Independent evaluation of Bump Buddies, Shoreditch Trust.

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Executive Summary

Bump Buddies (BB) offers a service to women who are experiencing a range of challenging issues during their pregnancy and early parenthood. These women may be homeless, asylum seekers, living in poverty, survivors of domestic violence, have poor mental health or previous traumatic experiences giving birth.

The service is provided by one full-time and two part-time staff and by volunteer mentors who are local mothers.

The BB programme is situated within Shoreditch Trust, a voluntary organisation in the London Borough of Hackney, and contributes to their strategic aim to reduce economic and social disadvantage in the borough.

This independent evaluation study was started by the researcher at the Centre for Social Justice and Change, University of East London in May 2016 and completed whilst visiting the Mannheim Centre for Crime and Criminology, London School of Economics, in July 2017.

Our research approach is problems-based and realistic and data collected and collated included academic studies, BB reports, project monitoring data, case files (14), self-completion questionnaires (7 by mentors and 25 by mentees) interviews with women (6), mentors (6) and partners (4) and three in-depth discussions with staff.

BB is an intervention at a critical juncture in the lives of women as they transition from pregnancy to giving birth and early motherhood and offers emotional and practical support at these times of heightened vulnerability, which are also opportunities for change.

Previous studies have found peer mentoring offers positive experiences but no discernible additional maternal or child outcomes even though there is strong evidence for the need to intervene to improve life chances of these families.

Implementation

The implementation of BB takes place in a challenging environment. Organisational arrangements, procedures, and the ethos of the BB staff team gives rise to practices that contribute to positive outcomes for the majority of women, and are key to understanding the success of the programme.

BB is well-respected and agencies contact staff to enable them to problem solve and locate sources of help for women with complex needs. Decisions to accept a case onto the programme can require difficult judgements and include taking into account mentors' safety.

Referrals are predominantly made by midwives from the local hospital (81%) and were Black African/Caribbean/British women (45%), followed by white British (25%) and Asians (14%) and other ethnic groups.

Between January 2014 and mid-February 2017 the project received 118 referrals and of these 58% had an assessment meeting and the other women were referred to other

agencies, and 47% of those who had an assessment meeting were allocated a mentor (32 cases).

In general, the time period from referral to an assessment and being matched with a mentor is between 8 and 19 working weeks.

Staff are active and effective key workers and the majority of women found them reassuring. They are positive about the practical and emotional support they receive from staff.

Staff have recruited, trained and supported 41 volunteer mentors who are positive about the training and largely positive about the support they received. These mentors are ethnically diverse, from different classes and local residents.

At the time of the research there were 13 active mentors and data shows that most mentors (75%) support one or two women before leaving the programme. Recruiting and training mentors is therefore an ongoing activity. However, recruiting new mentors is challenging.

Staff and mentors have trusting and equitable relationships that mentors find motivational.

Staff give mentors flexibility to form relationships with women they feel comfortable with and mentors acknowledge how each relationship can be quite different.

The overwhelming majority of mentoring relationships last until at least 3 months after the birth of the child. Only 10% of these relationships broke down prematurely.

For a minority of women their experiences of the programme are not entirely positive and some contact can be poorly received yet their outcomes are positive. Others are particularly hard to help. These findings indicate the challenging nature of this work.

BB contributes to the local community by increasing the skills and knowledge of mentors; by increasing the participation of mothers in local activities; and, improving working relationships across agencies to better support these women. At the time of the research there was little outreach work.

Outcomes

Staff skilfully assess women's situations, are realistic about which issues they can ameliorate, and have a clear strategy about how best to bring about improvements for women.

This robust approach enables the programme to achieve positive outcomes for the overwhelming majority of participants and lays the foundation for increased opportunities for mothers in the future and improving the life trajectory of their infants.

Mentors form mutually respectful relationships with women and enable them to develop self-respect. When mentors adopt an advocacy role they also build trusting relations with women.

A reciprocal relationship between staff, mentors and women gives women the confidence to engage with services and participate in activities and form social relationships with others.

Relationships between staff and women enable women to 'move on' by acting as a critical friend, taking on their difficult practical issues to give mentors space to focus on providing emotional women-centred support, and by forming trusting relationships that encourages women to use other services.

Quality relationships include staff not 'side-stepping' difficult issues, staff and mentors presenting information simply and clearly, and communicating feelings and emotions.

71% of women said felt more confident to make friends; 59% of those in contact with the fathers said they were better able to form cooperative relationships to care for their infant.

Emotional reassurance and practical assistance reduces everyday anxieties, enables women to solve their own problems, and gives them more confident to make better decisions.

The social relationships staff and mentors form with women increases their willingness to discuss their problems and to learn about services and to feel more able to seek help. These changes precede an increased use of services. Women's newly formed self-respect explains how these changes occur.

Over three-quarters (75%) of the women said that they felt more able to plan for their future, just under three-quarters (71%) were better able to enjoy being with their infant, suggesting the formation of a constructive relationship.

All women in contact with BB increased their use of services.

The BB programme contributes to the local community by:

- increasing the knowledge and social skills of mentors who are more able to find volunteer work and paid employment;

- increase the participation of mothers in community-based activities;

- contributing to an increased community capacity to care by facilitating a mutually supportive network of women workers across agencies who problem-solve and jointly offer an improved service.

Issues for discussion

Issues which could benefit from further discussion amongst agencies and would benefit from a collective solution include:

- How to make good judgements about the complexity of cases.
- Understanding reluctances to peer mentor and developing a joint recruitment programme.
- Learning more about the effectiveness of similar interventions for women facing adversity that have a different approach such as counselling or parenting courses.

- Developing stronger theories about how to assist those who are 'hard to help' to further improve outcomes.
- Considering how to improve partnership working and commissioning to support women staff across agencies and organisations who are over-stretched and to increase outcomes for women by having a greater collective impact.
- Considering the role of the BB programme as facilitating a greater collective impact in the London Borough of Hackney.

1. Introduction[1]

Bump Buddies (BB) is part of Shoreditch Trust's strategic aims to reduce economic and social disadvantage in Hackney. BB offers a service to women who are experiencing a range of challenging issues during their pregnancy and early parenthood. These women may be homeless, asylum seekers, living in poverty, survivors of domestic violence, have poor mental health or previous traumatic experiences giving birth.

BB offers a well-defined time-limited service during a crucial period in the life of a pregnant woman and early stages of motherhood and has the potential to positively influence the life chances of the infant by contributing to giving them the 'best start possible'. The service includes staff support for women and volunteer mentoring by mothers who live in local communities.

The research was commissioned by Shoreditch Trust and started by the researcher at the Centre for Social Justice and Change, School of Social Sciences, University of East London (UEL) in May 2016 and completed whilst visiting the Mannheim Centre for Crime and Criminology, London School of Economics in July 2017.

The purpose of this research is to describe how the BB programme works and the extent to which it has met its core outcomes. Information has been gathered to understand more about how practices work and with what effect. In general the term women is used for those receiving the service and occasionally they are referred to as mentees and mentors is used to describe the volunteers who are also women and occasionally they are referred to as Bump Buddies, the term used by the women receiving the service.

1.1 *Bump Buddies, Shoreditch Trust*

BB commenced in 2007 and has been continuously adapted and updated since then. In 2011 closer attention was paid to collecting monitoring data and its aims and objectives have been further refined. In 2017 the overall aims of the BB scheme are to:

1. Develop structures for the purpose of growth and change
2. Develop psychological and social resources to thrive despite adverse circumstances
3. Challenge entrenched inequalities

In addition BB has a well-developed service specification that includes strategic and service outcomes. The three strategic outcomes are: improved social relationships, enabling participation, and increased resilience. Seven service outcomes are outlined in the specification as follows: to improve emotional wellbeing, maternal health, mother-baby attachment, parent/child resilience, increase choice and control, making a positive contribution and raising aspirations.

1.1.1. *Management and staffing*

BB has three women members of staff one of whom works full-time and two part-time and who have worked together for two years. One member of staff is a manager and the roles of the staff are well-defined; they are key workers, recruit, train, and supervise the volunteer mentors, liaise with agencies, and undertake outreach work.

1.1.2. *Volunteer mentors*

Volunteer mentors are recruited through BB monthly newsletters, leafleting, outreach work in the community, and word of mouth. At the time of the research 11 volunteer mentors were actively mentoring and two trained mentors waiting for their first woman to mentor. Mentors are trained to focus on the woman's pregnancy and her early motherhood. Boundaries are set by staff to avoid mentors becoming too involved in all the other challenges facing the mentee such as housing problems or their immigration status. Three activities define the tasks of mentors and these are to provide information about pregnancy and local services, to give practical information, and offer emotional support. They receive training and ongoing support from staff and have weekly supervision meetings over the telephone.

The volunteer mentors support women through regular meetings, telephone calls and texting during pregnancy until approximately three months after the birth or when it is anticipated that the mother will be using her local children's centre.

2. What can we learn from the literature?

A plethora of research studies show how BB is situated at a critical juncture in the lives of pregnant women and has the potential to positively influence the life chances of infants by giving them the 'best start possible'.[2] Whilst findings from numerous studies show that children from poor backgrounds typically have poorer outcomes a review of the literature on supporting vulnerable pregnant women and new mothers in the community concluded that:

> Models for working with women from socially deprived backgrounds – peer mentoring, health visitor support, community drop-in and telephone support found no differences in maternal or child outcomes compared to usual care. (Semele *et al* 2015:37)[3]

This same review found that women's experiences of peer mentoring were positive, they valued the advice they received and the opportunity to meet others during pregnancy. Given the plight of these women it is easy to imagine how cups of tea, active listening and empathy can generate positive feelings and satisfaction. This study about the BB

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[2] Field, F. (2010) *The Foundation Years: preventing poor children becoming poor adults*. London: HM Government.

