mums and babies in mind

Supporting local leaders to improve perinatal mental health services

Evaluation Report

October 2018

CITY UNIVERSITY OF LONDON EST 1894

BIG LOTTERY FUND

NATIONAL LOTTERY FUNDED

MATERNAL MENTAL HEALTH ALLIANCE

Mental Health Foundation

Mums and Babies in Mind evaluation teams

City, University of London, evaluation team:

Professor Susan Ayers, Professor of Maternal and Child Health

Dr Ellinor Olander, Senior Lecturer in Maternal and Child Health

Dr Gabriella Romano, Clinical Psychologist/Researcher

Jenny Mcleish, Researcher

Mums and Babies in Mind (MABIM) team:

Sally Hogg, Strategic Lead

Anna France-Williams and Fiona Salter, Communications Manager

Dr Alain Gregoire, Clinical Lead

Acknowledgements

The authors of this report would like to thank the participants who attended the masterclasses for their voluntary feedback in the evaluation questionnaires as well as all those who took part in telephone interviews.

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Executive Summary

The Mums and Babies in Mind (MABIM) project was a three-year Big Lottery funded project hosted by the Mental Health Foundation on behalf of the Maternal Mental Health Alliance, running from September 2015 to September 2018. It was an initiative for commissioners and providers in four sites in the UK (Blackpool, Haringey, Southend and Gloucestershire) to "improve care and quality of life for mums with mental health problems during pregnancy and the first year of life, and their babies" through two strands of work. The first strand was support for local commissioners and providers which comprised (i) providing pathway assessment and bespoke support to four MABIM areas; (ii) delivery of a Leaders' Programme and (iii) professional development events and training. The second strand was sharing messages and learning from MABIM with a wider audience, which involved communications to share the learning from MABIM and support professionals around the UK; and conferences and awards.

The evaluation was conducted by researchers at City, University of London, and aimed to examine the strategies for change used by participants in MABIM, facilitators and barriers to change, and how these changes impacted on the local provision of services. The evaluation had three components: (1) qualitative interviews with 20 participants from MABIM sites (n=16) and non-MABIM sites (n=4); (2) quantitative feedback on the masterclasses (n=148) which included ratings and free text responses; and (3) a case study of a MABIM area to illustrate how the MABIM programme helped this area develop their services for women with perinatal mental health problems.

Results found MABIM was evaluated positively by participants who valued aspects of the programme such as the bespoke support, masterclasses and pathway assessment tool. Key aspects of MABIM's value were providing consultation, advice and support, increased learning, helping areas test out new practices, and providing validation and a sounding board for focusing priorities.

Participants in MABIM were highly motivated to improve services for women with perinatal mental health problems. They believed that passion was needed to drive change, and that engagement, relationship building and co-production is important for delivering change. Factors identified as facilitating change included creating time and space to think and connect, working with service users and commissioners, and having professionals involved who are able to influence change to services. Key barriers to change were lack of funding, staff and time. Instability within services also hindered change when resources and/or staffing were uncertain, services were fragmented or in a process of changing. This uncertainty created both conflict and sensitivity to future plans, as well as reluctance to implement changes until there was more certainty.

The impact of MABIM on services for women with perinatal mental health problems was hard to determine within the constraints of the current evaluation. The case study illustrates how MABIM helped service providers look at the care pathway as a whole, which resulted in a more cohesive pathway and facilitated the inclusion of multiple agencies, such as third sector organisations. The pathway assessment tool in this area suggests MABIM contributed to improvements in specific areas, such as specialist services, through targeted action on less developed elements of services. It was recognised that service change would also have been influenced by national changes in prioritisation and funding of services for women with perinatal mental health problems.

A number of recommendations are made for the development and future evaluation of MABIM or similar programmes. Key developments are providing MABIM support to more areas in the UK, removing barriers to attending masterclasses (such as making them available locally), and making sure participants have funding to attend. Barriers and facilitators could be more explicitly addressed, such as ensuring commissioners or other people who can make change happen are involved in the programme. Finally, it is important to determine the direct and indirect impact of MABIM on local services, as well as outcomes for women and children.

1. Introduction

1.1 Mums and Babies in Mind (MABIM)

Mental health problems can arise in pregnancy or after birth and most commonly consist of anxiety, depression, post-traumatic stress disorder following a difficult birth, and stress-related conditions such as adjustment disorder. It is estimated that between 10 and 20% of women suffer from mental health problems during pregnancy and the postnatal period. In the UK there is increasing awareness of the importance of perinatal mental health from a public health perspective, which has prompted prioritisation of perinatal mental health services and significant investment by the Government of £365 million announced in 2015 and 2016.

The Mums and Babies in Mind (MABIM) project was an initiative for commissioners and providers in four areas in the UK (Blackpool, Gloucestershire, Haringey, and Southend) to "improve care and quality of life for mums with mental health problems during pregnancy and the first year of life, and their babies" (MABIM tender document) through **two levels of work**:

Support for local commissioners and providers:

1. **Providing mapping and bespoke support to our four MABIM areas.**

   Support included designing and facilitating events with local partners; helping secure buy-in from senior managers; development of a 'Pathway Assessment Tool', which brought together standards from a range of different documents to enable leaders to identify strengths and gaps in provision; inputting on commissioning reviews and pathway development and supporting in the development of bids and proposals.

2. **Delivery of the Leaders' Programme.**

   A two-year multi-disciplinary programme of nine masterclasses aiming to enable leaders to learn from leading experts in policy, research and practice; be inspired by those with lived experiences and fellow change makers; share learning and develop new solutions to difficult challenges.

3. **Professional development events and training.**

   Common gaps in professional knowledge, skills and confidence, were addressed through events and training, such as GP training in perinatal mental health delivered in partnership with the Royal College of GPs and psychological skills training delivered in partnership with IAPT and the British Psychological Society.

Sharing the messages and learning from MABIM with a wider audience:

4. **Communications to share the learning from MABIM and support professionals around the UK.**

   To share insights from MABIM sites to support commissioners or providers around the country who were trying to improve services via tweeting at events; blogs of real case studies; creation of 'top tips' reports to capture learning from all Leaders' masterclasses and disseminate tools more widely (e.g. Pathway assessment tool).

5. **Conferences and awards.**

   The MABIM funding subsidised two, national annual maternal mental health conferences to connect, inform and inspire a wider group of professionals around the country through plenary presentations, workshops and poster presentations. The conferences highlighted academic research, showcased innovative practice and user experiences across the UK.

Much of the evaluation centred around the Leaders' Programme, a series of masterclasses on key topics relating to perinatal mental health. There were nine masterclasses in total, all held in London. Leaders were people from commissioner or provider organisations who were identified as 'someone who can make a real difference to services for women affected by perinatal mental illness and their families'. Some volunteered directly for the programme, others were suggested by colleagues. In areas where there was a clear local lead for perinatal mental health, MABIM staff worked with that person to recruit and select local leaders. Where there was no clear local lead, leaders were recruited through local networks and contacts. Approximately 60 people were involved in the Leaders programme, although some others attended one or two masterclasses.

Most enrolled at the start of the programme in summer 2016, although some did join throughout the programme as new services were established or roles and responsibilities changed.

Travel to each masterclass and accommodation was usually funded by participants' organisations, but some financial support for travel costs was available if necessary. Each masterclass comprised of a full day of activity, balancing input from experts and women with lived experience with the opportunity for attendees to learn from each other and discuss challenges. Facilitation of ongoing support networks and information exchange between leaders on the programme was arranged after each session. The content of the programme was designed with leaders to maximise engagement. Table 1 outlines the content of each masterclass.

