Effectiveness of a peer support intervention for Antenatal Depression:

A feasibility study.

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Abstract

Introduction

A feasibility study for a randomised controlled trial to assess the acceptability, recruitment, and feasibility of a peer support intervention for women with antenatal depression. The key premise of peer support is based upon the trust and empathetic understanding engendered by common experiences.

Methods

Women with antenatal depression were randomly assigned into a control (routine care alone which includes contact with a midwife in clinic every 2 weeks (weekly towards very latter stage of pregnancy), or access to a GP if required) or intervention group (6-weekly visits from a peer support worker in addition to routine care). Participants from both the control and intervention group, and the Peer Support Workers (PSWs) were then interviewed at the end of the six-week period. All participants, and the PSW’s, were also asked to keep log books during the trial to record their feelings and experiences. The results were then analysed using thematic analysis.

Results

 Five PSW’s were recruited and four provided peer support. Twenty pregnant women were recruited. The ten women who were randomised to receive peer support received all six sessions. The participants randomised to the control group did express their disappointment at not being allocated a PSW, but continued and completed the study.

The analysis of qualitative data from the PSWs and the participants in the intervention group with antenatal depression suggest the peer support intervention is acceptable, helpful and supportive to both pregnant women and PSWs. The women within the intervention group valued the peer support highly, reporting that being able to speak openly to a PSW meant that feelings of alienation, abnormality, isolation and stigma were replaced with social support, confidence, self-esteem and hope for recovery.

The PSWs reported a positive impact upon their own wellbeing and a realisation that they had, indeed, moved forward with their lives. A proportion of the women randomised to the control group described feelings of disappointment and frustration with the lack of support currently available to them.

To conclude, this feasibility study suggests a full randomised controlled trial (RCT) is warranted given the high recruitment, adherence, and acceptability of the intervention.

Introduction and Background**:**

Perinatal mental health is a major public health concern due to the effect on mother and baby, and carries a significant UK economic cost of approximately £8.1 billion per year, equivalent to approximately £10,000 for each UK birth (Bauer et al., 2014). Perinatal mental health research has traditionally focused on maternal postnatal depression (PND). However, antenatal depression has a similarly high incidence of 10-20% in developed countries (Biaggi et al., 2016), and is associated with psychological and physical morbidity, including poor birth outcomes, increased risk of maternal suicide (RCM, 2015), and emotional, behavioral and cognitive difficulties in offspring (O’Connor et al., 2003).

Pharmacological interventions during pregnancy are highly complex given the risks of fetal exposure to medication (NICE, 2014). Furthermore, women often do not like to take antidepressant medication in the perinatal period (Boath et al., 2004), and this, understandably, affects their engagement in treatment (Flynn et al 2006). There is also a paucity of research to offer any clear conclusions about the effectiveness of antidepressants for the prevention of perinatal depression (Molyneaux et al., 2018).

Affected women highlight the lack of tailored support for perinatal mental health and service provision that meets national standards, with the quality and availability of these services often depending on where you live, with inequality in provision existing (Cust, 2016a,b; Odette et al 2015). There is an, to date, unmet need to develop and validate non-pharmacological interventions for antenatal depression that can subsequently offer a greater choice for women.

The role of peer support worker is based on the premise that people with similar experiences can authentically support others with similar issues (Davidson et al 2006). Peer support may be mutual (between people who are currently unwell, in a group, or an online forum) or unidirectional (between a trained peer supporter who has recovered and a recipient who is unwell). As a form of social support, it is often conceptualised as comprising emotional, appraisal (affirmational), and informational support (Dennis 2003). Different forms of organised peer support have previously been found to be effective in preventing and/or reducing PND among high-risk women and assisting recovery in women who have PND (McLeish and Redshaw, 2017a,b; Cust 2016a; Carter et al., 2018), for example, group peer support (Jones et al., 2014); telephone support (Dennis et al., 2009; Letourneau and Secco, 2015); and individual peer support (Cust, 2016a).

Qualitative studies suggest that women value mental health peer support (MacLellan et al 2015). Such studies have explored some of the mechanisms of peer support that have benefitted woman (Pfeiffer et al, 2016). These include being able to speak openly to a peer who has experienced similar feelings of alienation, of feeling abnormal, isolated and experiencing stigma. Findings from these studies have included feelings of increased social support, confidence, self-esteem and hope for recovery (Dennis, 2010; Jones et al, 2014; Letourneau et al, 2007; Mauthner, 1995; McLeish and Redshaw, 2017a).