[3] Samele, C., Clewett, N., and V. Pinfold (2015) *Birth Companions commissioned literature review: Supporting vulnerable pregnant women and new mothers in the community*. Report by Informed Thinking and McPin Foundation. Also see Wiggins, M et al (2004) Postnatal support for mothers living in disadvantaged inner city areas: A randomised controlled trial, *Journal of Epidemiology and Community Health*, 59, 4: 288-295.

programme also finds high levels of satisfaction and appreciation by women but it also records numerous positive outcomes that are unlikely to be achieved by 'usual care'. So, how can this apparent discrepancy be explained? It is possible that existing research has inadequately conceptualised and implemented schemes, that researchers have either not measured or poorly measured factors that make a difference, or is the BB programme exceptional?

Findings from existing studies clearly illustrate that initiatives address high levels of need at a critical time in the lives of women.[4] Numerous health and care professionals such as midwives, health visitors and social workers have statutory responsibilities for these women and are well-placed to provide an effective service. Yet our understandings of how best to conceptualise community-based services and understand what practices are effective, and how to assess them is patchy and insufficient. The following examples illustrate the types of gaps in our knowledge:

- Health research has established clear links between poor antenatal care and poor birth outcomes but there is less evidence about what makes antenatal care effective, and in particular how to prevent increased DVA during pregnancy.[5]
- Characteristics of successful peer mentoring relationships are not fully understood; some initiatives use the principle of homophily - the assumption that perceived similarities fosters trust relationships to match mentors and mentees, but this has been found to be insufficient to establish trust.[6] Other peer mentoring schemes require mentors to have skills that establish equitable relationships with mentees which is thought to promote active and critical reflections on the mentees' circumstances, aspirations and capabilities. But how can this be achieved?

A brief foray into the literature shows agreement amongst many different types of studies that social and economic factors affect health, relationships, and self-worth, for example.[7] The following illustrates some of these associations and documents high levels of need amongst those living in poverty and adversity: connections have been found between poor mental health and economic and social circumstances which negatively impacts on mother-infant relationships and the social and emotional development of a child; stresses on parental relationships occur due to debt, low income, and shame that adversely affects children's behaviour. Poor housing and temporary accommodation add to the precarious lives of these families and further increases anxiety, a mother's susceptibility to postnatal

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[4] See for example, Raymond, J. (2009) 'Creating a safety net': Women's experiences of antenatal depression and their identification of helpful community support and services during pregnancy, *Midwifery*, 25: 39-49.

[5] Samele, C., Clewett, N., and V. Pinfold (2015) *Birth Companions commissioned literature review: Supporting vulnerable pregnant women and new mothers in the community*, report by Informed Thinking and McPin Foundation. Ling Chan, K., Brownridge, A., Fong, D., Tiwari, A., Cheong Leung, W., and P. Chung Ho (2012) Violence against pregnant women can increase the risk of child abuse: A longitudinal study, *Child Abuse & Neglect*, 36: 275-284.

[6] Harris, J. et al (2015) Can community-based peer support promote health literacy and reduce inequalities? A realist review, *Public Health Research*, 3, 3 (Scientific Summary).

[7] Marmot, M (2005) Social determinants of health inequalities, *The Lancet*, Vol.365 (9464), pp.1099-1104.

depression and reduces her capacity to care for a baby.[8] A strong association has also been found between families' socio-economic circumstances and chances that children will experience child abuse and neglect. [9]

In addition, women attribute their poor mental health to trying to live up to unrealistic expectations, lack of support, and social isolation.[10] Social pressures to be a 'good mother' as well as a lack of money intensify the withdrawal of women who are poor. As a consequence 'large and persistent' differences in cognitive and behavioural development of children from lower and higher income families are apparent by the age of three years, and persist into adulthood.[11]

If we turn our attention to services, studies have found that they can change expected trajectories of young children born into poverty and improve their life chances.[12] Such findings underscore the potential benefits of schemes like BB. However a raft of studies have also found that services can have little or no discernible impact and some detrimentally effect the lives of women and their infants.[13] In addition, some women have a strong distrust of services and there is a low take up of services by migrant women and those who are vulnerable with complex needs.[14] Racism and discrimination contribute to this distrust.[15]

The literature is less clear about how best to achieve fair and high quality practice.[16] Evidence suggests that quality social interactions are effective between a pregnant mother and a frontline worker and parent-infant relationships, for example. But what does this

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[8] Field, F (2010) *The Foundation Years: preventing poor children becoming poor adults*. London: HM Government.

[9] Ling Chan, K., Brownridge, A., Fong, D., Tiwari, A., Cheong Leung, W., and P. Chung Ho (2012) Violence against pregnant women can increase the risk of child abuse: A longitudinal study, *Child Abuse & Neglect*, 36: 275-284.

[10] Field, F. (2010) *The Foundation Years: preventing poor children becoming poor adults*. London: HM Government.

[11] Field, F. (2010) *The Foundation Years: preventing poor children becoming poor adults*. London: HM Government.

[12] Field, F. (2010) *The Foundation Years: preventing poor children becoming poor adults*. London: HM Government.

[13] See for example, Lindquist, A., Kurinczuk, JJ., Redshaw, M., and M. Knight (2014) Experiences, utilisation and outcomes of maternity care in England among women from different socio-economic groups: findings from the 2010 National Maternity Survey, *International Journal of Obstetrics and Gynaecology*, 1610-1617.

[14] Samele, C., Clewett, N., and V. Pinfold (2015) *Birth Companions commissioned literature review: Supporting vulnerable pregnant women and new mothers in the community*, report by Informed Thinking and McPin Foundation.

[15] Samele, C., Clewett, N., and V. Pinfold (2015) *Birth Companions commissioned literature review: Supporting vulnerable pregnant women and new mothers in the community*, report by Informed Thinking and McPin Foundation.

[16] Samele, C., Clewett, N., and V. Pinfold (2015) *Birth Companions commissioned literature review: Supporting vulnerable pregnant women and new mothers in the community*, report by Informed Thinking and McPin Foundation.

mean, what are the characteristics of a quality relationship? Similarly, integrated working between agencies is proposed but what does this mean, how can this be achieved?[17]

With cuts in public health and community services and increasing poverty and social and economic inequalities, remaining services are under increasing pressure and staff have high workloads.[18] Social Care have increased their threshold for working with families, for example. Further, low pay and increasing pay inequalities and shortages of health staff reduces morale, adding further strain on developing effective integrated practice.[19]

3. Research

3.1. Research approach

Our approach is problems-based and realistic. We start by finding out how social, psychological, economic, and community problems are formulated or characterised by an initiative, and ask 'to what problem is this intervention a solution?' An evaluation finds out if the problems to which an intervention was designed as a solution have been modified, and how, and takes into account unintended consequences or harm.

In keeping with realist evaluations,[20] we produce evidence on what works, for whom and under what conditions.

- ➢ We consider interventions as theories; these theories of change may be non-linear, inconsistent, and are causal only when they are active. Interventions impact upon the conditions that make them active and this can affect outcomes.
- ➢ The effectiveness of interventions is sensitive to the context within which they are implemented.
- ➢ Interactions with other social programmes affect the operations and outcomes of the intervention.
- ➢ Community factors influence the anticipated causal mechanisms.
- ➢ Interventions typically evolve and change as different decisions are made and an evaluation takes this 'life course' of an initiative into account when assessing its progress.

We think that it is useful to conceptualise interventions as having four key features and these structure our data collection and analysis:

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[17] Samele, C., Clewett, N., and V. Pinfold (2015) *Birth Companions commissioned literature review: Supporting vulnerable pregnant women and new mothers in the community*, report by Informed Thinking and McPin Foundation.

[18] Rowlingson, K (2011) Does income inequality cause health and social problems? Joseph Rowntree Foundation. (www.jrf.org.uk/publications). Also see http://www.telegraph.co.uk/health-fitness/body/ageing-midwives-crisis-student-midwives-must-trained-urgently/.

[19] Fawcett Society (2015) Equal pay day briefing: The gender pay gap: Facts, causes and solutions. Available at: http://www.fawcettsociety.org.uk/wp-content/uploads/2015/11/Equal-Pay-Day-Briefing-2015.pdf.

[20] Pawson, R., and N.Tilley (1997) Realistic Evaluation. London: Routledge.

a) Referrals: are the participants who can benefit from the intervention being referred/self-referrals?
b) Attractiveness: is the intervention relevant and does it act as a 'hook?'
c) Influencing: does the intervention change attitudes, 'mind sets', behaviour?
d) Facilitating: are there pathways to other programmes to meet multiple needs of participants over time?

The primary data collection is structured to gather information on these issues and in interviews we enquired about the reasons for making particular decisions rather than others as women progressed from pregnancy through to early motherhood. We also asked about women's circumstances and their feelings towards themselves and their infant.

Assessing outcomes is particularly challenging as new mothers gain experience and improve and studies with control groups typically show that both control groups and 'treatment' groups show improvement at equal rates.[21] Similarly assessing increased use of services is difficult given that women are in a new situation and they may be expected to use new and/or different services. We cannot be certain that they would have used children's centres if they not joined BB, although we do know that those who are most vulnerable less likely to access Sure Start Centres.

In this study the short term effects of the BB programme are taken into account, but the findings suggest that the scheme has laid the foundations for longer term benefits for the women and their children, although their realisation is somewhat contingent on the availability and quality of services BB has referred them to.