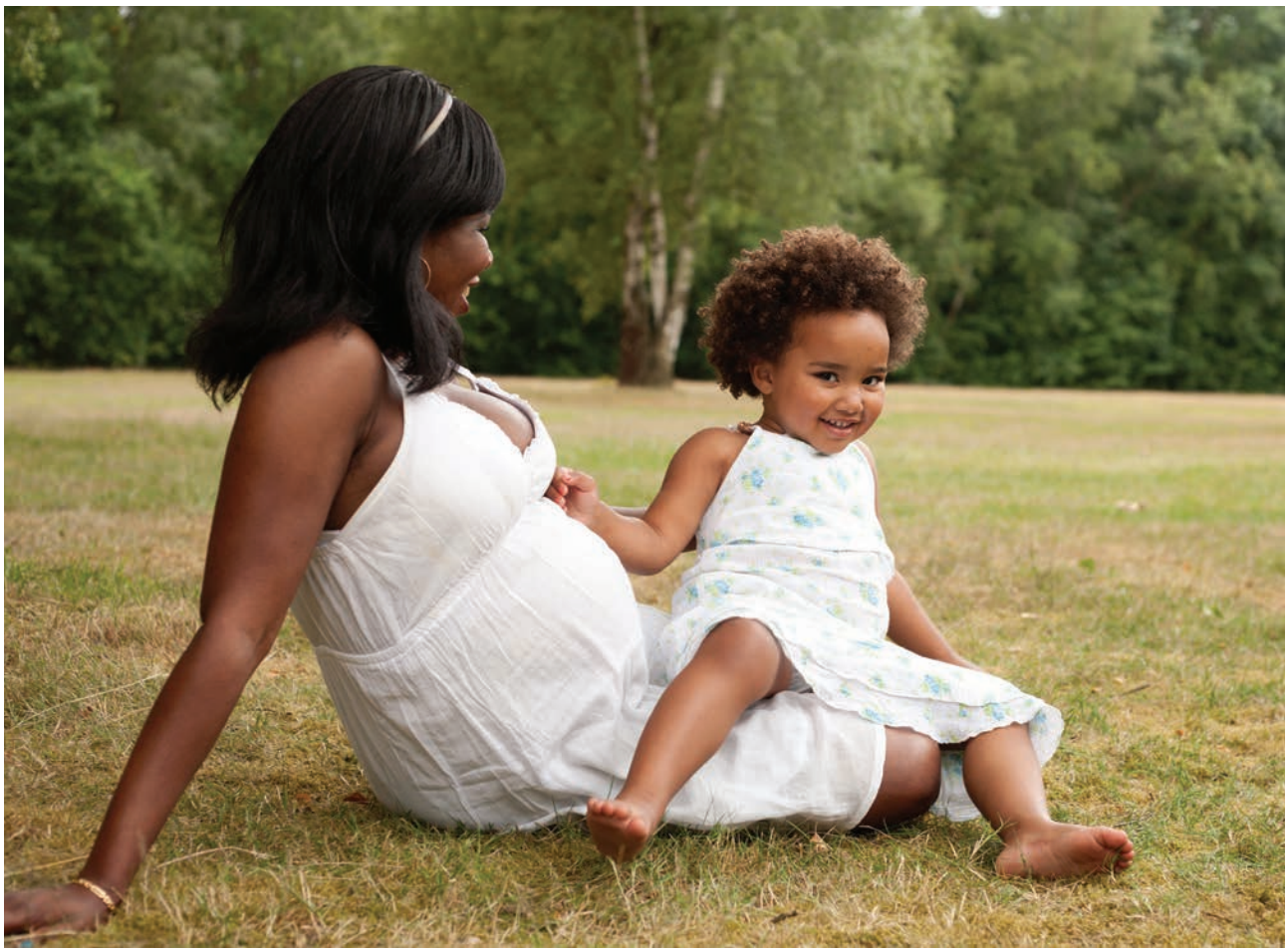


Table 1. Masterclasses run as part of the Leaders Programme

Masterclass Title	Date
1. Developing a specialist perinatal mental health community team This masterclass focussed on sharing lessons from existing services about to establish a successful specialist perinatal mental health community team.	**October 2016**
2. Commissioning perinatal mental health services This masterclass aimed to help Leaders to understand commissioning, including service specifications, data and outcomes, and the value of joined-up commissioning	**December 2016**
3. The role of midwives and health visitors This masterclass focussed on how midwives and health visitors can support women and their families, including the role of specialist professionals.	**March 2017**
4. User engagement and Insight This day covered ways to gain useful user insights and to engage service users in service design and delivery.	**July 2017**
5. Reaching All Communities This masterclass looked at the needs of traditionally forgotten or marginalised groups, including dads, young parents, those with babies in NICU and survivors of trauma.	**October 2017**
6. Change Leadership This was a late addition to the programme, and focussed on how to drive change and service improvement. Content included implementation science, quality improvement, change leadership and campaigning.	**January 2018**
7. Keeping the Baby In Mind This session covered science about the intergenerational transmission of mental health problem and examples of interventions to promote infant mental health.	**March 2018**
8. Sharing Challenges and Successes This masterclass enabled Leaders to hear from their peers about work happening in other local areas to improve services and pathways.	**May 2018**
9. Innovation This was an introduction to service design approaches and how they could enable innovation and service improvement.	**July 2018**

1.2 MABIM Evaluation

The evaluation of MABIM was led by Susan Ayers (Professor of Maternal and Child Health) and a team of researchers at the Centre for Maternal and Child Health Research at City, University of London. Susan has conducted research into perinatal mental health for over 20 years and has published extensively on this topic.

Dr Ellinor Olander (Senior lecturer in Maternal and Child Health) has conducted numerous studies on perinatal mental health and how healthcare professionals collaborate to support women during and after pregnancy. Jenny Mcleish is a researcher specialising in mental health peer support and Dr Gabriella Romano is a clinical psychologist and researcher, with a clinical and research background in health psychology.

The evaluation was conducted using a mixed-methods design to evaluate the MABIM programme, and identify facilitators and barriers to individuals implementing changes and improvements to services for women with perinatal mental health problems.

The evaluation focused on:

1. What are the key strategies for change used by participants in MABIM?
2. What are the identifiable facilitators and barriers for change in the four sites?
3. How have these changes impacted on the local provision of services for women affected by mental illness?

The three components of the MABIM evaluation are outlined in Box 1. These were a qualitative evaluation of MABIM, quantitative evaluation of the masterclasses, and a case study of an area participating in MABIM.

The evaluation took place from September 2016 to September 2018. The evaluation was initially designed and conducted by the Mental Health Foundation. However, following staff changes at the Mental Health Foundation the evaluation team at City, University of London, were asked to complete the evaluation.

Results of this evaluation will inform MABIM and the development of similar projects going forward, as well as contributing to the wider literature on how to develop and implement appropriate and effective services for perinatal mental health.

Box 1. Components of the MABIM evaluation

1. Qualitative evaluation of MABIM

20 interviews were conducted with participants from MABIM and non-MABIM sites. Interviews were transcribed and analysed using systematic thematic analysis.

2. Masterclass evaluation

148 feedback questionnaires on the masterclasses were obtained after the masterclasses. In addition to quantitative feedback, responses to open text questions were analysed using systematic thematic analysis.

3. Case study

Case study of an area participating in MABIM is used to illustrate how MABIM can support areas to develop services for women with perinatal mental health problems, as well as identifying barriers and facilitators to change. This draws on pathway assessment tools completed before and after MABIM, and interviews with 5 participants working in this area.

2. Methods

2.1 Design

This evaluation used a mixed-methods design where 20 participants were interviewed about their experiences of MABIM and/or implementing change (see 3.1 for results) and feedback questionnaires were collected after each masterclass (n=148, see 3.2 for results). A case study of an area that participated in MABIM is used to illustrate how MABIM supported areas to develop and improve their services for women with perinatal mental health problems, as well as barriers and facilitators of this (see 3.3).

2.2 Ethical Approvals

Ethical approval was obtained from the Research Ethics Committee in the School of Health Sciences at City, University of London.
The evaluation was conducted in line with the World Medical Association Declaration of Helsinki for medical research (2013). Data will be stored for at least five years after completion of the report. The master files and documents will be held by City, University of London, in secure archiving facilities. Each participant signed a consent form before completing the masterclass questionnaire and provided verbal consent before the interview began.

2.3 Participants

For the interviews, purposive sampling was used to ensure representation of project leads across all four MABIM sites (Blackpool, Gloucestershire, Haringey and Southend) as well as some participants from non-MABIM sites that may have accessed MABIM resources available on the internet or through conferences and other means.

Participants included people who had attended the Leaders' Programme, managers and colleagues of people attending the Leaders' Programme, and leaders in non-MABIM sites who used the pathway assessment tool and other resources. 20 participants were interviewed: 16 from MABIM site and 4 from non-MABIM sites. 148 feedback questionnaires were completed by individuals who attended one or more masterclasses.

2.4 Data Collection

2.4.1 Qualitative interviews

Recruitment
Participants were recruited by the Mental Health Foundation or City, University of London, research team. This was supported by the MABIM team who identified leaders from all areas who had consented to helping with the evaluation (from both MABIM and non-MABIM sites). An email inviting people to take part was sent to possible participants which included a Participant Information Sheet and Consent Form. Participants who were interested in taking part replied directly to a named researcher at the Mental Health Foundation or (latterly) City, University of London, and a 30-minute telephone interview was subsequently arranged.