Pfeiffer and colleagues (2011) state that additional studies are needed to determine the effectiveness of PSWs in primary care and other settings with limited mental health resources.

It has been suggested that screening and support for perinatal mental health should begin in the antenatal period (National Institute of Clinical Excellence (NICE), 2014; Howard et al 2015). NICE perinatal mental health guidelines (2014) recommended that all pregnant women should be asked about their mental health, using the Whooley questionnaire, at their initial appointment with their midwife – thus enabling the recognition of potential problems early and signposting to relevant agencies (NICE 2014).

The aim of this feasibility study (a randomised controlled trial) was:

To assess the recruitment, acceptability and effectiveness of six weekly, one-hour peer support visits for women with antenatal depression compared to a control group of women receiving standard care alone (midwifery support and GP).

To explore the peer support workers and women’s views and experiences of peer support.

Design

This was a feasibility study for a randomised controlled trial. Ten women, with antenatal depression, were randomised into the intervention group (peer support in addition to routine care) and ten women randomised into the control group (routine care alone). The study was based in the Midlands area within a community setting.

Inclusion

The inclusion criteria was that all participants were English speaking, 28-30 weeks' gestation, and first time mothers with no previous history of mental health issues, miscarriage or still birth. All women were identified by their midwife as potentially having antenatal depression following their response to the Whooley questionnaire.

Participants

Participants were randomised by a computer-generated package. Once a woman had been randomised they were consented by a member of the research team into the study and assigned a number. All data collected was assigned to the correct study number for the woman in order to maintain complete anonymity. The peer support intervention continued for a six-week period with a one-hour visit scheduled by a PSW each week. The visit was arranged in a venue agreeable to both the PSW and the woman to ensure that both parties felt as comfortable as possible.

 The PSWs and the women participating, both in the control and intervention group, were asked to keep a log book recording and reflecting upon their meetings. They were asked to maintain this for the six-week intervention period. Following completion of the six-week period the research team contacted all participants and a semi structured telephone interview was arranged. The interviews were, with consent, audio recorded and subsequently transcribed.

This study created a large amount of rich qualitative data, which was analysed by the researchers using a thematic analytical approach (Denscombe 2014).

Ethical approval was obtained from the Health Research Authority.

The research will only progress to a full RCT if the following criteria are met:

1. At least 80% of women are recruited via midwives.

2. At least 80% of the women recruited complete three or more peer support sessions.

3. Women report peer support to be acceptable to them during the telephone interviews.

4. PSW’s report providing peer support to be acceptable to them during the telephone interviews

7. The RCT design is deemed to be acceptable by the participants.

The research team had a number of meetings with the community midwifery (CMW) team at the potential recruitment site. The aim of these meetings was to ensure the midwives had a good understanding of the study and recognised the potential benefits for the women, and their families. The CMW would have the initial contact with the woman and it was of paramount importance that they understood the study, and were prepared to provide the support required to recruit the participants.

The PSW’s

The PSW’s were mothers who had suffered previously from antenatal depression but had recovered and were not receiving any form of psychotherapy, or taking antidepressant medication.

The Peer Support Workers (PSWs) were recruited via an advertisement that was placed in two local health centres and within the information point at the university campus where the research team are based. The aim was to recruit five PSWs. Eight applications were received and reviewed, and six applicants were invited for interview. Five PSW’s were recruited, however only four PSW’s provided peer support due to the unavailability of the fifth PSW when the support was required (due to workload and family demands).

An NHS site organised, and funded, both the references and the disclosure and barring service (DBS) reviews of the PSW’s. The disclosure and barring information is legally required for any volunteer or employee who will be working with either children or potentially vulnerable adults.

Training of PSW’s

Two members of the research team led the training session (both hold teaching qualifications and are registered practitioners). A two-day training session was delivered to the five PSW’s in which they were provided with a full explanation of the study both verbally and in written format, the aims and objectives of the research study, safeguarding/child protection, the importance of maintaining confidentiality, and the role of the PSW. There was no formal training in terms of counselling methods - the aim of the study being to ascertain what effect, if any, receiving support from a peer who had experienced depression in the antenatal period would have. The PSW’s simply wanted to provide support to the women as a fellow ‘mother to mother’. They wanted to listen, guide, and support in ways that may have helped them when they were experiencing similar emotions. They were all unanimous in the decision to not receive any formal style of therapeutic training. This decision was completely respected by the research team.