3.2 Data collection

Information for this study was collated from various sources and a multi-method approach to data collection was used to gather information from staff, mentors and women and the context within which the programme is managed. Secondary data sources included project monitoring data, case files, evaluation reports written by staff, information from websites, and the academic literature.

Secondary data:

Fourteen case files were made available to the researcher by BB staff. They were anonymised, password protected and read at the Shoreditch Trust office. The staff were asked to provide a range of different cases, some which were successful and some which were less successful. The cases included women who were reluctant to engage, those who did not have a mentor, those with mentors, some which ended prematurely and some which were extended beyond the usual 3 months after the birth. These findings indicate that a variety of cases were made available to the researcher.

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[21] See for example, McAuley, C. et al (2004) Young families under stress: outcomes and costs of Home-Start support, Findings, Joseph Rowntree Foundation, September.

Primary data collected included:

Face-to-face interviews were conducted with six women who were in the early stages of motherhood. They were ethnically diverse, of different faith or no faith and one had a life-long physical disability. Interviews were mainly conducted in a public place and lasted between 30 minutes to over an hour. Two interviews were recorded and transcribed to facilitate analysis and for the four others, which took place in noisy cafés, notes were taken contemporaneously and additional notes and reflections completed immediately after the conversation finished.

Face-to-face interviews were conducted with six volunteer women mentors. They were ethnically diverse, from different classes, and of different faith or no faith. They lived locally and were mothers, some had young children whilst others had children who were adults. The interviews took place in public places and were recorded and transcribed or where the venue was too noisy notes were taken contemporaneously and additional notes and reflections completed immediately after the conversation finished. These interviews typically lasted between 45 minutes and one hour.

Face-to-face interviews were conducted with partner agencies and these interviews lasted between 30 and 60 minutes and interviewees were all women and all delivering services. To ensure the confidentiality of these interviews details of which agencies participated are disguised.

Self-completion questionnaires were on-line. They were completed by 25 women who were mostly black African (36%) black Caribbean (20%), white British (16%) and equal numbers of Asian, White European and 'Other' ethnicity (each 8%), and mixed ethnicity. They were predominantly aged between 26 and 35 years with no one below the aged of 26 years and 8 had a long term health issue and/or physical disabilities. The majority of respondents lived in council or housing association flats, and others lived in private rented accommodation or temporary or emergency accommodation.

Seven mentors completed a questionnaire and they were White British/Irish/European (4) or black African/Caribbean/black British (2), and one non-respondent, they were mostly 36 – 45 years old (4), 66 years and over (2) and one was 26-35 years old.

The self-completion questionnaire data were entered onto a statistical package for social scientists to facilitate analysis.

Formal conversations with staff included an initial meeting and two mid-way through the research. Several informal conversations took place to clarify the monitoring data.

3.3. Data representativeness

Achieving a sample of research participants who are representative of mentors and women at the time of the research is extremely difficult to achieve. However, the reliability of research findings can also be achieved by including a wide range of different types of

participants whose experiences maybe typical of their group. This approach is particularly important for the BB programme and those who were interviewed and the findings from the self-completion questionnaires suggest that a wide range of women did participate in the research.

Interviewee names and contact details were given to the researchers by Shoreditch Trust staff and we asked for a variety of participants from all those who were attending at the time of the research and who staff had contact details for.

We have little information about how to assess the representativeness of those who completed a questionnaires. A minority of mentors (7) and mentees (25) participated but they represent the ethnic diversity portrayed in the monitoring data and the responses vary from the very satisfied to the dissatisfied. In this sense the responses are representative of the full range of possible responses.

3.4. Data analysis

All data were analysed from the situated logic of the participants. We used this information to generate hypotheses about how the project works and used the data to refute these hypotheses and selected those that best fit the data.[22]

Where a service is relevant to concerns and challenges faced by its recipients and is well implemented then we can be more certain that the intervention has contributed to the outcomes. We considered causality and other factors that may contribute to the outcomes. In our judgement there are strong reasons to believe that the BB programme contributed to the changes identified in the study due to the sound implementation of the scheme and the staff, mentors and women's descriptions of the effects of the scheme. We worded questions on the questionnaire that started with a phase like 'Since attending Bump Buddies…' to encourage the respondent to relate any changes to the initiative. We also asked if there was a positive change, no change or a negative change for each factor, for example; 'Since coming to Bump Buddies, I feel more confident, less confident, or about the same, to… make friends'. This format gave respondents the opportunity to give a range of responses intended to increase their honesty.

Quotes are used to illustrate and as evidence.

3.5. Limits of study

This independent evaluation study is focussed on short-term and self-reported changes arising from participating on the BB scheme. The findings are dependent on the honesty of participants and, as a check, the interview schedule and questionnaire included some similar questions and responses to these questions remained consistent.

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[22] Sampson, A. (2007) 'Developing robust approaches to evaluating social programmes', *Evaluation*, 13 (4), 469-485.

Types of programme like BB have a plethora of possible health, social and economic outcomes and similar initiatives are assessed in a variety of ways with some prioritising reductions in caesarean births and results of tests to evaluate the physical health of new born babies, for example. This medial approach to assessing BB has not been the focus of this study as reports and interviews with mentors and staff suggested that these outcomes did not represent the core outcomes of the scheme. There may, however, be some specifically health related outcomes that have not been measured in this study.

4. BB programme outcomes

It follows from the discussion above that the focus of this study is on outcomes arising from everyday routine activities of the BB programme. Four relevant and inter-related outcomes have been identified from the BB service specification and they are as follows:

Improved social relationships: to reduce social isolation by forming meaningful relationships with BB staff, mentors and other women with children in their local area and with those in a similar situation by:

➢ Offering emotional support by listening to women, recognising their strengths and ambitions, and finding practical solutions including providing information about services and ways of meeting other women and opportunities to form friendships.
➢ To understand that asking for help and receiving help is neither a sign of inadequacy nor shameful and of benefit to themselves and their infant.
➢ Accompanying women to health services, children's centres and other activities should they wish support.

Improved coping strategies and confidence to make better informed decisions: to reduce feelings of inadequacy, despair and anxiety to enable women to respond positively to adversity; and, encourage them to create space to focus on becoming/being a mother and to reflect on their experiences of mothering to develop a positive relationship with their infant by:

➢ Offering experiential knowledge and information to discuss parenting and what it means to become a mother, to enable women to understand that they can articulate their preferences and have a birth plan of their choice, for example; and, discussing how to develop a positive relationship with their infant and with the father that is beneficial to them and their child.
➢ Advising on the value of women considering further education and employment possibilities for themselves and on the importance of creating a learning home environment for a child's development.

Increased use of services: to reduce low take up of statutory health services and local provision to ensure the best possible health for women, their infant(s) and other family members to improve their quality of life and the emotional and social development of their child(ren) by:

- ➢ Offering experiential knowledge and information about how women can keep themselves and their infant(s) healthy by attending clinics, taking up immunisations, eating a healthy diet, and attending groups.
- ➢ Healthy living includes proactively reducing stress in the women's lives by supporting them to establish routines, to access services that can reduce their everyday worries about housing and insecure immigration status, for example.

Contributions to local community: to address social and economic disadvantage and increasing inequalities in Hackney by:

- ➢ Increasing local skills and knowledge of services and activities in the area by training local women to be mentors and enabling them to make a greater contribution to their community by finding paid employment, returning to education, and volunteering.
- ➢ Supporting pregnant and new mothers to participate in local activities and contribute to building social networks and comradery amongst women.
- ➢ Developing mutually supportive and knowledgeable relationships amongst women health, social care, and community workers across agencies to improve the collective capacity to care and quality of local services.
- ➢ Through outreach work that involves attending community events, visits to other organisations and shopping outlets to recruit mentors and to encourage women to use maternity services as soon as they are pregnant.

5. Implementation

BB is situated in a challenging working environment where a plethora of anxieties are often projected onto staff and mentors and demands are made on them that requires thought, energy, and finely balanced judgements. BB also lies at the intersection of many statutory and voluntary sector organisations each with their own remit, responsibilities and agendas with whom staff, mentors, and mentees negotiate and navigate to ameliorate the anxiety-provoking issues women are experiencing. In these circumstances maintaining a focus on the purpose of BB can be difficult; for example, resolving women's immigration or homeless problem could become dominant priorities at the expense of supporting them as a mother, and these strong pulls away from the main remit of BB gives added significance to the robust implementation of the programme.

It is also apparent that the implementation of BB programme yields outcomes which are undocumented and there are likely to be positive impacts on the lives of many more women than the data suggest. Further, there are less tangible and difficult to capture influences that affect how the programme is implemented which are likely to contribute to outcomes. These include unarticulated feelings and emotions, and changes which are particular to a woman's situation.

In these circumstances two aspects of the implementation of the programme are particularly pertinent: the organisational arrangements which are structured by the

intentions and ethos of the programme and inform how the BB scheme is delivered; and, procedures in practice. Each is discussed in turn.

5.1 *Organisational arrangements*

Three aspects of the organisational arrangements are discussed in this section; the location of the BB programme within Shoreditch Trust, procedures, and the ethos of the staff team.

5.1.1. *BB programme within Shoreditch Trust*

Shoreditch Trust has internal structures to support staff and disseminate experiences and practices amongst projects they manage. The manager of BB is director of their Wellbeing Strategy and this strengthens links between this strategy and the BB programme. In 2016 Shoreditch Trust piloted a number of initiatives for staff as part of their Wellbeing Strategy. The sessions included space for addressing emotional issues and were held in a safe, supportive and inspiring atmosphere where trust and confidentiality are respected.