Interviews
Semi-structured interviews were conducted using the interview schedule developed by the Mental Health Foundation. Interview questions were designed to meet the evaluation objectives. Key interview questions are outlined in Table 2. Short telephone interviews (30-minutes) were conducted by a researcher experienced in qualitative data collection. Interviews were recorded and sent to an external transcription organisation for transcription under a service data agreement in accordance with General Data Protection Regulation guidance.

Table 2. Semi-structured interview questions

Perinatal Mental Health
1. How do you think perinatal mental health is being tackled locally/nationally?
2. In terms of good practice where do you access guidelines?
3. What do you feel you need to create change in your locality?
Impact of MABiM
4. What was your motivation for joining the MABIM programme
5. How has MABIM supported you?
6. What do you feel are the barriers to change?
7. Have you noticed/implemented any changes to maternal mental health as a result of the MABIM masterclasses?[1]
Recommendations for future development
8. If you had to run the MABIM Leaders Programme again, what would you recommend?

Analysis
Data were analysed using systematic thematic analysis (Braun & Clarke, 2006). A combined inductive and deductive approach was used where key themes for barriers and facilitators were pre-specified, and remaining themes emerged from the data. Data were analysed using the following steps: first, all transcripts were read to become familiar with the data. Transcripts were then read again and all initial codes identified and coded. When no further codes emerged (i.e. data saturation) all the codes were examined by two researchers and those that were most frequent or could be combined into themes identified and used to create a coding schedule. Finally, all interviews were coded using the coding schedule. Interviews were analysed using systematic thematic analysis facilitated by NVivo, a specialist computer software package

2.4.2 Masterclass questionnaires

Questionnaires were designed by the research team at the Mental Health Foundation to obtain feedback on participants' experiences of the masterclasses and their understanding and perceived ability to change services for women with perinatal mental health problems. Questionnaires included quantitative items to obtain feedback on the venue, content, format, style, quality of speakers and helpfulness of each class; as well as participants' beliefs about creating change within their services.

Questionnaires also included open text questions about how helpful they found each masterclass, why it was helpful, beliefs about creating change, and any barriers to change. The design of the questionnaire was refined after masterclass 1 so the information obtained for masterclass 1 is different to that obtained for masterclasses (2 to 9).

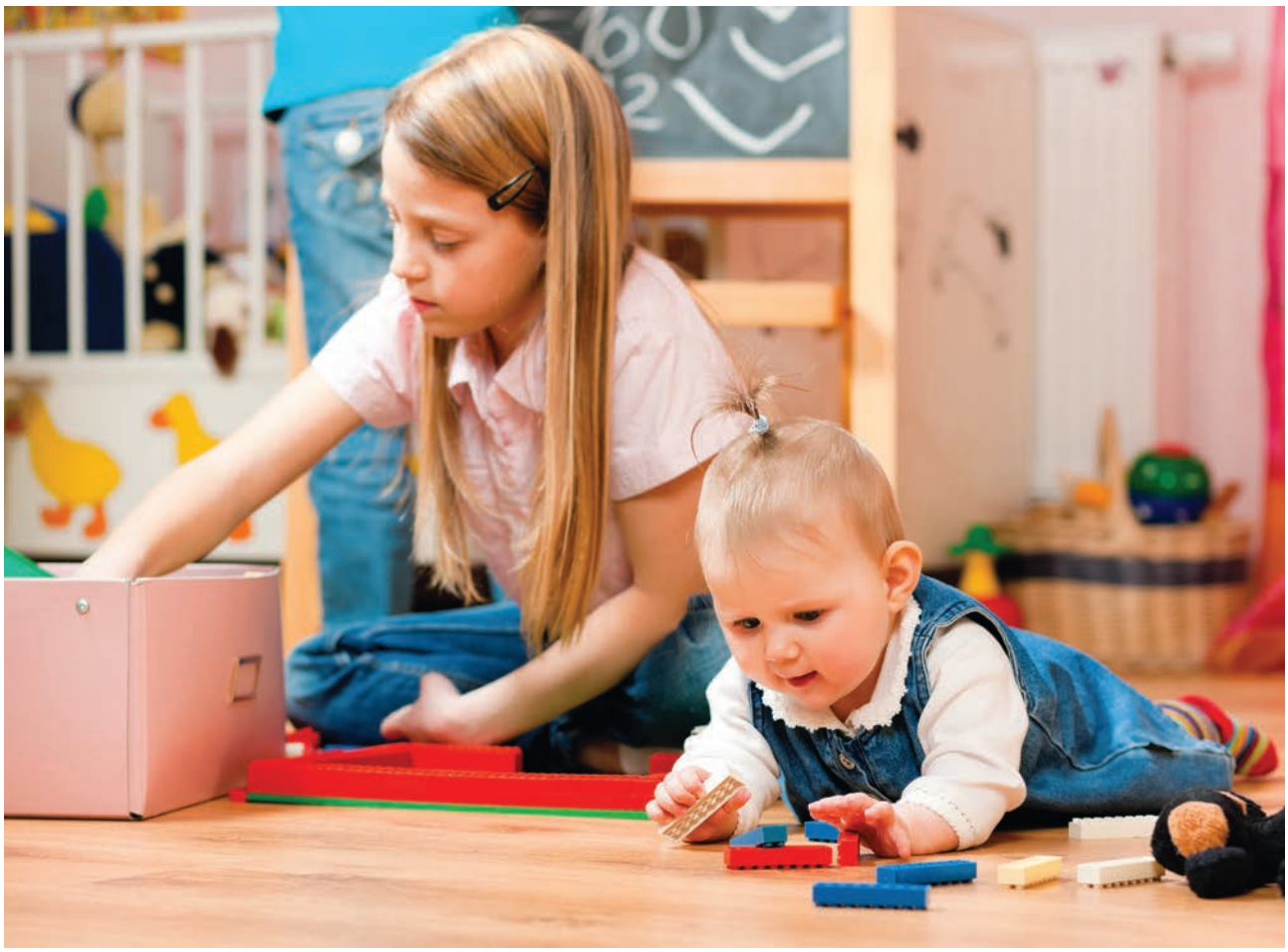
1. For participants who had not attended the Leaders programme or masterclasses these questions were adapted to ask more generally about the MABIM programme.

Questionnaires were distributed at the end of each masterclass. Completing the questionnaire was voluntary and participants were asked to indicate whether they consented to be contacted in the future for evaluation purposes. Data from completed questionnaires was entered into a statistical software package (Statistical Package for the Social Sciences, SPSS). Descriptive statistics are used in this report.

2.4.3 Case study and pathway assessment tool

The case study provides a vignette of an area where learning from MABIM was used to develop services for women with perinatal mental health problems. This case study uses information from the pathway assessment tool and 5 qualitative interviews with healthcare professionals and others working in this area. These interviews were completed as part of the qualitative interview study (section 2.4.1)

Pathway assessment tools were completed by two areas in the first year of MABIM, and again at the end of MABIM. The pathway assessment tool asked commissioners or service leads to rate the provision of care in 14 areas: Care pathway, Clinical and commissioning networks, Workforce training and development, Commissioning, Maternity services, General practitioners, Health visitors, Family nurse partnership, Specialist perinatal mental health services, Adult mental health services & CAMHS, Community and children's services, Infant mental health, Services for dads, and the Third sector. Services were rated from 0 (None of this is true in my area) to 5 (We are doing all of these things well). An overall score (0 to 5 as above) was also calculated.



3. Results

3.1 Qualitative evaluation of MABIM

3.1.1 Demographic characteristics of participants

Participants were included from all four sites (n=16) as well as non-MABIM sites (n=4). They were mostly female (90%) and came from a diverse range of backgrounds and job roles in services such as NHS Services, Child and Maternal Services and Mental Health Services among others. (see Table 3.1).

Table 3.1 Demographic characteristics of participants (n=20)

		N (%)
Gender	Male	**2 (10)**
	Female	**18 (90)**
Sites	Blackpool	**3 (15)**
	Southend	**4 (20)**
	Haringey	**3 (15)**
	Gloucestershire	**6 (30)**
	Non-MABIM (Bradford, Warwickshire, Nottingham)	**4 (20)**
Job Role	Scheme Manager	**1 (5)**
	Commissioning Manager	**3 (15)**
	Development Support Officer	**1 (5)**
	Midwife	**1 (5)**
	Researcher	**1 (5)**
	Junior Sister	**1 (5)**
	Clinical Lead	**1 (5)**
	Specialist Health Visitor	**2 (10)**
	Programme Facilitator	**1 (5)**
	Governance Operations Lead	**1 (5)**
	Psychological Therapist	**1 (5)**
	Service Manager	**1 (5)**
	Project Manager	**1 (5)**
	Child Centre Director	**1 (5)**
	Commissioner	**2 (10)**
	Performance and Development Lead	**1 (5)**

3.1.2 Evaluations of MABIM

Analysis of the interviews identified seven main themes across three areas: (1) evaluations of MABIM, (2) facilitators and barriers to change, and (3) maintaining good practice (see Table 3.2 for themes and sub-themes).