 The PSWs were also asked to sign a consent form to say that they had received information about the study and understood that they could withdraw from the role at any time.

Analysis

Nine participants from the intervention group and six from the control group were interviewed. Four participants from the control group did not consent to interview. One participant from the intervention group was unable to consent to interview due to unrelated health issues. Four PSW’s were interviewed. All participants from the intervention group completed the six-week intervention.

Data was also gathered from the logbooks of PSWs and participants, and the semi structured telephone interviews with participants in both the control and intervention group. A thematic analysing of data was utilised to attempt to identify common themes within both the logbook recordings and the data from the telephone interviews. The information was read and re-read and recurring comments were highlighted. This enabled the research team to explore and provide clarification of the themes that emerged.

For ease of reporting, these themes are divided into sections related to which group the participant belonged to. Participants were all give a pseudonym.

**Intervention Group**

**Six themes that arose from the intervention group participants were as follows**,

 ***‘Time to spend’***

As demonstrated in an earlier study (Cust 2016a,b), several participants within the intervention group reported that they really appreciated having time to spend with their peer support worker. They felt that time was being provided to focus on this aspect of their health, concentrating on issues concerning their mental health. This was in comparison to their previous contact with health professionals, in particular midwives, where there was a lot of time spent *'form filling and providing information* *about themselves'*, within a relatively short appointment time.

‘*It was nice to be able to talk to the PSW without feeling that they were in a rush or that they had a checklist they had to get through.’ (Millie)*

***‘Empathy’ ‘lived experience of the PSWs’,***

The themes of PSWs providing empathy and sharing lived experience came across strongly in the data collected. Participants spoke about this in a very positive way in terms of enabling them to ‘*open completely and connect with the PSW’.* This was, again, similar to the findings of other studies (Cust 2016a,b and McLeish and Redshaw 2017).

 ‘*I felt that the PSW had been exactly where I am now. She understood me and I felt that she could genuinely feel what I was going through.’ (Claire)*

***‘Non-judgemental’,***

The participants often perceived that they were being negatively judged by the health care professionals that they had previously had contact with. This was not the case with the PSWs, and several participants stated that they felt that they could say anything to their PSW without the fear of ‘*being judged*.’ Quotes such as the following were typical,

‘*She put me at ease. I don’t always feel I can say what I am thinking to the midwife, in fact I don't think that I ever can really.’* *(Kirsty)*

***‘Gap in services’,***

While the postcode lottery of services for perinatal mental health has been highlighted, all participants stated that there was a lack of services for those women who were not ‘*suicidal*’ or ‘*psychotic*’, but still desperately needed support.

 ‘*I was pleased to experience help from a PSW there doesn’t appear to be a lot around unless you are actually feeling completely suicidal’ (Sophie)*

**‘Fear of intervention ending.’**

As again demonstrated within earlier research, Cust (2016), 4 of the intervention group participants expressed feelings of concern and anxiety leading up to the completion of the support visits.

 ‘*I wondered how I was going to cope without my support from my worker, particularly before my last visit.’ (Carly)*

*'I dreaded my visits ending, I was really going to miss this support.' (Emma)*

***‘Making a difference’***

A resounding theme that emerged frequently within the data by all women within the intervention group was that their PSW '*really made a* *'difference'.* The participants felt that the peer support made a positive impact upon their mental wellbeing, and how they now felt about their pregnancy. Further comments included,

 ‘*I feel much stronger now and I am actually looking forward to meeting my baby. I don’t just see my baby as an ‘it’ but actually feel it is ‘my baby’*.’ *(Rebecca)*

**Control Group**

**The two themes that emerged from the control group participants were also categorised and are as follows,**

**No help available**

The control group described their feelings of ‘*despair and frustration’* at the lack of appropriate help available.

They all expressed feelings of ‘*disappointment’ that* they were not allocated into the intervention group.