5.1.2. *Procedures*

Staff perceive the BB programme as having four well-defined heightened opportunities for change when a woman's status alters and she is in the process of adapting to her new situation. For each transition clear procedures exist to enable staff to optimise these opportunities. They are as follows:

Procedures that maximise heightened opportunities for change

Initial assessment meeting: Assessment meetings are attended by two members of staff and a volunteer and typically last between 90 and 120 minutes. They discuss pregnancy, shared and co-parenting, siblings, advice services, local services and discuss a woman's health and the development of their infant. At the end of meeting a decision has been made whether or not the woman will be allocated a mentor. Immediate actions and information about the medium and longer term are promised to the woman.

First meeting with a mentor: the role of the mentor is outlined by staff and the mentor. If a woman wishes to proceed boundaries and expectations are discussed and a written agreement is signed by all parties.

Meet the new baby meeting: staff meet the woman and her new born baby to discuss her birth experience and post-birth support.

Next steps meeting: this takes place between three and six months after the baby is born. The mentor and member of staff bring the mentoring to a close and discuss a woman's future plans for herself and her child.

The project's documentation shows that there is a clear audit trail for each case and referral forms, assessment forms, and contact sheets are continuously updated and kept with all correspondence in case files. In an environment where issues can be contentious this recording serves to protect the women, mentors and staff. They act as a vital reference

guide to trace an often complex journey through numerous services and enables staff to assess if progress is being made.

There is a one-to-one support form that includes a risk assessment with risks such as neglect, domestic violence and isolation recorded as well as a woman's existing network of support. This assessment enables staff to make more informed decisions about mentors' personal safety and makes mentors feel valued. The consent of women is gained to share information with the midwife, a social worker for a child protection plan.

BB staff match mentors with mentees prior to meeting a woman. They select mentors according to their availability and their capacity to support. A mentor who is a DVA survivor is not chosen where a mentee is experiencing DVA, for example. Nor is culture or faith used to match women but rather the shared experience of motherhood.

How staff and volunteer mentors work with women is also clearly specified. This shapes the content of the training course for mentors, facilitates cooperative staff-mentor working relationships, and forms the basis for a strong team. The programme is accredited by the Mentoring and Befriending Foundation, UK and the training has two key features that structure practice. These are:

- ✓ Key worker support; with women staff identify their areas of need, their skills and attributes, assist them access services and community resources, and facilitate joined up working amongst agencies to support the woman and her family.
- ✓ I-2-1 peer mentoring; train volunteers who live locally to be mentors who support women to develop their psychological and social skills, to create an understanding of positive parenting and social relationships, to share information and support them to meet those in a similar position to enable new mothers to participate in local activities and to be part of a social group.

Four practice principles underpin the programme and inform how the support, coaching and mentoring works in practice. These practice principles further facilitate consistent practice amongst the BB team and have been identified as key characteristics of peer support for women during pregnancy and early parenthood. [23]

They are:

- A responsive and flexible approach
- Practical advice
- Emotional support
- Information on healthy lifestyles

These practices are apparent in the implementation of the BB programme and are discussed throughout the report.

5.1.3. *The ethos of the BB staff team*

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[23] McLeish, J., and Redshaw, M. (2015) Peer support during pregnancy and early parenthood: a qualitative study of models and perceptions, *BMC Pregnancy and Childbirth*, 15: 257 – 271.

The BB staff team creates a strong ethos that includes regular reflective practice meetings, acknowledging the emotional impact of the work on themselves and the need to maintain capacity to absorb and process emotional toil. Within the team they are respectful of different perspectives, mutually supportive, and have well-developed ideas about how the BB programme should work to produce the best possible outcomes for mothers and their infants.

As a consequence, BB staff have created a secure base from which they work that is continuously maintained and renewed. This enables the team to remain positive, have a strong 'can do' attitude, and maintain a capacity to care. They engage with women emotionally with laughter, humour, physical contact and allowing women to cry. Similarly they have open and friendly relationships with the mentors and with women working in other agencies and partner organisations. They also have the knowledge and confidence to assess if services and activities are of a 'high quality' or 'not good enough' and encourage women to use, and refer to, the best.

This team ethos also gives staff the confidence to identify and engage with problematic and 'overwhelming' issues rather than 'side-stepping' them, which is a feature of some caring agencies and leads to escalating problems and poor outcomes.[24] BB staff have honest discussions with women about serious mental health, illegal drug use, DVA, poor parenting, the baby being removed at birth by Social Care and they clearly articulate, without using such phrases as 'if' or 'maybe' or 'possibly' that soften the message to women, the adverse effect of these issues on parent-infant relationships and the child's development. These types of discussions also take place with mentors and frontline staff working in other agencies.

These findings suggest that the ethos of the team has a pivotal role in understanding the implementation of the programme, how it works, and outcomes.

5.2 *Procedures in practice*

5.2.1. *Referrals*

Referring partners comment very favourably on the short and simple referral forms, the importance of the confidentiality protocols which are in place, and the willingness of staff to discuss cases. A midwife's comments reflected the views of others when she said:

Bump Buddies are well-supervised and supported and this gives me confidence to refer. (Midwife)

The above comment also reflects the consensus amongst referring partners that Bump Buddies is a 'special' scheme as another midwife observes:

Their support is very special for these families which makes it important. (Midwife)

Partner organisations mentioned how BB staff are excellent at supporting parenting and this contributes to the excellent reputation of BB. The easy referral process is flexible and also encourages agencies to refer to the project.

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[24] See for example, Munro, E (2011) Review of child protection: final report. London: Department of Education.

Monitoring data are available from 1st January 2014 to mid-February 2017 and during this period 118 referrals were made to Bump Buddies. The overwhelming majority of referrals were made by midwives from Homerton Hospital (81%). Other referrals included self-referrals (7%), Hackney Children and Young Peoples Services (6%), voluntary organisations (5%) and one referral from Hackney Learning Trust. The voluntary organisations include Shelter, Family Action, Hestia, and Shoreditch Trust.

A third (33%) of the women referred/self-referrals were aged between 17 and 25 years, and almost half (45%) were aged 26 to 35 years, and 18% aged 36 years and over. Thus, to date young teenager mothers have not participated in BB.

Where information on ethnicity is available, the majority of the women were black African/Caribbean/British, and reflects the ethnic diversity of the London Borough of Hackney. The following table summarises the recorded ethnicities of referrals:

Table 5.1.   Recorded ethnicities of referrals – 1st January 2014 to Mid-February 2017

Ethnicity	Percentage
Black African/Caribbean/British	45
White European/British/Irish	25
Asian/British Asian	14
Dual heritage	8
Other	8

Ten women said that they had disabilities and this includes those with a physical or mental impairment that adversely effects their normal day-to-day activities. The data on those who are refugees and asylum seekers is incomplete but they have a presence on the scheme.

Data from case files and interviews with referring agencies suggest that health workers and community organisations have a good understanding of the types of women well-suited to attending the BB programme. Questionnaire respondents' said that they agreed to participate for the following reasons and indicate the value of BB programme for these women:

Table 5.2.   Reasons women participated in BB

Reason	Percentage
Anxious about giving birth & had little or no support	68
Wanted support from a woman volunteer	66
Sounded like a good scheme	44
Felt under pressure to join	7

One respondent who 'felt under pressure to join' describes what they meant in the following comment:

My midwife just called Bump Buddies because I didn't have any help. (Questionnaire respondent)

Their responses throughout the rest of the questionnaire show that seemingly unpromising beginnings led to positive outcomes. These findings are discussed in more detail later in the report.

5.2.2. *From referral to meeting a mentor*

The implementation of the programme from the initial referral to the meeting to allocate a mentor is discussed in this section. The other key procedural or milestone meetings, visiting the baby and the next steps meeting, are discussed in the following section on key worker support provided by BB staff.

Data on referrals, assessments, and matching mentors with mentees meetings are available from March 2015 until February 2017. Of those who were referred and had an assessment meeting, there is information on 36 cases, just over half (53%) of all those assessed. Table 5.3 below details the number of working weeks from the date of referral to the assessment meeting. The quickest meeting happened on the same day as the referral and the slowest assessment meeting took place 17 working weeks after the referral.

Table 5.3. Number of working weeks between referral and assessment meeting between March 2015 and December 2016 (n=36)

Number of working weeks	Percentage (Number) of cases
Under 4	8 (3)
4 - 7	42 (15)
8 - 11	33 (12)
12- 15	8 (3)
16 - 19	8 (3)

Note: bank holidays and other holiday periods such as Easter weekends have not been taken into account when calculating working weeks.

Data are available on all the 32 initial meetings between mentors and mentees and the information on the length of time it took to hold a meeting after the referral meeting is recorded in table 5.4 below. From the referral date to the matching meeting often takes between 8 and 19 working weeks.

Table 5.4. Number of working weeks between referral and initial meeting with mentor between March 2015 and February 2017 (n=32)

Number of working weeks	Percentage (Number) of cases
Under 4	13(4)
4 - 7	16(5)
8 - 11	19(6)
12- 15	19(6)
16 - 19	22(7)
20 or more	13(4)

Note: Bank holidays and other holiday periods such as Easter weekends have not been taken into account when calculating working weeks.

The findings presented in the two tables above show that the time from referral to the initial assessment meeting and to a meeting with a mentor is often slow and some women will be many months into their pregnancy before support is put in place.

The monitoring data presented in the figure below shows that an assessment meeting took place for 58% of referrals and that 47% of those who had an assessment meeting also had a meeting with a mentor. Thus, just over a quarter (27%) of the women referred/self-referrals had an initial meeting with a mentor. However no data are available on women who staff worked with but did not have a mentor and therefore the number of women who the programme has worked with will be higher than 32 women.