The first theme was the **value of MABIM**. Participants valued many aspects of the MABIM project from the bespoke support and consultations, the use of the pathway assessment tool and the Leaderships programme. MABIM's value was reflected upon as being in essence a hub for reflection, consultation, advice and support, learning, testing out new practices, validation and a sounding board for focusing priorities.

Participants valued the pathway assessment tool and bespoke support:

> We are actively using the Mapping Tool and have held mapping events so that mapping tool has also been used as the basis for developing our action plan and we have also appended that to the Government's arrangement so that the system leaders can see for themselves actually where some of the priority areas are and things like that

> If we have any questions and we ask them, they always get back to us. They are good at connecting us with people with our questions. They are very good at communicating actually.

MABIM helped build confidence through collaborative learning

> I think the power of the process, the collaborative process is something that I would use, and definitely be using as a model of the work that I am doing, because I think the facilitation of it was really positive in the way that it was done, and I definitely will use that going forward with other works that I do.

> I don't know how to say it really, confidence, it was a confidence boost, because I think I've been in the room with like-minded people, who (are) thinking about things in the same way; (it) has been a confidence boost in the way that then I can present that stuff to people in my local area, who don't necessarily think the same way that I do.

It also facilitated learning about national services for women with perinatal mental health problems, potentially prompting services to adopt new practices.

> ...we've managed to bring in things like video interactive guidance, so we're learning from what's happening nationally and just looking at what works from a local level and bring in additional things in, where necessary, so that's good

Recommendations were offered for how MABIM might improve in the future to maintain or develop further helpful practices. These included more areas to be involved so more people and services could benefit.

> I guess on a national level then just probably more awareness of the project. I imagine that quite a few of the people who can potentially benefit...from MABIM have been involved but then there are probably just as many people that have missed out because they are really just not aware of it.

Other suggestions were for masterclasses to be more easily accessible and for there to be more regular support or contact between classes to help individuals transfer learning from the masterclasses into services.

> The only thing is, to come up North a little bit before, because obviously it's a huge day for us getting on the train at 5 o'clock in the morning, and not getting home until 9 o'clock at night.

But they were all very spread out, so they just felt like three times over the last year I have spent the day with a group of wonderful people, exciting people, people that are quite interested and passionate about perinatal mental health. And then I have left and I have just gone back to my daily work, where no one is interested. And then maybe, you know a few months later I have gone to another one and that's that really. So I have always enjoyed being there, but I am not sure what it was all about really.

3.1.3 Facilitators and barriers to change

Factors identified as **facilitators** of change included creating time and space to think and connect, working with service users and commissioners, and having professionals in a team who are able to influence change to services.

You can't get people to do new and different things without that kind of support and also the space to be able to think and work out what it is they need to do, so I think that is what we have tried to do.

...but if we can collaborate really with those who have lived the experience and our commissioners to start to help the whole system that would be, if we have the right people with the passion who want to be involved and spend time doing that, that would be really great.

we have had some suitably knowledgeable clinicians who have been able to say this must be a priority and so therefore it is, and we were able to get ourselves into a good position when it came to bidding for the money.

A number of factors were identified as inhibiting the process of change and development in services for women with perinatal mental health problems. Key **barriers** were lack of resources, in terms of lack of funding, staff and time.

Yes I think it is like I said before it is resources, I think the willingness is there to do it, it is just having the time to get out there and promote everything.

Yes obviously people because of the cuts then everybody is stretched really thin, so you have got lots of work and not enough time, and it could do with a lot more staff obviously but there isn't that.

Another key barrier was working in fragmented systems or ways.

I think the system is still too chopped up.

Just a complete lack of join-up. When I am speaking to our commissioners I have [money] to put into perinatal and infant mental health, we have all the things going on, and people can't do it because they are so ground down in trying to work out whether they are in STP, whether they are part of an area, it is just chaos in the NHS around how the teams and different things are being set up which makes it very difficult locally to get anything to happen, and to plan because every week it changes as to who is involved and who is doing things so locally it is really kind of ground almost to a halt.

Instability and uncertainty within services illustrated how changes could be blocked if resources and/or staffing were uncertain, services were fragmented or in a process of changing, which created a sense of uncertainty and sensitivity to future plans.

...nobody really knows where it is going and who is doing what element of it and that makes it very difficult. And then locally people don't want to be setting something up in case it doesn't fit in with whatever is going to be designed on a much bigger footprint.

Just to put context in, we've been in a tendering process that has dragged out over the last eighteen months and it's still ongoing. And so in terms of what we deliver and offer, that has been very much up in the air and it's having a negative impact on things like staff retention and decision making and all of.

3.1.4 Maintaining good practice

A theme on **good practice** highlighted how participants accessed and applied good practice. The MABIM website was used by participants to access information on the latest good practice.

I have gone to and kind of more recently looking on stuff like the MABIM website to see what is new and when I am writing anything it would be my place to go or to point people to if they need to know more.

Participants also commented on the helpfulness of having experts through lived experience involved in service development.

We have also got an expert by experience involved as well, so obviously that provides a different level of kind of standards as well, so yes that has been quite helpful in terms of recruitment and team training and service development, that we have got an active expert by experience involved in that as well.

However, the difficulty maintaining good practice and standards in an over-stretched system without adequate resources was also commented on.

...so it's very difficult within that to try and provide a standard that we feel is so important. Because staff are over stretched, and actually it's been a big challenge to help support those who are the champions, to complete their video interactive guidance training. Because of the workload verses capacity demands, you know it's been a real struggle.

Finally, a theme on **sustainability and development** looked at how to maintain and further develop services for women with perinatal mental health problems. Factors mentioned included using innovative ideas, strategic practice, avoiding a 'one-size fits all' model, or avoiding focusing too much on one area of service.

you can't do what everybody else does because every area is so different, they have got different funding, the team looks different and so you can't just copy another model exactly, you know, or you might not be at the right stage to do that same thing. It is being quite creative and trying experimenting as you go as well.

[the MABIM team] said' "Have a fridge that keeps ideas cool", so that you've got these projects and these things that you can very quickly turnaround to put in for funding that pops up.

...there is still a huge gap for women who haven't got a diagnosed severe mental illness but who might suffer really quite significant problems and I don't think that any of the NHS England money and kind of focus is on that at the moment but definitely there has been big and very welcome improvements in secondary care without a doubt.

Table 3.2 Themes and sub-themes from qualitative interviews

Theme	Description of the theme	Sub-themes
Evaluation of MABIM		
Value of MABIM	The theme includes positive feedback on aspects of the MABIM project from the value of consultations, the use of the Pathway assessment tool and the Leaderships programme. MABIM's value is reflected upon as being in essence a hub for reflection, consultation, advice and support, learning, testing out new practices, validation and a sound board for focusing priorities.	• value of the pathway assessment tool • consultation and support • confidence building • learning • adopting new practices
Recommendations	Recommendations are offered as to how MABIM might improve in the future or maintain/develop helpful practices. These include a proposal for more networks to be aware of the project, fewer changes in personnel, an unknown future with life after MABIM and a location that is closer to reach.	• Involve more areas • life after MABIM • more accessible location
Barriers and facilitators to change		
Facilitators	A range of factors identified as being influential in the process of change. For example, creating time and space to think and connect, working with service users and commissioners, and having professionals in a team who are able to influence.	• Time and space to think • Involving services users and commissioners • Involving people who are able to influence change
Barriers	A wide range of factors identified as inhibiting the process of change and development in perinatal mental health. For example, time, money, staffing and fragmented systems.	• Lack of time and money • Lack of staff • Fragmented systems
Instability and uncertainty	Concern about services being unstable, fragmented and in a process of change creating a sense of uncertainty and sensitivity to future plans.	
Maintaining good practice		
Good practice	Narratives highlight the access and application of good practice. Professionals outline where they access information to support good practice. There is an awareness in the value of applying good practice in the workplace with a conflict of not always being able to apply good practice due to the nature of the system in which practitioners operate in.	• access to good practice via MABIM website • difficulty maintaining standards alongside good practice guidelines • application of standards via service user involvement
Sustainability and development	A range of ideas and reflections provided in relation to sustainability of services as well as how to keep services developing. Ideas included being innovative, strategic practice, avoiding fitting to a 'one-size fits all' model, avoiding focusing too much on one area of service.	• innovative ideas/one size fits all • strategic practice • avoid a 'one-size fits all' approach • avoid too much focus on one area

3.2 Masterclass evaluation

The results presented here from information collected in 148 questionnaires[2] completed at the end of each of the nine masterclasses. Completing questionnaires was voluntary so they were not completed by everyone who attended. Due to the change in questionnaire design between the first masterclass and subsequent masterclasses, some information is reported separately or not available.