- ‘*I was delighted when I heard about this intervention as I have told people I am was feeling very low and tearful but felt disappointed not to be receiving visits from a peer support worker. I guess it’s good though to know that mental health is not being ignored.’*  *(Fay)*

**Stigmatised**

The participants in the control group also described feeling of being ‘*judged’* and ‘*stigmatised’.*

All were very aware that professionals have limited time to spend with them and this often made them feel that they were an ‘*imposition.’*

‘Women within this group felt that professionals had little understanding and demonstrated *‘text book empathy.’*

‘*Often the midwife starts off by asking, are you feeling any happier today, it’s the way she says it - as if I really should be* *feeling great’ (Amy)*

**Peer Support Workers**

**The five themes that arose from the interviews with the PSWs are as follows,**

***Felt useful and purposeful***

A number of the PSWs commented that being involved in providing this intervention had made them feel ‘*useful’*. They all commented that it had felt ‘*uplifting*’ to be able to use what had been such ‘*a negative experience in such a positive way’.*

Three of the PSWs commented that they felt that it would have been very difficult for them to have delivered the intervention if they did not now feel mentally strong having received some help themselves.

*’I felt as if this was my purpose, that I had been given the opportunity to give something back, that something positive had to come out of the terrible time that I had had.’(Kay)*

***Recognition of progress made in their own mental health journey.***

Two of the PSWs reflected that during the intervention they had a ‘*light bulb’* moment when they realised how far they had come in their ‘*own personal recovery’.* They described it *'as a huge feeling of relief.'*

*‘Providing the support to my lady made me recognise my own strength, how ill had actually been but how hugely different I now felt. It was therapy for me too!' (Sharon)*

***Need for Supervision***

 One of the PSW’s commented how distressing she had found a visit in which the woman had shared her previous traumatic history. Following the visit, she realised she needed to contact the research study supervisor and received appropriate support.

 ‘*It just bought memories flooding back, it was, at that moment, just too close to home, I recognised that I needed to gain some support from the supervision team – which I did and it really helped.’(Laura)*

 ***Guilt***

 Two of the PSWs felt that there should not have been a time limit on the intervention. They felt a natural conclusion to the visits would have been more acceptable. They described feelings of guilt at providing all the support and then ‘*withdrawing their help’*. And simply '*abandoning their mother'.*

*‘I wish that I could have visited for longer, that I could offer support until it was felt that my job had been completed. I felt guilty when the visits came to an end.’(Sharon)*

***Help not Hindrance.***

Three of the PSWs described their feelings of anxiety as to whether they were really making a difference. One of them expressed concern that by encouraging the participant to concentrate on her feelings she was perhaps having a negative impact.

 '*I worry that I am asking her to focus upon her negative thoughts too much, should I just try to get her to think positively? But then I don't feel that that is what I would have wanted. I wanted to talk about how dreadful I actually felt.' (Molly)*

Discussion

Summary of Findings

The aim of this feasibility study was to review recruitment, establish whether support provided by a woman with previous experience of antenatal depression would prove a positive intervention, and be acceptable to a woman with existing antenatal depression. The researchers also wanted to assess whether such an intervention was robust and advantageous, in comparison to existing services.

The recruitment process of the participants for the control group took longer than anticipated. This may have been due to a misunderstanding of the information imparted or a confusion as to whom the midwives should directly liaise with. It is therefore recommended that there is a single, named researcher for the midwives to connect with. Recruitment of the twenty participants was achieved over 4 weeks. However, it is recognised that not all community midwives participated in recruitment and there were 2-3 ‘champions’. Without their support recruitment would have taken a lot longer or may not have been achieved at all. This does demonstrate how important the communication and time spent discussing the outline of the study with the community midwives was in terms of gaining their support.

The Whooley questionnaire was used for this study as this was the existing method of screening used by the participating Trust. However, the simple yes/no response to only a few questions made it difficult to grade/score the level of antenatal depression that participants entered the study with. It is proposed that future research will utilise the Edinburgh Postnatal Depression Scale (EPDS) and a clinical diagnostic interview as this enables a scoring process and results can be compared longitudinally. This may assist in enabling the research team to assess the impact of the intervention in terms of recovery.

 The research team felt that participants in both the control and intervention groups should be made aware, from the beginning of the study, that they could contact a member of the research team (both professionals within the field) should they have any issues concerning their PSW. Each participant was provided with the relevant contact details. One participant did contact a member of the research team during the study. This highlighted the importance of this communication channel as if this support had not been available a participant may have discontinued her involvement in the study and, indeed, left with negative connotations – missing the potentially valuable opportunity of support from a PSW.

Feeding this back to the PSW in question was rather sensitive, but necessary, and the PSW was reassured that this was not a personal slight. Further supervision and support was provided to the PSW.

