is low intake?). Often the symptoms of these disorders are not apparent at birth or during the early months of life, but become more apparent as the child develops, and are often underdiagnosed.
Moderate alcohol consumption during pregnancy increases the risk of a woman having a baby with deficits in social skills, gross and fine motor function, neural correlates of response inhibition and memory in childhood. The evidence shows that even drinking more than one to two units a week increases the risk of having a baby who is small for gestational age, of low birth weight and has restricted growth. However, the risk to babies of women who consume small amounts of alcohol before they know they are pregnant or during pregnancy has been determined to be low.1

Lower initiation of breastfeeding and breastfeeding rates are associated with alcohol consumption during pregnancy and immediately post birth.7 Consuming alcohol whilst breastfeeding can affect the behaviour of the baby, including sleeping patterns. Women who consume alcohol whilst pregnant are likely to continue after the birth. Moreover, research classifying women as at high-risk and low-risk of alcohol consumption found that high-risk women were more than twice as likely not to breastfeed, and that women who are aware of the risks are more likely to stop breastfeeding.8

Alcohol consumption is also a major risk factor in sudden infant death syndrome (SIDS) or cot death. The risk of SIDS is increased if babies co-sleep with an adult, and further increased if women who co-sleep with their infants have consumed alcohol.9 Blair et al10 found that many of the deaths in a co-sleeping environment resulted from a significant interaction between co-sleeping and recent parental use of alcohol or drugs (31% versus 3% of random controls). Additionally O'Leary et al11 found that the risk of infant death was more than double for babies of women diagnosed with an alcohol disorder during pregnancy.

**Risk factors for alcohol consumption during conception, pregnancy and breastfeeding**

Alcohol consumption prior to conception is a significant risk factor for alcohol consumption during pregnancy.12 The majority of women either do not drink (19%) or stop completely once they are pregnant (40%). However, almost a third of women do continue to consume alcohol once pregnant.1,13 Risk factors for moderate and excessive alcohol consumption for pregnant women include being aged 35 and over, ethnicity (white), having a professional or managerial occupation, and moderate to high alcohol consumption prior to pregnancy. Women may consume alcohol for social reasons or as a coping mechanism, which makes reducing consumption more complex.13

**The impact of guidelines on alcohol consumption**

There is a direct correlation between increased understanding of the impact of alcohol consumption and increasing levels of education, however many women ignore advice about alcohol consumption. It is unclear why women do not abstain; they may be aware of the health impacts of the alcohol consumption but they may not fully understand them or believe they are consuming alcohol within a safe limit. This has been compounded in recent years by media coverage and conflicting guidelines that have advocated abstinence and a safe low-level of consumption.
Women may continue to consume alcohol despite being advised about the evidence for abstinence. Dunney et al found that a quarter of women studied in a Dublin hospital consumed alcohol throughout pregnancy, and a third during breastfeeding even after receiving advice on alcohol consumption. With regard to education level, research shows that although highly educated women understand the risks better, they are more likely than less well-educated women to consume alcohol during pregnancy and whilst breastfeeding.

Women’s disregard for advice may be due in part to previous conflicting advice and guidance that in England and Wales suggested safe limits of alcohol consumption. Women may also be aware of advice to their mother’s generation by health professionals to boost their iron levels by drinking Guinness. Consequently, many women find it difficult to understand why this was once acceptable, and even encouraged, but recommended no longer.

Historically, women may not have adhered to guidance because it was inconsistent and difficult to understand (for both mothers and health professionals). One qualitative study on women’s attitudes to alcohol consumption and sources of information in the UK found that women recognised the conflicting advice appearing in the media, and that this was reflected in a lack of direction from midwives.