Figure 5.1. Number of referrals, assessment meetings, and meetings matching a woman with a mentor

All referrals = 118

Assessment meetings = 68

Women matched with mentor = 32
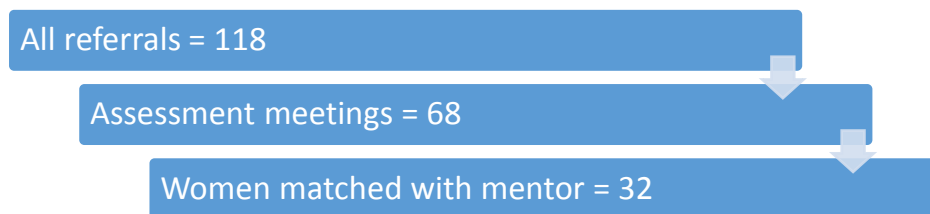
Note: there are no data available on the number of women allocated only to a member of staff.

All enquires are recorded as referrals and if, for example, a midwife is concerned about a pregnant woman they may ring BB staff to discuss her situation knowing that the case is not within the remit of BB. Health workers make these calls when they have a complex case that they find difficult to assess. They contact BB staff out of respect for their knowledge and they value the honest conversations which lead to a clearer understanding of how best to proceed. The comments below illustrate how they are not expecting cases to be taken up by BB:

Even if a woman is not BB appropriate their advice is invaluable and they always offer something helpful. (Partner agency)

If I do not know what to do to help a woman I ring BB … they have a good knack of finding someone to help. (Partner agency)

Partner interviewees talked about an increasing number of women with complex needs, substance misuse, and DVA. Staff may not accept these referrals when they feel mentors' safety may be put at risk. Other reasons referrals are not accepted include where a woman has no connections with Hackney, when staff decide a woman already has support in place and they wish to avoid replication of services or in cases where their 'value added' is not apparent. A referral may happen late in pregnancy and there may be a waiting list due to a shortage of mentors and these women are not accepted.

Many referrals that do not progress have outcomes from the assessment meetings. Although this information is not systematically recorded, the referral conversations include

an agreed set of actions for these women. The following comments extracted from a case file give some insights into these possible outcomes.

> A pregnant woman who is fleeing DVA and living in one room with two children was referred to; a legal centre to sort out her immigration status, a DVA specialist organisation, and a community organisation for her ethnic group.

A total of 68 assessment meetings took place between March 2015 and February 2017. At these meetings staff aim to develop a joint understanding of who the woman is, her areas of need, and to be able to suggest some practical solutions in response to her situation. This includes the allocation of a mentor. By the end of the meeting BB staff aim to leave women with something positive and typically send an email giving information about where they can seek further assistance and encourage women to contact BB again if they have further questions.

Thus just over half of those who attended an assessment meeting (53%) had no more contact or little contact with the BB programme after the meeting. An absence of systematic data on outcomes for those who only attended an assessment meeting precludes an analysis but women discussed their assessment meeting in interviews and outcomes were practical and offered reassurance. The following account gives a sense of how assessment meetings make a difference to women:

I was depressed and felt suicidal… I was in temporary accommodation with two children, in one room… I was pregnant and had a lot on my mind…. They [BB staff] were very helpful… they gave me food vouchers, referred me to Shelter… It was big relief at the beginning and most important, they made me feel like I was still somebody. (Woman)

Of those who attended an assessment meeting 47% were allocated a mentor. Reasons for not being allocated a mentor include a woman declining the offer or staff deciding that they will be the sole key worker due to the complexity of her needs.

Assessing the implementation of the procedures described above is difficult; on the one hand there are many positive features and on the other there are areas where improvement may be possible. Firstly, the time between a referral and matching a woman with a mentor or Bump Buddy can be a difficult waiting period for a woman particularly if she is late on in her pregnancy and feels that she is not coping, as this woman explained:

I suppose I just felt very vulnerable…. they took a long time finding me one [a mentor]. (Woman)

Secondly, questions remain about assessing the complexity of cases; when do they become too complex for mentors? Are staff too cautious in their assessments?

A data analysis of attrition by referral type and by ethnicity shows that when comparing data on all those referred with those who have an initial meeting with a mentor, the latter group are more likely to be self-referrals and referrals from the voluntary sector, are disproportionately more likely to be White or dual heritage, with ages remaining similar to all those referred. The greater attrition rate for black women may imply that they have more complex situations and that it may be harder for staff to develop trusting relations

with them where the women have experienced discrimination? More detailed research is required to find out more about this puzzle.

Thirdly, findings related to the responses of women to two of the key milestone meetings are summarised in table 5.5 below. Staff take the lead in both these meetings. The findings show that the overwhelming majority found both meetings positive and reassuring.

Table 5.5. Responses of women to the assessment meeting and first meeting with a mentor

	Positive & reassuring Percentage (number)	Made me feel anxious Percentage (number)	Felt indifferent/ neutral Percentage (number)	Not sure Percentage (number)	Not have a meeting Percentage (number)
Assessment meeting	84 (21)	8 (2)	0	4 (1)	4 (1)
First meeting with mentor	80 (20)	4 (1)	8 (2)	4 (1)	4 (1)

Note: Not all mentees will have a mentor.

A further analysis of the minority of respondents who gave other than 'positive and reassuring' responses found that one woman who was unsure following the assessment meeting then gave largely negative responses, for example she found that the first meeting with the mentor made them her feel anxious, she felt less able to ask for help, less confident to solve he own problems and to contact services. On the other hand, of the two women who felt anxious following the initial meeting, one had positive experiences and outcomes and the other who felt indifferent about the first meeting with the mentor then went on to have positive experiences and outcomes. Another woman who felt indifferent about the first meeting with the mentor felt less able to ask for help and to receive support. These examples are based on the experiences of four women and should be treated with caution but they do indicate that whilst a poor assessment meeting can result in negative outcomes, poor beginnings or a shaky moment does not necessarily lead to poor outcomes. This possibility is further reinforced by the experiences of four other women who 'felt under pressure to join'; three went on to have positive outcomes and one woman had mostly positive outcomes. These findings give some insights into the challenges facing staff and mentors and how remaining positive and maintaining contact with women can be worthwhile.

5.2.3. *Key worker support by BB staff*

The findings from multiple data sources strongly suggest that BB staff have a clear understanding of their role and its limits, the statutory and voluntary sector, and women's precarious situation, and these factors enable them to be active and effective key workers. Where findings are less positive the findings show that complex relationships exist between

offering and receiving help and that achieving change can be very difficult.[25] A complicating factor can be a woman's fears that her baby and children will be removed by Social Care, a worry frequently expressed in interviews and an issue that leads women to keep things private.

Findings from case files and self-completion questionnaires show that women who are accepted onto the programme have multiple problems that cause high levels of anxieties. They also highlight the significance of the key worker role and the importance of BB for these women. The following data summaries the type, and extent, of issues experienced by women.

Case file data

Of the 14 case files 11 women were either 'sofa surfing' with friends, in temporary housing, living in overcrowded conditions and/or in adult only accommodation.

10 case files contained information on past and present intimate relationships and of these two women had supportive partners who wanted to be active fathers. For the other 8 women there were domestic violence and abuse (DVA) and safety concerns. Some were fleeing DVA and others remained in violent relationships. Women worried about the violent fathers and the safety of their infants.

Six case files referred to women experiencing debilitating poverty that affected their pregnancy. These included; no credit to use a mobile phone, women with no income and no benefits, no clothes or possessions, no money to pay for gas for cooking and heating, rent arrears, no food, and two women were exhausted from either working 12 hour shifts without a break or having three jobs to try and make enough money for the additional costs of having a child and to cover the time they will take off work.

Five women were known to Social Care due to issues such as child abuse and neglect, mental health, and DVA.

Absent from the case files was information about health services and this suggests that women were either satisfied with their maternity health care or, perhaps, they were not expressing their concerns?

Further information from questionnaire respondents show that the majority experienced multiple problems and stresses associated with living in poverty. The findings presented in the table below serves to further reiterate the significance of the key worker role.

Table 5.6.   Difficulties women mentees said they are experiencing

Issue	Respondents experiencing problem Percentage
Finances & budgeting	96
Housing	88

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[25] Reder, P., and Fredman, G. (1996) The relationship to help: Interacting beliefs about the treatment process, *Clinical Child Psychology and Psychiatry*, 1,3: 457-467.

Other problems (unspecified)	88
Benefits	84
Family	84
Immigration status	52

In response to these issues the following types of actions were taken by BB staff in their key worker role. The findings suggest that staff have a well-defined understanding of what actions to take, when to participate, and when to withdraw. The actions listed below also encapsulates how staff work with women and demonstrate their women centred approach.

Examples of actions taken by BB staff:

- Personalised signposting to advice organisations.
- Encouraging women to engage with relevant services.
- Obtaining active consent from women to share personal information: staff clarified with women what information about their situation and past history, they could share, if any, with single agencies and in a joint agency setting.
- Adding value to joint agency working:
  - Withdrawing from a meeting where the woman had support from others, for example, a family worker, to avoid replication
  - Withdrawing where there were already a host of statutory and voluntary agencies 'wrapping round' a woman, to reduce duplication.

- Explaining their role and opinions to women prior to multi-agency meetings such those convened by Social Care who have concerns about the safety of the baby.
- Discussing parenting and modelling good practice and discussing healthy relationships.
- Dissemination of health information including immunisations, breast feeding, birth registration and using health services.
- Appreciation that their role is time-limited and women require sustained support by introducing them to other services and programmes of activities for the mothers and for their infants.
- Discussing aspirations for the future and giving out information on training and education courses, volunteering opportunities and paid employment in the future.

The following case captures the types of practical actions taken by BB staff and is typical of many other cases in the research.