As already discussed, all ten women in the intervention group reported the intervention as being both acceptable, highly supportive and useful. The women appreciated the feeling that the PSW’s had time to spend focusing on them and the issues concerning their mental health. They felt that the PSWs demonstrated empathy and understanding. Four of the ten women did comment that they had experienced some feelings of concern and anxiety leading up to the completion of the support visits. It could be argued that this demonstrated dependency on the PSW. Whilst this may appear concerning, the research team reflected that these women did receive enhanced support in comparison with their peer group (other pregnant women with antenatal depression in this area), and routine care from maternity services was still provided. In terms of the benefits of the intervention it was agreed by all four women that these far outweighed any negatives. Sadly, both the PSW’s and all of the participants that took part in this study commented on the lack of services available in the area for women suffering from depression in the perinatal period.

The PSWs commented that they felt participation in this research had been positive in terms of reflecting upon their own mental health, and how far they had progressed in their own personal journey. This is an interesting reflection, and an unexpected outcome of the intervention. Whilst we had hoped that the intervention would make a difference to the participants, we did not envisage that it would have such a positive impact on the PSW’s.

On one occasion, a PSW became concerned as to how traumatic she had found it when a woman confided openly to her - including events that had occurred in her childhood. The PSW realised she needed to contact the research study supervisor and she received support. This highlights the requirement for robust, protected supervision, which has been recognised and encompassed into the bid for a larger, future study.

Recommendations

It is hoped that, following on from this small-scale study, funding will be sourced within the following year for a much larger exploration into the effectiveness of peer support for women in the antenatal period, identified as having antenatal depression by their midwife.

This study has highlighted a number of key points which will be discussed within the following section.

The research team recognised that in addition to the screening process (which is designed to protect PSWs and participants), strong supervision and support to recruited PSWs is a vital element to ensure the success of this intervention.

A finding echoed in a previous study (Cust 2016) is that prior to the participation of PSWs in providing support to women it is vital that they are sufficiently recovered from their own antenatal/postnatal depression. This is to ensure they are not vulnerable, and that they are well enough to be able to provide effective support to their participant in a meaningful way. It is important that this finding is recognised and addressed in the design of a larger scale study.

Effective communication between the research team and the clinicians (midwives) is imperative – and regular face to face meetings must be arranged to ensure that all parties are fully aware of up to date data and progress within the study.

It is important that the PSW’s receive relevant training prior to commencing their role and that there is ongoing, robust supervision provided to the PSWs. This should include consideration of the finding of ‘feelings of guilt’ at the completion of the study that some of the PSW’s reported. The PSW’s need to be fully aware of what their role may involve and the commitment required to carry out this role.

The research team also need to recognise the importance of women being able to change their PSW if necessary, and to have the direct contact details of a member of the research team if any queries/ concerns arise.

The researchers felt that the interviews with potential PSW’s were crucial to enable information to be provided about the study. An applicant may decide that the role, actually, is not right for them, or the timing is not feasible within their lives. It would certainly be better to find this out prior to commencement of the role. The interview process also enables a level of assessment to be made as to whether the candidate is at an appropriate stage in their own personal recovery to be able to participate in this role effectively.

This feasibility study was limited to self-reported measures of depression and understanding, recruitment to, and acceptability of the intervention.

**Conclusion**

The recruitment and retention of participants to both the intervention and control group was positive. The research team have recognised the importance of assessing the suitability of the PSW - in particular ascertaining whether they are mentally strong enough within their own recovery to be able to fulfil the role. The importance of PSWs being fully informed and that a mechanism exists for both the PSWs and the participants to enable them to contact a member of the research team with any concerns has also been highlighted. These concerns require prompt action and indeed, may include the need to communicate with the community midwife, for example if there are any safeguarding concerns.

The research team were able to gather rich data through the interviews and the log books from all participants and the PSWs. The randomised controlled trial (RCT) method was advantageous in enabling comparisons to be made, particularly in relation to whether the routine care women receive with depression, in the antenatal period, can be improved upon. Thematic analysis enabled a thorough exploration of the themes embedded within the data. One to one peer support for one hour a week, for six weeks, was acceptable and had a positive impact upon women with antenatal depression. The peer support role was also, somewhat unexpectedly, beneficial to the PSWs.

Further, larger studies, within the field of peer support for perinatal mental health are required, and subsequently planned, for the following year.

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