3.2.1 Demographic characteristics of participants

Masterclasses were attended by a range of healthcare professionals from different disciplines, including psychiatrists, psychologists, nurses, midwives, health visitors, managers and commissioners (see Appendix A for more information on participants).

The majority were female with an average age of 48 years old. The distribution of attendance of participants by site was captured in the first masterclass with professionals who attended being fairly equally distributed across the MABIM areas.

3.2.2 Masterclass evaluation: Quantitative results

All masterclasses were evaluated very positively. Participants who completed questionnaires at the first masterclass on developing a specialist perinatal community team (n=24) rated the session highly on a number of items including venue, content, format, style, quality of speakers and helpfulness of the action sets. Average ratings ranged from 8.9 to 9.9 out of 10 (with 0=poor and 10=excellent). Ratings for masterclasses 2 to 9 were similar with participants highly rating the helpfulness of the classes with scores ranging on average from 8.35 to 9.75 out of 10 (with 0 = not at all helpful to 10 = very helpful) (see Table 3.3). Participants also felt the training helped their understanding of the importance of improving services for women with perinatal mental health problems, with ratings ranging on average from 8.25 to 9.15 out of 10 (with 1=low and 10=high).

High ratings were also reported across all masterclasses in relation to participants' knowledge about the benefits of acting to improve perinatal mental health, the risks of not acting, and their understanding of what good practice looks like, with ratings ranging on average from 7.75 to 9.75 out of 10.

Participants scored particularly highly on believing they could create change and that the training helped their understanding of perinatal mental health and how to improve this within their service. In masterclasses 1 to 9 between 95% and 100% of participants said that after the masterclass they believed they could create a change; and between 88% and 100% of participants said the masterclass training helped their understanding of perinatal mental health and how to improve this within their service (see Table 3.4).

2. Individuals attended various masterclasses so the total number of questionnaires is not equivalent to the total number of participants.

Table 3.3. Evaluation of masterclasses 2 to 9

	Commissioning PMH Services (MC2)	Midwives and Health Visitors (MC3)	User Engagement and Insight (MC4)	Reaching all Communities (MC5)	Change Leadership (MC6)	Keeping the Baby in Mind (MC7)	Sharing Challenges and Successes (MC8)	Innovation (MC9)
	Mean (SD) Total Count							
How helpful did you find today's masterclass? (1=not at all, 10=very)	8.67 (0.90)	8.35 (1.53)	8.81 (0.98)	9.25 (0.91)	8.9 (1.00)	8.76 (1.30)	8.63 (1.60)	9.75 (0.50)
TOTAL COUNT	**15**	**20**	**11**	**20**	**16**	**17**	**19**	**4**
Did today's training help your understanding of the importance of improving PMH services? (1=low, 10=high)	8.64 (1.08)	8.20 (1.93)	8.82 (0.87)	9.15 (1.81)	8.19 (1.87)	8.62 (1.82)	8.95 (1.39)	8.25 (2.06)
TOTAL COUNT	**15**	**20**	**11**	**20**	**16**	**16**	**19**	**4**
Did today's training help your understanding of the benefits of acting to improve perinatal mental health? (1=low, 10=high)	8.60 (1.68)	8.20 (1.88)	8.82 (0.87)	9.25 (1.11)	8.12 (1.54)	8.75 (1.53)	9.11 (1.07)	9.00 (1.15)
TOTAL COUNT	**15**	**20**	**11**	**20**	**16**	**16**	**18**	**4**
Did today's training help your understanding of the risk of not acting? (1=low, 10=high)	**8.20 (1.70)**	**7.95 (2.23)**	**8.00 (1.67)**	**9.15 (1.42)**	**8.56 (1.59)**	**8.44 (1.67)**	**8.61 (1.53)**	**7.75 (2.62)**
TOTAL COUNT	**15**	**20**	**11**	**20**	**16**	**16**	**18**	**4**
Did today's training help your understanding of what good practice looks like? (1=low, 10=high)	7.80 (1.42)	8.45 (1.76)	9.00 (0.89)	9.05 (1.43)	8.87 (1.36)	8.75 (1.06)	9.22 (0.94)	9.75 (0.50)
TOTAL COUNT	**15**	**20**	**11**	**20**	**16**	**16**	**18**	**4**

Table 3.4 Impact of masterclasses on participants' beliefs about creating change and improving services

	Developing a Specialist PMH Community Team (MC1)	Commissioning PMH Services (MC2)	Midwives and Health Visitors (MC3)	User Engagement and Insight (MC4)	Reaching all Communities (MC5)	Change Leadership (MC6)	Keeping the Baby in Mind (MC7)	Sharing Challenges and Successes (MC8)	Innovation (MC9)
	% (n) Total Count								
Following today's masterclass do you believe you can **create a change**?									
YES	95% (18)	100% (15)	95% (19)	90% (9)	100% (18)	100% (15)	100% (14)	94.7% (18)	100% (4)
NO	–	–	–	10% (1)	–	–	–	5.3% (1)	–
DON'T KNOW	5.3% (1)	–	5% (1)	–	–	–	–	–	–
TOTAL COUNT	**19**	**15**	**20**	**10**	**18**	**15**	**14**	**19**	**4**
Did today's training help your understanding of perinatal mental health and **how to improve this within your service**?									
YES	88% (15)	93.3% (14)	100% (19)	100% (11)	89.5% (17)	86.7% (13)	93.8% (15)	94.7% (18)	100% (4)
NO	5.9% (1)	6.7% (1)	–	–	10.5% (2)	13.3% (2)	6.3% (1)	5.3% (1)	–
DON'T KNOW	5.9% (1)	–	–	–	–	–	–	–	–
TOTAL COUNT	**17**	**15**	**19**	**11**	**19**	**15**	**16**	**19**	**4**

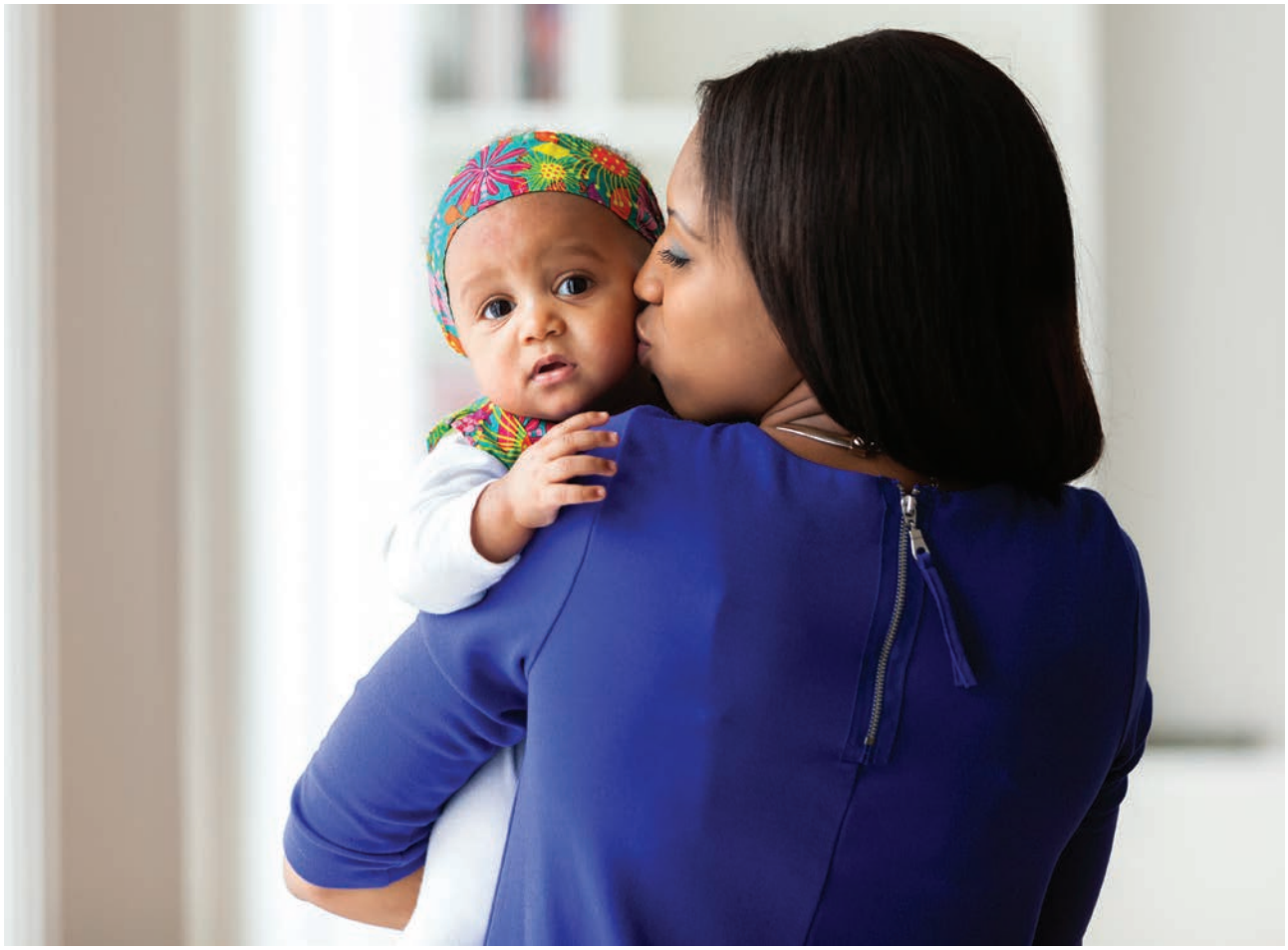
3.2.3 Masterclass evaluation: Free text responses