Practical actions

A woman was staying with friends and felt very alone. In response to her situation staff took the following practical actions; referred her to the Citizen's Advice Bureau and a maternity help line; contacted Shelter's housing advisor and Coram's Children's Legal Centre, a Woman's Therapy Centre and City and Hackney Wellbeing Network. After the birth staff organised a car to collect the woman from hospital and found her baby clothes. Staff responded to calls from the women about benefits and difficulty with paying rent. Staff contacted Shelter's housing advisor to find affordable

accommodation. BB staff suggested that she opened a bank account with a credit union. They helped her complete a maternity allowance form and the mentor took her a high chair and car seat the staff had found. The mentor continued to offer the woman emotional support.

The following extracts from another casefile illustrates the type of collaborative working undertaken by BB staff.

Collaborative working

A midwife referred a woman with deteriorating mental health and concerns about a relapse in substance misuse. She also made a referral into Social Care. The midwife intended to create a professional network for this woman to ensure a smooth transition of support from pregnancy into early motherhood. BB staff responded by putting a mentoring relationship in place almost immediately. The staff offered extra regular support to the mentor and received telephone calls from women who needed emotional support and reassurance. She became very stressed about her housing situation and very worried about being hospitalised due to her poor mental health. BB staff undertook a joint visit with a family support worker, liaised with the Health Visitor and worked closely with the social worker. BB staff reassured her that Social Care were not concerned enough to take her baby into care. BB staff and the mentor identified her lack of life skills including budgeting, organisational skills and lack of routine, all of which they helped her develop. The mentor accompanied the woman to a group for women who had substance misuse issues and to the local children's centre to attend activities.

The findings also reveal the significance of the staff's in-depth knowledge of how the various systems work and where is best to 'activate' them to bring about improvements for women. For example legal advice and support, housing allocations system, Social Care and removing children into state care.

The key worker role also creates space for the mentors to maintain a focus on a woman's pregnancy, birth and early motherhood. The staff liaise closely with the mentors and their relationship reinforces the boundaries of mentoring. Mentors commented on how staff listen and discuss issues and possible solutions, suggesting equality, as this mentor describes:

They were always there and I felt well supported… we discussed alterative perspectives for resolving women's problems. (Mentor)

Two members of staff 'meet the baby' shortly after the birth and use this opportunity to talk about breastfeeding, parenting and other concerns the mother may have. Table 5.7 below shows that the overwhelming majority found the meeting positive and reassuring and no women found that the meeting made them feel anxious. Two women were not sure and one felt neutral or indifferent.

Table 5.7.   Responses of women mentees to the 'meet the baby' meeting

	Positive & reassuring Percentage (number)	Made me feel anxious Percentage (number)	Felt indifferent/ neutral Percentage (number)	Not sure Percentage (number)	Not have a meeting Percentage (number)
Visit by staff to meet baby	68 (17)	0	4 (1)	8 (2)	20 (5)

Note: those who have not had a meeting will have been pregnant when they completed the questionnaire.

Once again these findings give some insights into the challenges of offering meaningful support to some women. They also suggest that despite some indifferent and uncertain experiences positive outcomes can be achieved and further underline how difficult it is to implement such schemes and how the key worker role is very demanding.

5.2.4. *Recruitment, training and supporting peer mentors*

Table 5.8 below shows that when most funds were available for outreach work the recruitment of mentors rose and in 2013 a total of 16 women were trained compared to 2016 when funds were low recruitment fell to four women. It is possible that other factors are adding to difficulties recruiting and these include additional stress and economic hardship due to the government's austerity programme making it more difficult for local women to commit to mentoring. This table shows that a total of 41 mentors have been trained during the life time of the programme, 28 have left, and 13 are currently trained and/or are actively mentoring.

Table 5.8.   The year mentors trained and the year they left the programme

	Prior to 2013	2013	2014	2015	2016/17	**Total number**
Number of mentors trained	7	16	7	7	4	**41**
Number of mentors who left BB	0	0	7	16	5	**28**
Number of trained/active mentors					13	**13**

Of the 28 mentors who have stopped mentoring three quarters mentored one or two women (75%) and five mentored three women and one mentored 8 women. Of the 13 active mentors two are waiting for their first woman to mentor, the majority (62%) have either mentored one or two women and the three remaining mentors have supported three, four, and five women respectively. If the dominant pattern of mentoring one or two women before leaving remains then the expectation is that BB will need to replace the majority of current mentors in the near future. Thus, to sustain the programme recruiting and training mentors is an ongoing activity. The table below shows that local mothers from different ethnic backgrounds train as mentors.

Table 5.9. Ethnicity of local mothers trained as mentors

Ethnicity	Number of mentors
Asian (Pakistani and Indian)	4
Black Caribbean, African, British	13
Kurdish	3
Mixed ethnicity	2
White British	15
White European and White Other (Italian, French, Brazilian)	4

Although data on class is not systematically collated it became apparent during the interviews with mentors that they came from different classes ranging from migrant professional women to those whose families have lived locally in social housing for generations.

Training

Mentors were positive about the training they received. All questionnaire respondents found that the training enabled them to know what was expected of them, gave them confidence, and they all found the support from staff motivational. They were all appreciative of the written agreement between themselves and the mentees which managed expectations about their role. The information on services, activities and resources provided by BB staff was typically personalised with a contact name and address and all the mentors said that this enabled them to support mentees better. Most agreed that the newsletter helped them think about their role and how to offer better support (71%), whilst for two mentors it made no difference.

All the respondents felt that the staff listened to their opinions and experiences to develop the programme, a finding that is an example of the 'equitable principle' in practice. One mentor expressed relationships as follows:

There is no hierarchy of power. (Mentor)

Mentors were also asked about possible challenging situations that may occur when mentoring and if they received sufficient and appropriate support from staff. For the most part mentors had not experienced situations that they found difficult and this suggests that the training and support they received is sufficient and enables mentors to cope with many of the challenges they face. The positive and enthusiast responses towards training and the support from staff creates a culture of enthusiasm, confidence and commitment and these factors are likely to improve outcomes for pregnant women and new mothers.

The findings below give some insights into the challenges embedded in mentoring relationships including working with women who make decisions which the mentors and staff consider to be less than optimal such as not breast feeding and continuing to smoke cigarettes. Interviews with mentors suggest that the level of support they would like from

staff varies and the findings from the questionnaire indicate that staff sometimes underestimate the support mentors would like. As the findings presented below show a few mentors were not sure if they had enough support from staff and some would have liked more support on particular occasions.

Staff support for mentors in difficult situations

Whilst the majority of mentors strongly agreed or agreed that staff were useful 'sounding boards' and offered different options to solve difficult situations, one mentor 'strongly disagreed'.

When staff set boundaries to their mentoring role that negatively impacted on the mentor's relationship with the mentee, three mentors were not sure if they had enough support.

When mentees were difficult to contact two mentors would have liked more support.

When a mentee was in a crisis situation and needed urgent support two mentors would have liked more support from staff and one was not sure if they had enough support.

When mentees made decisions that the mentor did not agree with (for example, not breast feeding), two mentors were not sure if they had enough support and one would have liked more support.

When mentees did not take the advice given to mentors (for example, to stop smoking) two mentors were not sure if they had enough support.

These findings indicate how some mentors would prefer more reassurance in specific situations; for example they see their role as normalising concerns for women such as their concerns about tiredness and not knowing how much breast milk a baby is drinking. Several mentors commented that it can be difficult to assess 'what is normal' and they check with staff for reassurance. Mentors appreciated group meetings and social gatherings and these occasions reinforce feelings of belonging to the programme and of equal status.

Typically, mentors are reluctant to complete administrative tasks and prefer to feedback to staff over the telephone and to have a chat. The following comment by a mentor who does not complete her administrative tasks is representative of others:

I am naughty. I try to fit too much into my day. I like to feedback over the phone. (Mentor)

5.2.5. *Contributing to the local community*

One of the intentions of BB is to make a broader contribution to the local community and four activities mark this contribution. The implementation of these activities is summarised as follows:

All mentors were trained and this training gave mentors increased knowledge of services and activities and their training and experience enhanced their job prospects. These findings are described in the following section on outcomes.

Mentors and staff successfully worked with women to increase their participation in local activities and to create a supportive social network. Data from numerous primary and

secondary sources documents how BB staff facilitated improved integrated working amongst workers from different agencies. Prior to and during the research period local events were held in which BB staff participated and they also organised events to celebrate their scheme.

During the research period limited funded meant that there was no dedicated outreach worker able to attend community events and facilities to generally encourage women to use maternity services or to recruit mentors. These tasks were fulfilled by existing staff who are working to full capacity. A monthly newsletter distributed electronically up-dates partners on information related to BB and gives information about other agencies which partners may find useful. Christmas Hampers were also distributed to women and in interviews they were extremely appreciative of the hampers and toys for their children, although one woman commented that she does not eat English food. The following comments by a very grateful women reflects the opinions of others:

Everything was there. And that was amazing!... they are still thinking of me, which was reassuring as well, and it made me feel good… toys, everything, turkey, everything!... and I am so grateful. (Woman)

Through community events and informal contacts in Hackney BB also publicises the importance of pregnant women accessing maternity care from early pregnancy.

5.3 Mentoring

5.3.1. *How mentors engage with women*

Mentors described how establishing a relationship with a woman is challenging and requires 'persistence' and 'patience'. Those who had mentored several women all commented on how each person is different and it is best to 'go with the flow'. Mentors used to variety of ways to engage with women including texting, telephone calls, arranging meetings in parks or cafés, and offering to accompany them to their hospital appointments. Mentors explained that they try to connect with women by emphasising that they are not 'professionals' and by finding commonalities.