The influence of health professionals and interventions to reduce alcohol consumption

The evidence for effective interventions for reducing alcohol consumption in women planning to conceive or who are pregnant or breastfeeding is inconsistent and weak. However, due to their frequent contact with women, health professionals such as midwives and GPs are well-placed to intervene. Moreover, interventions are more effective if women have the same midwife throughout pregnancy, and are able to develop a relationship with him or her. With the use of screening tools, ranging from a simple set of questions to a comprehensive questionnaire, health professionals can identity women who consume alcohol more effectively, although not always.

The most effective intervention in reducing alcohol consumption before, during and after pregnancy is the provision of information and advice to the mother, both during a face-to-face consultation and with a leaflet to take home, thereby enabling her to make an informed choice. Information must also be up-to-date and evidence-based and presented in systematic way that reflects the best practice.

Government guidelines for health professionals to advise women on reducing alcohol consumption appear to be effective. Brief interventions - which encourage reflection on unhealthy behaviour with a view to initiating change - are effective in reducing alcohol consumption and are well-received by women and midwives. There is some concern, however, that their use could alienate pregnant women. Health professionals also need appropriate training and confidence, but unfortunately this is often lacking. The evidence suggests that midwives and other health professionals should routinely ask women about their alcohol consumption.
Motivational interviewing is an alternative and potentially effective intervention. This person-centred counselling technique explores unhealthy behaviour to identify factors that will motivate change, and uses these to achieve a change in unhealthy behaviour. It is effective at reducing alcohol consumption prenatally, but the evidence on its effectiveness during pregnancy is not clear.\textsuperscript{30,31}

Increasingly, the general public are using Apps and websites such as Change for Life as sources of information and as behaviour change tools. The potential for web-based interventions to reduce alcohol consumption amongst pregnant women has received little attention so far from the research community, although one web-based self-help guided change intervention to reduce alcohol consumption during pregnancy was just as effective as a mail-based version, with 58% reducing their risk.\textsuperscript{32} Other web-based interventions were acceptable and effective in pilot trials and warrant further research.\textsuperscript{33,34}

Partners have a key role to play in influencing mothers’ decisions about alcohol consumption.\textsuperscript{15} Partners can provide support and encouragement, including through considering whether to give up alcohol consumption themselves.\textsuperscript{29} Inclusion of partners can also improve the effectiveness of brief interventions.\textsuperscript{23}

The incomplete knowledge of many health professionals is a barrier to providing effective interventions that would enable women to make an informed choice about alcohol consumption.\textsuperscript{21,35} Consequently, most women do not receive comprehensive up-to-date evidence-based information about the impact of alcohol consumption. Without increasing training, understanding and awareness among health professionals, it is difficult for them to identify those most at risk, and identify and deliver the most effective interventions.\textsuperscript{13,17}

**Conclusion**

Alcohol consumption is a key public health issue that can lead to poor health outcomes. Following years of conflicting guidance, the UK government now advises no alcohol consumption prior to conception or during pregnancy. There is strong evidence that moderate and excessive alcohol consumption can have a negative impact on a baby’s health, both before birth and during early childhood. Providing advice and support to women about alcohol consumption during pregnancy is challenging because although many women to understand the risk of alcohol consumption, they may not necessarily alter their behaviour. Partners should also be included in interventions as they can provide support and encouragement.

However, the majority of health professionals urgently need to improve their knowledge and skills in advising women about reducing alcohol consumption. Further research is needed on the development of effective interventions.
References


24. Moyer A, Finney JW. Brief interventions for alcohol problems: factors that facilitate...
Key points

- UK guidance: women planning to become pregnant and pregnant women should not consume alcohol.
- Long-term alcohol consumption is associated with cancer, and other serious health conditions.
- Women who consume alcohol prior to conception are likely to continue to do so during pregnancy.
- Excessive and moderate alcohol consumption during pregnancy is associated with miscarriage, poorer birth outcomes and long-term health issues for the baby.
- Educated white women over the age of 35 are more likely to consume alcohol and continue to do so once pregnant.
- Alcohol consumption during breastfeeding can impact the baby’s behaviour and initiation and duration of breastfeeding.
- Health professionals’ knowledge and understanding of alcohol consumption is poor and makes them less confident to discuss with pregnant women.
How many units is low intake?