The masterclass evaluation included free text boxes that asked participants to answer the following questions in their own words: How helpful did you find today's masterclass and why? and Please state why you believe you can create a change and any barriers you face. Written responses to these items were analysed using thematic analysis.[3]

In line with the previous findings, participants reported finding the masterclasses very helpful. Four themes were identified for why they were helpful: (1) the quality of speakers, (2) the opportunity to share practice and network with others working in similar areas, (3) that the masterclasses were thought provoking and helping them develop their thinking in terms of improving services and (4) provided unique insights into specific topics such as leadership (see Table 3.5 for themes and written quotes). These themes are based on 92 participants' responses.

In response to the question about creating change three themes emerged. Participants reported: (1) that passion was needed to drive change, (2) that engagement, relationship building and co-production is needed for delivering change and (3) they had specialist interest in specific population groups who may need services. These themes are based on 7 participants' responses so may not be generalisable.

Three main barriers to change were identified: (1) lack of resources, (2) inability to influence change due to job role, and (3) poor communication, where systems and individuals do not communicate with each other. These themes were based on 16 participants' responses so may not be generalisable.



3. Please note these questions were not included in masterclass 1 so results are based on evaluation of masterclasses 2-9. Not all participants wrote responses so number of responses is shown in Table 3.5.

Table 3.2 Themes and sub-themes from qualitative interviews

How helpful did you find today's masterclass and why? (N=92)

Main theme	Description of theme	Quotes
1. Quality of Speakers	Narratives capture an appreciation for the quality of the experience in terms of respective speakers' expertise in a subject area, style of delivery and being inspired and motivated to apply theory in practice.	***'wide range of inspirational speakers and lots of ideas to stimulate my thinking'*** ***'very powerful lived experience speaker; excellent; enjoyed all the speakers motivating'*** ***'loved the emphasis on baby's MH and excellent; v knowledgeable speakers'***
2. Sharing and Networking	Narratives captured the usefulness of meeting and connecting with practitioners or professionals working in similar fields of work. A sense of feeling validated in current practices, feel part of a bigger network working towards a common goal and the gaining of first-hand knowledge both by professionals and service users.	***'new contacts to help and connect (within and outside area) lots of new knowledge and perspective'*** ***'informative making you think about different things; meeting and learning from others*** ***'interesting to talk to commissioners and understand how everyone is finding it complex'***
3. Thought Provoking	Narratives captured the way the content invited participants to think about particular ways to enhance practice, develop a new perspective and/or consolidate previous learning	***'I've done leadership courses in the past but this really consolidated my past learning and focused more on the relationships rather than just tools/models to use'*** ***'bigger focus on the how has been really practical and helpful'***
4. Unique Insights	Particular issues/topics resonated for participants across masterclasses which felt pertinent/unique to their role or continual professional development. For example: how to work with an agency, learning about leadership not management, trauma in mothers in prison.	***'better understanding of difficult possibilities in support for mothers and fathers dealing with perinatal mental health issues'*** ***'really enjoyed complex trauma, mothers in prison and neo-natal'***

Please state why you believe you can create change (n=7)

Main theme	Description of theme	Quotes
1. Passion	Recognition that in order to pursue change a need for passion is required fundamentally to drive a process forward.	***'power to affect change is not related to your job role – all that is needed is passion.'*** ***'I have passion and commitment so I'm just going to keep focused on the future.'*** ***'it's going to be hard as have no PNMH service at present as no consultant psychiatrist involvement; its' harder to define obstetricians role too; but I am passionate, energetic and determined'***
2. Engagement and Relationship Building	Creating relationships and making links with other professionals, communities or organisations.	***'working co-productively with community and partners will make positive changes'*** ***'gathering data but also creating relationships engaging with all people who can help you deliver that change'*** ***'understanding issues and more able/more ideas about how to educate and engage others'***
3. Specialist Interests	Narratives captured the way the content invited participants to think about particular ways to enhance practice, develop a new perspective and/or consolidate previous learning	***'peer support this is on my radar; also enhanced thinking about premature babies and their parents'*** ***'creating models for perinatal service and specifically complex trauma'*** ***'thinking more about prioritising fathers – we think about it but need to implement developing interventions offered by health visiting.'***

Please state any barriers you face (to create a change) (n=16)

Main theme	Description of theme	Quotes
1. Resource	Participants commented on the lack of resources to implement changes. Resources were identified mainly as a lack of available funding in the organisation and staffing.	***'In my primary care service there is little support for change without additional funding which so far is not forthcoming – I live in hope!'*** ***'possibly many barriers – significantly funding'*** ***'having sufficient capacity of staff to deliver services to all who need them across a wide rural area is a big barrier'*** ***'lack of resource'***
2. Influence	The job people are in was a key factor identified by participants as getting in the way of making change happen. This is in an addition to uncertainty within a job role	***'Barriers – convincing members of the team that it's important'*** ***'changes to my role may mean I am less able to focus on PMH'***
3. Communication	A sense of being unable to communicate knowledge that will be heard within an existing model of working, as well as reaching out and having the means to communicate effectively with service users.	***'challenging the medical model'*** ***'Barriers – systems and people not talking to each other – poor engagement from those most able to support systems change workforce development'*** ***'accessing service users to engage and affect change'***

3.3 Case Study

This case study outlines the experiences of MABIM from one area (Area B) which applied learning from MABIM to implement initiatives and changes to services. This case study is based on five interviews with professionals in this area who came from different disciplinary backgrounds and were at different levels of seniority (e.g. nurse, commissioner, third sector manager). Information from the pathway assessment tool of services in Area B before and after taking part in the MABIM programme is also included

3.3.1 Developing services for women with perinatal mental health problems

The pathway assessment of services for women with perinatal mental health problems in Area B shows four areas of services were rated more highly overall at the end of MABIM (Table 3.6 on page 24). These were specialist perinatal mental health services, community and children's services, services for Dads and third sector organisations.

Examination of more detailed ratings suggested these improvements occurred through targeted action on weaker elements of these services. For example, specialist perinatal mental health services improved in ratings for the prevention pathway (from 1 to 3) and providing preconception advice (from 2 to 4); whereas standards were maintained in relation to having a multidisciplinary specialist community perinatal mental health team and clear links to Mother and Baby Units which were rated similarly in the first and second assessment (3 and 2 respectively).

Other services in the pathway assessment were maintained and rated the same in the first and second assessment (Table 3.6). Most of these scored 3 or more i.e. 'we are doing many of these things but we don't know if they are working'.

3.3.2 Examples of initiatives in services for women with perinatal mental health problems

Five interviews with professionals working in Area B identified a number of perinatal mental health initiatives during MABIM, some of which were facilitated by the MABIM programme and others which started before MABIM. In primary care, ongoing initiatives included developing a programme to train health visitors in CBT; piloting psycho-education groups for women with postnatal depression or anxiety; and working with community services to develop drop-in sessions for women from BME communities ('friendship café') and group peer support ('Mothers in Mind').