The following comments by mentors reflects the approach of others when they explain how they form relationships:

I find things I have in common with them to establish that you are on the same level and not looking down on them. (Mentor)

Expressed by another mentor as:

We're all Mums together living in Hackney. (Mentor)

These comments convey how mentors seek to establish equality in their relationship,[26] described explicitly by one mentor as follows:

My body language and disposition is important to them. As a parent we are both equal… You need to have equality. (Mentor)

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[26] Several mentors were clear that they were not equal due to class and educational differences but their role was to achieve equality in their relationships with women.

As a well-known academic commented 'by treating each other as equals we affirm mutual respect'.[27] The implementation of respectful relationships includes fostering self-respect. Self-respect comes from a feeling that being a mother is inherently worthwhile and that as a mother they are doing something well. Acts which convey respect are those which acknowledge women and are a source of personal development and self-esteem. The following comments are indicative of establishing of respectful relationships:

It is validation of them as a human being, a person who is of interest (Mentor)

They asked me how I felt… I wasn't used to that… I felt valued (Woman)

She is always giving me options. Not forcing me to do anything… It is a fair service. (Woman)

Mentors recognised that respect includes recognition that women differ from themselves and that it is important to acknowledge these differences and affirm their situation as this mentor describes:

I ask them about their culture. One mentee was Muslim and I'm Christian. She respected me and I respected her. It was mutual respect. She explained what things mean as a Muslim. It was nice. (Mentor)

This mentor is also respectful of the choices women make:

I always encourage breast feeding and bonding time but it is always up to them. (Mentor)

Some mentors advocated on behalf of women and where mentors take on an advocacy role their relationship also includes building trusting relations, a finding that is reflected in the literature.[28]

5.3.2. *Forming lasting relationships*

The mentoring relationship is brought to a close at a 'next steps' meeting between a member of staff, mentor, and a woman. The monitoring data show that of the 32 mentoring relationships 8 were active at the time of the research and within the expected time period of the project. Of the remaining 24 cases three quarters (75%) were successfully closed with a 'next steps' meeting. Of the remaining 6 cases, three women continued to need support and their mentoring period was extended and three of the mentoring relationships had broken down. Thus, at the time of data collection just under 10% of all cases had broken down. Without comparative data from other similar programmes it is difficult to assess this finding but given the multitude of problems experienced by these women and their reluctance to engage with services this seems a low rate of breakdown in relationships between mentors and women.

Relationships are also sustained by BB staff who offer practical assistance, typically by giving mentors additional information and using this knowledge to help mentors solve problems described by a mentor as follows:

[27] Sennett, R. (2003) *Respect: The formation of character in an age of inequality*. London: Routledge.
[28] See for example, McLeish, J., and M. Redshaw (2015) Peer support during pregnancy and early parenthood: A qualitative study of models and perceptions, *Pregnancy and Childbirth*, 15: 1-14.

Staff have an encyclopaedic knowledge… I check out information with them [and] they mention things I've not thought about before and that's helpful. (Mentor 2)

This mentor also commented, like others, about staff giving them flexibility to form relationships which they felt comfortable with. This approach is likely to contribute to the formation of enduring relationships as it gives mentors the space to negotiate respectful and trusting relationships. Indeed, mentors who had supported more than one woman explained how their relationships did vary even though women had similar issues such as social isolation and anxiety. Mentors also appreciate this respectful and trusting approach as this interviewee explains:

The staff trust me to form an appropriate relationship… I have freedom to form relationships in a way I feel comfortable with. (Mentor 2)

This finding that respect is a key characteristic of mentoring relationships at BB has implications for addressing social inequalities. It has been proposed that respect acquires particular significance in an age of inequality where there is a general failure to convey mutual respect across boundaries of inequality.[29] Richard Sennett has argued that for those 'at the bottom of the social order' earning and achieve self-respect is particularly difficult due to societal disapproval for those perceived as 'needy'. The scarcity of respect makes the lives of these people even more difficult and inhibits their ability to change their situation. Achieving mentoring relationships based on mutual respect offers potential for these women to improve their lives.

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[29] Sennett, R. (2003) *Respect: The formation of character in an age of inequality*. London: Routledge.

6. Outcomes

One particular strength of the BB programme is that staff made strong connections between identifying problems which are key issues for women and putting in place practices well-suited to alleviating the difficulties they have identified. Notably staff selected issues which they can realistically influence such as improved social relationships and increased use of services. As a result BB has contributed to positive and immediate outcomes for the majority of women who engage with the programme. These outcomes have improved women's perspectives on their lives, and everyday experiences, and these changes are likely to positively influence the initial life course of their infants. Partner agencies liked the way that BB staff are 'very committed to making change'.

To substantiate these conclusions four inter-related programme outcomes are considered; improved social relationships, improved coping strategies and confidence to make better informed decisions, increased use of services, and contribution to the local community. Each are discussed in turn.

6.1 Improved social relationships

Characteristics of the problem include: a brittle and defensive demeanour, feelings of shame, guilt and inadequacy, poor communication and social skills which result in difficulties forming friendships and constructive relationships with services. Thus forming social relationships is considered to be central to preventing mothers with babies becoming socially isolated and feeling socially excluded, unwilling to access health and support services, and unable to use services effectively to improve the development of their child.

Partner agencies recognised the significance of social relationships and one interviewee's comments reflected others when she talked about BB:

At its heart it's about good social relationships. (Partner Agency)

Social relationships discussed in this section are those related to BB practices and findings describe the characteristics of the relationships to explain how they are connected to an outcome. The following relationships are described: mentor-women; staff-women; those with the infant's father; and, making friends. The formation of mentoring and staff relationships make other constructive relationships possible.

6.1.1. *Mentor-women relationships*

Although the datasets from which the findings are drawn are small, mentors consider 'enabling a mentee to see her progress', an approach that fosters self-respect, and 'mutual respect' as the two most important factors for forming a mentoring relationship:

Key factors in forming a mentor-mentee relationship
Enabling a mentee to see the progress she has made:
100% strongly agree
Mutual respect between mentor and mentee:
71% strongly agree
29% agree

Other factors which mentors consider to be important in forming relationships, but less significant, are:

➢ Sharing your own experiences of pregnancy and having a new born baby:
>   57% strongly agree
>   29% agree
>   14% disagree (one mentor)

➢ Giving a mentee her own space and choice how she uses her time with the mentor:
>   43% strongly agree
>   57% agree

➢ Explore decision making with a mentee and help her see that there are different options:
>   43% strongly agree
>   57% agree

There was less agreement amongst mentors about the significance of forming a relationship that is between women and about mentors acting as advocates on behalf of mentees.

Mentors were also asked to consider characteristics of relationships with mentees that improve a women's transition into early motherhood and these are summarised below:

Characteristics of social relationships that improve mentees' transition into early motherhood

Accepting praise
>   57% strongly agree
>   43% agree

Accepting reassurance
>   43% strongly agree
>   57% agree

Expressing anxieties and worries
>   57% strongly agree
>   29% agree
>   14% neutral (one mentor)

Improved confidence to say 'no'
>   29% strongly agree
>   57% agree
>   14% neutral (one mentor)

These findings presented above give some insights into the types of social interaction mentors consider to be enabling. During interviews with mentors and women the types of factors or mechanisms that linked characteristics of social relationships to outcomes became apparent and included;

A partner agency said that for one woman:

BB helped her identify with her stomach, to learn about it means to be a parent. (Partner agency)

Some felt, however, that it was difficult to capture outcomes:

I cannot describe the power of the relationship between the women and the mentor… it has profound long term effects that cannot be measured. (Partner agency)

This comment captures how outcomes from positive mentoring relationships can be subtle and our findings show that they vary according to the initial situation of the pregnant mother. A partner agency considered improvements in a woman's skin condition to be an outcome, a mentor noted how a woman started to wear lipstick and 'nicer clothes', whilst others talked about women actively participating in a group rather than being silent and passive during sessions.

6.1.2. *Staff-women relationships*

Our findings suggest a consistency in approach between staff and mentors towards the mentee; their relationship building is complementary and reinforcing and their effects probably indistinguishable in many respects. However, some characteristics of the relationship with staff are more pronounced due, in part, to their position of authority as employees of an organisation and their experience of running BB over several years. In particular staff are able to act as a 'critical friend' and suggest to women that there are alternative ways of doing things:

… when the issue came about my child going to school or not going to school, they were very clear… at the time he was about to miss two weeks of school… They pushed me actually to do something for my own good, for the good of my son, which I really appreciated at the end…. which I'm very pleased about (Woman)

Staff draw on their knowledge of services and how they work to manage the expectations of women about what is achievable. Introducing a 'dose of realism' is not always easy, particularly when the reality of the housing situation in London is explained to women and they find themselves rehoused in sub-standard housing a long way from the children's centre they know. The following comments illustrate different types of realism staff discuss with women:

Sometimes you have to ask 'Have you heard of the housing crisis?' (BB staff)

At other times staff need to persuade a woman that she needs help, as this woman commented:

I didn't realised I needed support. But they made me realise I needed support… And I am grateful for that. (Woman)

Where staff take on responsibility for managing more difficult aspects of a case they give mentors space to maintain constructive relationships with the women. A mentor explains the value of this:

Staff knew housing was a big issue for her and said that I shouldn't discuss housing. I sympathised and left it at that… I was able to support her as a mother. (Mentor)

The BB ethos and approachability of staff is conducive to developing a general expectation of goodwill which supports the formation of trust and provides women with a sense of security and a capacity to trust. This woman commented:

They made me feel like I'm really a human, still a human… the way they communicated with me is like we'd known each other for a while and they made me comfortable actually. And I trusted them. I don't know why (laughs). So I opened up and I told them everything. (Woman)

Women's distrust of services and organisations is a barrier to accessing support and enabling women to place trust in an organisation can be a significant achievement. Trusting a project and an organisation facilitates a sense that help and support can be invoked if needed and is both 'useful and enabling' and encourages women to use other services.[30]

Fostering trusting relationships with women who were 'looked after children' can be particularly challenging for staff and mentors. In an interview a woman explained how she relived the trauma of being sexually abused as a child whilst giving birth, a common experience for sexually abused and neglected children. For those reliving childhood trauma the kindness and reassurance offered by staff has added significance. Staff are also aware that these women do not know children's songs which they consider to be 'roots' and 'anchors' for early mother-baby relationships and recognise how difficult it is for these women attending classes and activities for mothers and babies. From the interviews it is apparent that these sensitivities enable staff to build trusting relationships with a group of women who are particularly distrusting.