- Units represent the alcohol content of a drink, which is usually expressed by the standard measure ABV (alcohol by volume) to indicate the amount of alcohol as a percentage of the total volume of liquid. For example, if a wine is “12% ABV” or “alcohol volume 12%” it means that alcohol comprises 12% of the volume of the wine.

- The total units in any drink can be calculated by multiplying its total volume (in ml) by its ABV and dividing the result by 1,000.

- Example: the number of units in a pint (568ml) of strong lager (ABV 5.2%): 5.2 (%) x 568 (ml) ÷ 1,000 = 2.95 units

- A 750ml bottle of red, white or rosé wine (ABV 13.5%) contains 10 units.

- A handy tool is Alcohol Concern’s [unit calculator](http://www.nhs.uk/Livewell/alcohol/Pages/alcohol-units.aspx).

- Moderate drinking is classified as consuming 15-34 units per week and binge drinking is consuming more than twice the lower risk levels in one day (>6 units).

Adapted from [http://www.nhs.uk/Livewell/alcohol/Pages/alcohol-units.aspx](http://www.nhs.uk/Livewell/alcohol/Pages/alcohol-units.aspx)

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Helen Castledine is a research networker and represents her NCT branch at her local MSLC. With a degree in history, Helen worked as a youth worker and completed a Masters in community and health development before moving into public health. Over the past ten years she has gained an MSc in Public Health and held senior posts. Helen’s four children range from ten years to five months in age.

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Practice Points

- Support should be women-centred, evidence-based, empowering and non-judgemental. It is important to understand why women consume alcohol during pregnancy.

- Practitioners need to ensure their knowledge and understanding of the impact of alcohol consumption on pregnancy, babies and breastfeeding is up-to-date.

- Practitioners should be aware of local support and where to signpost women for effective long-term support.

- Practitioners should provide women with up-to-date information to make informed choices and take home leaflets to back this up.

- Practitioners should support both women and their partners.
Group reflective support – not just another meeting!

Ann Parker outlines the benefits of group reflective support for all practitioners

NCT are introducing group reflective support as a supportive mechanism for all practitioners. Group reflective support is not another meeting but the opportunity to build empathic relationships between everyone involved in providing NCT direct-to-parent services in order to improve the experience for parents. Group reflection is the opportunity to facilitate the development of practice through reflection, discussion and deeper understanding.¹

Practitioners’ meetings and group reflective support

In some areas practitioners are having regular meetings to discuss practice and issues relevant to their area. Group reflective support differs from a practice meeting by looking at a particular topic, piece of research, a new book etc. Some areas have started to incorporate group reflection into the first hour of practitioners’ meetings, with the second hour for ‘business as usual’ discussions about local issues and practical arrangements. Practitioners benefit from shared knowledge and experience.² Group reflective practice is based on the Ooijens supervision model whereby practitioners are given the opportunity to explore a topic in more depth.³ This also provides space for practitioners to explore with others their responses to a situation.
It would be wonderful for every practitioner to have the opportunity for supervision; unfortunately NCT’s budget does not stretch that far. However, having a specific focus for an hour can enhance learning and hopefully draw local practitioners closer together to create a supportive and cohesive working group.\(^4\)

There are four different styles of group supervision upon which group reflective support is based.

1. Authoritative — this is similar to one-to-one supervision with other members of the group observing. This may be useful to those new to this way of working.
2. Participative — the group facilitator is very much ‘in charge’ of the group but also invites other members to participate. It may encourage quieter members to contribute.
3. Cooperative — a facilitated group with all members taking responsibility for learning and participating.
4. Peer group — all members take responsibility, but it is more difficult to identify the group facilitator.