In maternity and neonatal services initiatives put in place during MABIM included developing a leaflet for parents of babies on the neonatal intensive care unit (NICU) for inclusion in admission packs; having displays for parents on NICU about emotional wellbeing and mental health; more linking of services (e.g. NICU and IAPT); covering perinatal mental health in mandatory study days; involving parents with lived experiences; and using examples of best practice in other areas to persuade commissioners to fund services in Area B.

3.3.3 Strategies for change

Strategies for change identified by people working in Area B were broadly consistent with themes from the qualitative evaluation (Section 3.1). A key mechanism of change mentioned by three of the five people interviewed in Area B was the bespoke support from the MABIM team to help service providers look at the care pathway and services for women with perinatal mental health problems as a whole. This was described as resulting in a more cohesive pathway, as well as facilitating the inclusion of multiple agencies, such as third sector organisations.

> Having an opportunity for him [MABIM clinical lead] to come to [Area B] and help us to develop our pathways and get advice from him about, you know what might work and what wouldn't, and what's realistic and that sort of thing. And it enabled I suppose a service within [Area B] to be a lot more cohesive.

Table 3.6 Mapping of services for women with perinatal mental health problems during and after MABIM

	Pre-assessment September 2016* Ratings (0-5)	Post-assessment November 2018* Ratings (0-5)
Overall Rating	3	3
Care Pathway	4	4
Clinical and Commissioning Networks	4	4
Workforce Training and Development	3	3
Commissioning	3	3
Maternity Services	3	3
General Practitioners	2	2
Health Visitors	3	3
Family Nurse Partnership	3	3
Specialist PMH Services	1	2
Adult Mental Health Services & CAMHS	2	2
Community and Children's Services	2	3
Infant Mental Health	3	3
Services for Dads	1	2
Third Sector	2	3

*** Key to ratings**

0 None of this is true in my area
1 One or two of these things are true in some areas:
2 A few of these things are true
3 We are doing many of these things but we don't know if they are working;
4 We are doing many of these things and are confident in the quality
5 We are doing all of these things well.

The inclusion of commissioners in that process was seen to be important.

> Well I think because the Clinical Commissioners in [Area B] were part of the project, and because the project was kind of really pushing people to look at the pathway really holistically. So it meant that quite early on, there were quite a lot of sort of multi-agency meetings that were set up, around that, and I do think that MABIM really supported that framework if you like, of what have we got? Where are we at? What's, okay there's the specialist support, but actually what's happening in the community. I just think it was really helpful.

Good communication both within and between services was seen as key in terms of developing and improving PMH services.

> You need to have really good communication between all services so mental health, midwifery, health visiting, possibly social services, ...and the GP as well, yes, so that people are working together and trying to give appropriate advice so that one service doesn't think another service is seeing them so the health visitors might think they are still having mental health services and mental health services think they are seeing a health visitor and in fact they are not seeing anybody, so good communication.

Resources were critical and were mentioned in terms of being a facilitator and barrier to change. The MABIM strategic lead supported Area B to successfully apply for funding from NHS England which helped them improve their specialist services. This improvement in specialist services is reflected in pathway assessment tool ratings in Table 3.6.

> Because they [MABIM] helped us get the NHS England money, that is what has made a difference, is getting a specialist service.

However, lack of resources was most often mentioned by participants as a barrier to change, mostly in relation to lack of funding and time.

> I think funding is always a bit of barrier, absolutely. I think the appetite is there to change. I think what's always tricky as well is there is so many little groups doing things it is having the capacity to actually get out there and find out what everybody is doing... what kind of support we can give them, you know it all takes a lot of time... so yes lack of resource really I think both financially and sort of time wise really I would say.

> We have got to reduce the number of health visitors within [Area B]... by 2020, which is slimming down the service really. So it's very difficult within that to try and provide a standard that we feel is so important. Because staff are over stretched, and actually it's been a big challenge to help support those who are the [PMH] champions.

However, in terms of development and change, starting from a position of strength was mentioned by the commissioner as providing them with the impetus to keep improving, thus contributing to the sustainability of services.

> Thinking actually we are doing something really well, so let's keep going, rather than thinking oh god we have got such a massive hill to climb – thinking actually we are being quite innovative in [Area B] so let's keep that ball rolling.

Individual participants were highly motivated to change services but sometimes faced frustration in terms of difficulties implementing initiatives. Less senior staff had limited influence and these staff had to work creatively and persistently to overcome this, often doing so in their own time.

> How motivated I am – very high! – 9 [out of 10]. My ability to affect a change is very low... the problem is not with motivation; the problem is with ability to affect change.

> and so as much as there being successes, I've still, I don't want to say failures, because that's not true, but in some ways it can feel like that, when you are frustrated.

Creative ways of overcoming barriers included getting support from others attending the masterclasses to think of ways to facilitate change; working as a group to bypass blockages (or individuals who weren't engaged); getting more people involved; being proactive and persevering in the face of blockages and resistance; raising awareness locally; and sharing learning from the masterclasses with colleagues.

> I do keep thinking about what [MABIM clinical lead] said about you have to, you do have to take people with you and you do have to just keep, you just have to keep doing what you can do and as long as you don't give up, then what you're doing is okay, it will be, do you know what I mean? You probably will get there, and that is true.

Consistent with other aspects of the evaluation, support from MABIM was appreciated and valued.

> I think it's been a really, really positive thing, I think it created a lot of really great stuff in this area. I think it really helped [Area B] to really get its head round what was needed and obviously that's not finished yet, it's an ongoing thing, but I think that MABIM was definitely a really positive support of all of that.

The importance of the national context of increased funding and drivers to improve services for women with perinatal mental health problems was recognised as interacting with MABIMs work and being influential in changes to services for women with perinatal mental health problems.

> I suppose it would be difficult to say exactly where it's MABIM and where it's just the perinatal agenda, but...I think that the Maternal Mental Health Alliance has been a huge driving force in developing better services and getting funding out there and we've had a Specialist Perinatal Mental Health team set up, because of that, and I think all of that has been very much supported by MABIM.

4. Discussion and conclusion

4.1 Summary of findings

This project evaluated the MABIM programme and identified facilitators and barriers to individuals implementing changes and improvements to their local services for women with perinatal mental health problems. The project aimed to identify key strategies for change used by participants, as well as facilitators and barriers to change, and how changes impacted on the local provision of services for women with perinatal mental health problems. These are considered in turn below.

4.1.1 MABIM evaluation

Findings show that participants evaluated the MABIM programme positively and valued many aspects of this programme, particularly the bespoke support, masterclasses and pathway assessment tool. MABIM's value was reflected upon as being in essence a hub for reflection, consultation, advice and support, learning, testing out new practices, validation and a sounding board for focusing priorities. The case study illustrated how MABIM also supported multiple agencies to work together and encouraged a whole system perspective.

Participants evaluated the masterclasses very highly and reported high levels of knowledge about services for women with perinatal mental health problems and good practice. Analysis of free text responses suggested masterclasses were helpful because of the high quality of speakers, the opportunity to share practice and network with others working in similar areas, masterclasses being thought provoking and also providing insights into specific topics such as leadership.

4.1.2 Key facilitators and barriers to change

Participants in the evaluation were all highly motivated to improve services for women with perinatal mental health problems and believed they could create change. Facilitators of change included having people with the passion to drive change, engaging staff and managers, creating time and space for professionals to think and connect, working with service users and commissioners, and having professionals in a team who are able to influence and affect service change. For example, participants' responses to free text questions showed they thought passion was central to drive change and that engagement with other professionals, communities or organisations; relationship building and co-production is needed for delivering these changes.

Three key barriers to change were identified throughout this evaluation: (1) lack of resources, (2) difficulty to influence change, and (3) poor communication and/or fragmented services. Lack of resources were mentioned in relation to funding, time and staffing. The conflict between lack of resources and desire to improve services for women with perinatal mental health problems was frequently mentioned. Uncertainty of current or future resources/staffing was also identified as hindering change. This uncertainty created both conflict and sensitivity to future plans, as well as reluctance to implement changes until there was more certainty.

The importance of peoples' **ability to influence change** came up as a facilitator and barrier to change. The qualitative findings, masterclass feedback and case study illustrate how essential it is to have staff who can influence change involved, such as commissioners and consultant psychiatrists. The converse also arose, with people reporting how hard and frustrating it is for those with less ability to influence change (e.g. nurses and midwives working with managers who were not supportive of their initiatives).