Feedback received from group reflective support study days has indicated that a session may involve a mixture of these styles of group work. Practitioners were most comfortable with the cooperative model as it seemed similar in style to their sessions with antenatal or postnatal parents. However, participative group working also seemed to have a place, encouraging everyone to participate while enabling the facilitator to include quieter people and encourage more dominant individuals to take a step back. The authoritative model was deemed not as useful: although it may help one person to have their situation explored in depth, other group members might become restless. The peer group approach could work well for an experienced group but some participants may have doubts about what the facilitator is actually doing.

**Group reflective support in practice**

The NCT practitioners’ annual returns survey in 2015 shows clearly that some areas of the UK have regular practitioners’ meetings, while other areas have seen a decline. There could be many reasons, including that other types of meetings have taken priority, more practitioners have work outside of NCT and the logistics of the geographical area concerned. For areas where regular practitioners’ meetings already take place it is simple to add in some group reflective support. Other areas will need more work to start up a practitioners’ meeting with group reflection. In some areas this may be very difficult and there may be other opportunities such as using Skype. The aim is to run group reflective support sessions twice a year for the same group of practitioners, in combination with a regular practitioners’ meeting. The group reflective support project will be evaluated in spring 2017 to see if practitioners feel more supported and valued by NCT.
Conclusion

By encouraging practitioners to meet to discuss and reflect on relevant topics, and through using group reflective support, we can build stronger and more cohesive relationships, and have greater understanding of each other’s roles. Ultimately, this will have impact on the expectant parents and parents that we work with.5

More information

I would suggest that any NCT practitioner who feels that group reflective support would work in their area should encourage a local Excellent Practitioner to attend one of the planned NCT study days listed on Babble. Alternatively they are welcome to contact me so that I can keep a note of their area to see if a facilitator is willing to travel to there. Ann.Parker@nct.org.uk

Ann Parker has been a breastfeeding counsellor since December 2004. She qualified as a supervisor in 2008, an assessor in 2012, a tutor in 2014 and a mentor in 2015. She initially became involved after meeting her local NCT coffee group — some of whom she has remained friends with ever since. After struggling to breastfeed her eldest son Jack and bursting into tears when visiting her GP, an infant feeding coordinator diagnosed him as having a high arched palette and supported her. Ann wanted to give something back and has been with NCT ever since. She never tires of supporting other women.

References

Clea Harmer: NCT’s loss is Sands’ gain

Clea Harmer tells Julie Clayton about her transformational journey with NCT, work as Head of NCT College, and what she is looking forward to when she leaves to become Chief Executive of the Stillbirth and Neonatal Death Society (Sands)

How did you first get involved with NCT?

There’s no single point where I joined NCT; in a funny way it has always been a part of my life. I was an ‘NCT Baby’ because, whilst pregnant with me in the 1960s, my mother did NCT classes with Sylvia Close, and I then grew up with my mother being one of the first NCT breastfeeding counsellors and then one of the first breastfeeding tutors.

I myself studied medicine and qualified as a doctor, and at that stage wasn’t involved with NCT at all; surprisingly, with hindsight, it didn’t seem relevant! But when I became pregnant my mother suggested that we do NCT classes. I remember listening to our NCT antenatal teacher, and being bewildered by the fact that what she was saying was so different from what I had learnt as a doctor. I ’knew’ that women should be in bed during labour, but here was a woman saying that you could (and should) walk around! I decided that the only thing I could do was to give birth and try and work out who was right.
I gave birth and it was very obvious to me who was right – not me! I decided to get more involved in NCT, and to share the fact that giving birth doesn’t necessarily have to be a medicalised event. In retrospect I can see that I started out as a very over-enthusiastic NCT student who wanted to tell everyone how to give birth, but I had some very good tutors who helped me see that my role was not to go around telling parents what to do, but to support them in making an informed choice.

Wanting to spend time with my young family, I stopped hospital medicine and did some community medicine, some postgraduate medical editing for the medical publisher Edward Arnold, and some teaching. As I could see the enormous value of my NCT work, I decided to become more involved with NCT and became an assessor and then a tutor. In June 2011 I became Degree and Diploma manager which was a three-day a week job supporting the NCT’s course at the University of Bedfordshire. The idea was that I could do this at home and continue to fit it round my family. But by October 2011, several things had come together – HEFCE funding for higher education was removed, an executive decision was made to end NCT’s partnership with the University of Bedfordshire, and the government launched the Pregnancy, Birth and Beyond initiative. It felt like a stellar explosion and I suddenly had to steer a ship that needed to find a new programme, find new funding, and find a university partner.

As a part of this, and in order to provide a ‘home’ for practitioners within NCT, NCT College was created 4 years ago to ‘hold’ both students and practitioners; and I was lucky enough to become Head of NCT College.

**NCT College was created only four years ago - it seems so well established**

That is because there is such a fantastic team to work with, and to some extent it has been a real case of ‘necessity being mother of invention’. I felt very strongly that NCT students and practitioners deserved the very best we could do, so there was no plan B – we just had to get our skates on and do it. But change on that scale can be difficult, and it was important to me to take everyone with us and make them feel safe and held. That was perhaps the most challenging bit.

**It must have required an enormous amount of thought to bring everyone together like that.**

It is really important to value and acknowledge the enormous amount of work that was being done by the voluntary practitioner bodies at that time - they were managing and administering the licensing, assessment and support processes with systems that were set up to cope with a fraction of the number of practitioners that we now have. Part of making changes was acknowledging all of this great work, but communicating very clearly what we saw as the benefits of introducing a new system. This was easier because we were practitioners ourselves, and I hope understood what some of the concerns and anxieties would be.
I also used all the skills that I heard learnt with NCT over the years; what NCT training does fantastically well is to teach a person-centred approach. If you apply the principles of person-centred respect and empathy to everything you do, it enables you to accomplish this kind of change. I think most practitioners understand and value the fact that the skills they learn reach way beyond their work as NCT practitioners. I know I certainly do.

**What achievement are you most proud of at NCT?**

I think rather than being proud of achievements, I feel that it has been a privilege to have been a part of many different things. It has been a privilege to have supported parents at such an important part of their lives; it has been a privilege to watch the transformational journey students make through their training; and it has been an enormous privilege being part of the team who work to keep NCT College on the road.

**What do you feel you have gained most personally from NCT?**

An enormous amount! As a parent I made a wonderful group of friends with children the same age. I also made the most fantastic group of friends who trained with me as a practitioner and as a tutor - friends that stick with you wherever you are and whatever you are.

But I suppose, most fundamentally, I owe my own journey of personal growth and development to NCT. I have learnt to understand the many different ways of knowing, understanding, and learning. I have learnt the importance of respecting and understanding the many different positions that people have on everything from parenting to how they work.

**What’s on your immediate agenda when you take up your position at Sands?**

Sands is a truly amazing organisation, and before I do anything at all I want to listen and truly understand all that it does and all that it wants to do.

The work that Sands does can be thought of in three parts: firstly it offers support to parents (and family and friends) who have a baby who dies, secondly it works with health care professionals to ensure that the care bereaved parents receive is the best it can possibly be, and thirdly it works to research and understand how and why babies die and to identify what can be done to reduce this.

The stillbirth and neonatal death rate in the UK, compared to other similar countries, is very poor – 15 babies die every day in the UK, and each baby that dies leaves parents with empty arms. It’s really fundamental – we should be doing everything we can to reduce the number of avoidable deaths so that parents don’t have to suffer that lasting loss and devastation.

So I need to understand and learn as much as I can; it’s an amazing privilege to have the opportunity to make a difference to people’s lives, by trying to reduce the rates of stillbirth and neonatal deaths, by supporting parents who do suffer a loss, and by making sure the bereavement services are the very best that anybody could hope for. I feel very lucky indeed.