Creative ways of overcoming this included getting support and ideas from other people attending the masterclasses; working as a group to bypass managers who blocked change; getting more people involved; being proactive and persevering in the face of resistance; raising awareness locally; and sharing learning from the masterclasses with as many colleagues as possible.

Poor communication and fragmented services were the other main barriers to change. This was mentioned in relation to poor communication between individuals, between services and between individuals and systems. Free text responses to the masterclass evaluation also indicated the importance of communicating with people who can influence change, as well as highlighting the lack of means to communicate effectively with service users. Fragmentation of services hindered this communication and change. The case study illustrates how the bespoke MABIM support helped one area overcome this through work with multiple agencies to consider their perinatal mental health pathway holistically. This bespoke advice recognises the different profiles of services for women with perinatal mental health problems in different areas. It also counters the 'one-size fits all' approach which participants of the qualitative evaluation thought was unhelpful.

As a solution, free text responses to the masterclass evaluation identified the importance of engagement and relationship building, which presumably should increase communication and overcome fragmentation. Respondents mentioned the importance of creating relationships and making links with other professionals, communities or organisations. Similarly, the importance of working co-productively with community and partners, sharing information and creating relationships with those who can help deliver changes.

4.1.3 Impact on services for women with perinatal mental health problems

It is clear that MABIM was positively evaluated and valued by participants. However, it is hard to determine the impact of MABIM on services for women with perinatal mental health problems within the constraints of the current evaluation.

The case study suggests MABIM contributed to change in specific service areas such as specialist services through targeted action on weaker elements of these services. However, participants recognised these changes may also have been influenced by national changes in the prioritisation and funding of services for women with perinatal mental health problems. Unfortunately, interviews and questionnaires were completed during or very shortly after MABIM when the full impact of MABIM on services may not have been clear. Thus, the impact of MABIM on services for women with perinatal mental health problems is difficult to determine.

One issue that is pertinent is how to maintain and develop services for women with perinatal mental health problems. Factors to facilitate this included using innovative ideas, strategic practice, avoiding fitting to a 'one-size fits all' model, and an evolving model where one area of services is not solely focused on to the detriment of others. The case study suggests the pathway assessment tool and masterclasses may be useful for commissioners by highlighting areas of strength in services for women with perinatal mental health problems as well as areas that need developing, in this case study providing a willingness and impetus for more change. Another factor relevant to sustainability and development is the contrast in the qualitative evaluation between attending MABIM masterclasses with people who are passionate about perinatal mental health and the reality of local services where few people are interested. This has implications for recommendations for the development of MABIM (see Section 4.3).

4.2 Strengths and limitations

This evaluation has a number of strengths and limitations. Strengths include the qualitative evaluation of MABIM which had a large and diverse sample of participants, many of whom had taken part in the leadership programme masterclasses. Participants were involved from all of the MABIM sites and also some non-MABIM sites to understand how non-MABIM sites also use MABIM resources which are freely available on the web.

The evaluation of the masterclasses provided information for each masterclass and a good number of responses overall. Attendance was low for certain masterclasses, which may be due to the topic or other issues such as attendees not being able to leave their job and travel to the masterclasses. This may particularly be an issue for midwives and health visitors who need to apply for funding to attend classes and arrange cover for their clinical duties. Future masterclasses should consider using other locations or electronic methods to make classes available locally.

A key limitation was that interviews were conducted during or shortly after the MABIM programme when it was difficult to evaluate the impact of the programme. Similarly, many individuals did not attend all the masterclasses and it may be that if they completed the whole programme they would have been more effective at transforming local services. However, the MABIM masterclass programme may be more attractive for people if they know they can dip in and out of it and attend classes that are most relevant to their role, expertise and need. Qualitative data supports this by suggesting there were benefits of the masterclasses for participants who did not attend all masterclasses. It is therefore recommended that the programme is kept as one where attendance of all sessions is recommended but not compulsory.

The evaluation of masterclasses was impeded by the change in questionnaire items between the first and subsequent masterclasses. This meant a comparison from baseline was impossible, so the report provides data on post-masterclass scores without having scores before individuals attended masterclasses. Future evaluations should therefore make sure data is collected both before and after the masterclasses.

4.3 Recommendations

A number of recommendations can be made with regard to the future development and evaluation of MABIM or similar programmes. Key recommendations are providing MABIM to more areas in the UK, removing barriers to attending masterclasses (such as making them available more locally or through electronic methods), making sure participants have funding to attend classes, and conducting a rigorous evaluation of impact. The barriers and facilitators identified by this evaluation could be more explicitly addressed. For example, MABIM and similar programmes cannot be an effective lever for change in a local area unless commissioners or other people who can make change happen are involved in the programme. Conversely, there is no point in providing MABIM in an area where they are not engaged. Finally, it is important to determine the direct and indirect impact of MABIM on local services, as well as outcomes for women and children.

4.4 Conclusions

This project found that MABIM was evaluated very positively and valued by participants. Masterclasses were very highly rated, and the bespoke support, pathway assessment tool and resources also commended by participants in the qualitative evaluation. Facilitators of change were individuals having the passion to drive change, engagement of staff and managers, creating time and space for professionals to think and connect, working with service users and commissioners, and having professionals in a team who are able to influence and effect service change. The main barriers to change were lack of resources, some individuals having difficulty influencing change, poor communication and fragmented services.

These results will inform the development of the MABIM programme, as well as contributing to the wider literature on how to develop and implement change to services for women with perinatal mental health problems. A number of recommendations are made for the development of MABIM or similar programmes. Future research is needed to look at the impact of MABIM and similar initiatives on services for women with perinatal mental health problems and outcomes for women and their families.

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Appendices

Appendix A: Demographic information for participants at masterclasses

	Developing a specialist perinatal community (MC1)	Commissioning PMH services (MC2)	Midwives and health visitors (MC 3)	User Engagement and Insight (MC4)
Age – Mean (SD)	46.08 (7.94)	48.3 (6.9)	48.7 (7.75)	47.0 (9.12)
Gender % (n)				
Male	4.2 (1)	–	8 (2)	–
Female	95.8 (23)	100 (15)	84.0 (21)	84 (21)
TOTAL COUNT	**24**	**15**	**23**	**21**
Sites % (n)				
Blackpool	21.7 (5)	Not known	Not known	Not known
Southend	26.1 (6)			
Haringey	21.7 (5)			
Gloucestershire	26.1 (6)			
Non-MABiM	4.3 (1)			
TOTAL COUNT	**23**			
Occupation % (n)				
Psychiatrist	12.5 (3)	13.3 (2)	4.3 (1)	9.1 (2)
Psychologist	12.5 (3)	6.7 (1)	8.7 (2)	–
Psychotherapist	4.2 (1)	–	4.3 (1)	–
Nurse	12.5 (3)	–	4.3 (1)	4.5 (1)
Midwife	8.3 (2)	6.7 (1)	34.8 (8)	4.5 (1)
Health Visitor	12.5 (3)	6.7(1)	17.4 (4)	4.5 (1)
Manager or Lead	25.0 (6)	20.0 (3)	17.4 (4)	54.5 (12)
Commissioner	8.3 (2)	17.6 (3)	4.3 (1)	–
Support/Key Worker	-	-	4.3 (1)	–
Officer	–	–	–	9.1 (2)
TOTAL COUNT	**23**	**11**	**23**	**19**

* information is only available for participants who completed evaluation questionnaires (n=3 to 24)

Reaching all communities (MC5)	Change Leadership (MC6)	Keeping the baby in mind (MC7)	Sharing challenges and successes (MC8)	Innovation (MC9)
41.9 (10.54)	46.1 (6.75)	45.2 (8.77)	43.1 (8.55)	46.0 (2.64)
2.9 (1)	–	7.7 (2)	–	–
76.5 (26)	90 (18)	84.6 (22)	100 (19)	100 (4)
27	**18**	**24**	**19**	**4**
Not known	Not known	Not known	Not known	Not known
–	5.6 (1)	–	10.5 (2)	–
21.4 (6)	5.6 (1)	20.8 (5)	–	–
–	5.6 (1)	–	–	–
10.7(3)	5.6 (1)	16.7(4)	5.3 (1)	–
3.6 (1)	5.6 (1)	4.2 (1)	15.8 (3)	–
14.3 (4)	5.6 (1)	8.3 (2)	–	25.0 (1)
28.6 (8)	44.4 (8)	29.2 (7)	10.5 (2)	50.0 (2)
3.6 (1)	–	–	5.3 (1)	–
3.6 (1)	5.6 (1)	–	10.5 (2)	–
–	–	–	–	–
24	**15**	**19**	**11**	**3**

mums and babies in mind

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