6.1.3. *Relationship with infant's father*

Another issue that is often difficult for staff and mentors to work with are family relationships and in particular supporting a woman to make decisions about the role of the father. Particularly testing is where there is a history of DVA. Some women prefer to use the courts to prevent the father from having contact with his child whilst others choose to allow the father supervised contact and this decision requires a woman to have some communication with the father. BB staff are clear that their role is about discussing and supporting the woman to develop constructive relationship between the mother and father about the care for their infant. They emphasize that this type of arrangement is best for the mother and infant.

Just over two-thirds of the questionnaire respondents (68%) had a partner and the findings show that:

- The majority of these women said that they were better able to form more co-operative relationship with their partner to care for their infant (59%)

- Some women did not identify a change in this relationship (29%)

- Two women were not sure if they were more able to form a co-operative relationship.

6.1.4. *Making friends*

The intention is that women learn how to form positive social relationships from their contact with staff and mentors and with their increased confidence to cope they find it easier to form friendships. Findings from the self-completion question show that:

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[30] This discussion on trust is informed by an article that draws on three different theories of trust advocated by Harin, Uslander, and Giddens, although these theorists concur that trust comprises of 'perceptions of competency and right intentions of others' (See Bradford, B., Sargeant, E., Murphy, K., and J. Jackson (2017), 'A leap of faith? Trust in the police among immigrants in England and Wales', *British Journal of Criminology*, 57:381-401).

- The majority of respondents felt more confident to make friends (71%)
- A quarter felt about the same (25%) and,
- One respondent felt less confident (4%)

6.1.5. *Summary of how improved social relationships make a difference*

Key features of the tripartite relationship between staff, mentors and women are depicted in the figure below and suggest that a principle of equality exists between the three groups of women. Each group are active participants in this reciprocal relationship and it argued that where these relationships are achieved then outcomes for women and their infant are most likely. When a woman does not have a mentor then the staff take on a dual role and act as a member of staff and mentor.

The two figures below draw on the findings to show the preconditions that are necessary for achieving improved maternal and infant outcomes. Where women have reported that their relationships have not changed or they are unsure that they have improved then it is argued that they are likely to have fewer positive outcomes.

Figure 6.1 draws attention to key features of the reciprocal tripartite relationships between staff, mentors and women. These relationships will include many characteristics but the purpose of the diagram below is to highlight those most important for bringing about change.

Figure 6.1.   Key features of reciprocal relationships between staff, mentors, and women

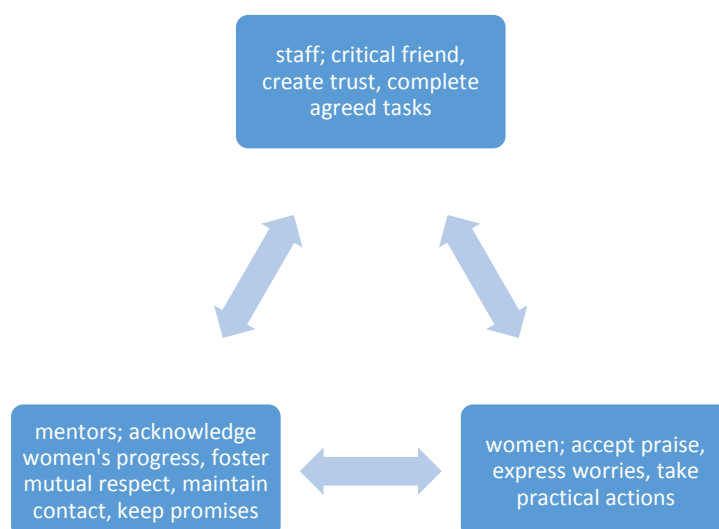Figure 6.2 below summarises how women are able to use the experiences, knowledge, and skills they have gained from their relationships with staff and mentors in other settings and for different purposes. In essence, these social relationships motivate women and give them confidence to reach out to others and to make friends, to attend activities and use services, and are able to support others.

Figure 6.2. How learning from relationships with staff and mentors facilitates women's social integration
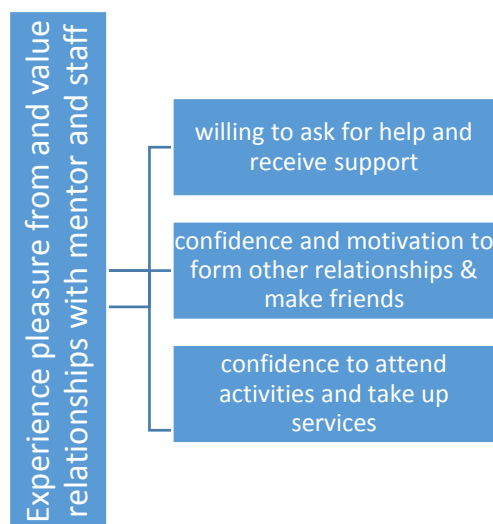
6.2 *Improved coping strategies and confidence to make better informed decisions*

Characteristics of the problem include: ongoing high levels of stress and anxiety; events that cause a crisis and a woman can no longer look after herself, support her family, or manage to complete everyday tasks such as shopping, cooking, eating, and keeping clean; an inability to think straight to resolve problems and a keen sense of inadequacy and worthlessness. Thus enabling women to manage their everyday lives, and to have the capacity to plan for the birth of their baby and care for their infant are identified as key factors that bring about change.

Findings from the self-completion questionnaire show that the overwhelming majority of women felt reassured by the emotional and practical support they received.

Table 6.1. The extent to which mentors are able to reassure women about issues related to pregnancy and early motherhood

Issues reassured by	Respondents Percentage
Feelings during pregnancy	92
Making a birth plan	71
Infant feeding	79
Caring for baby	88

Staff and mentors worked with pregnant mothers to reduce their anxieties and stress by encouraging them to complete practical tasks before their baby is born and the following table shows that at least half the women completed these tasks.
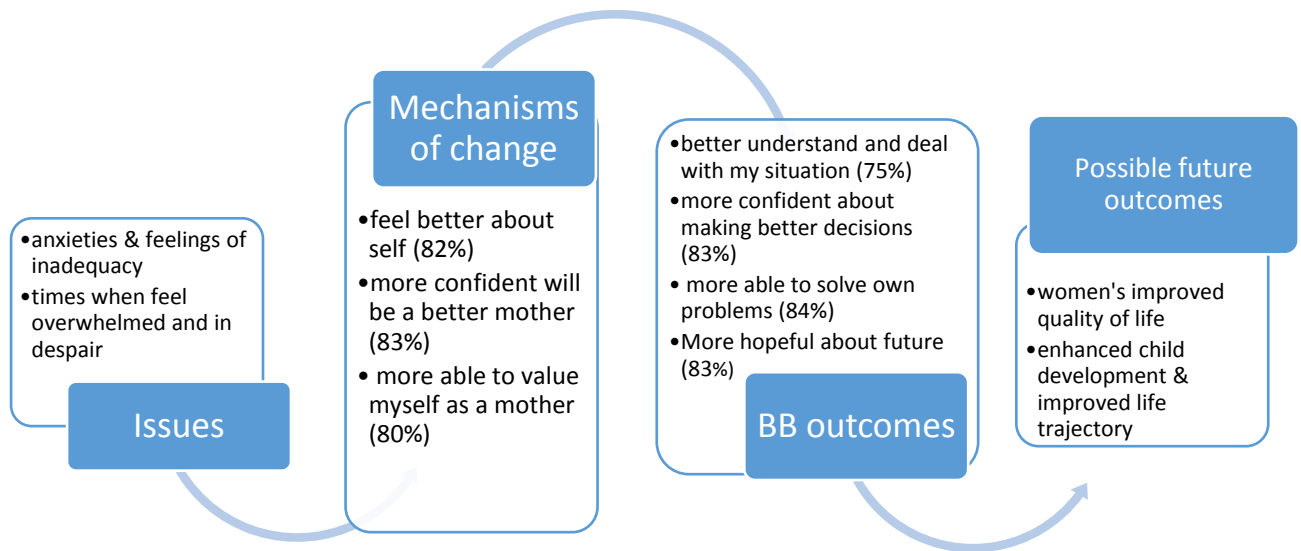
Table 6.2.   Practical tasks to reduce anxieties prior to a birth

Task	Completed Percentage	Not wish to/not able to Percentage
Get baby clothes & equipment	74	26
Budgeted for extra costs of having a baby	60	40
Made flat safe for infant	50	50
Organised for other child(ren) to go to school	56	44
Made sure enough food in home	86	18

Interviews with the women reveal how they are unable to take some practical actions due to their poverty. BB staff obtain baby clothes and equipment for free and they give out food bank vouchers for the overwhelming majority of women they support. Other tasks that have financial implications are less likely to be completed by women, although BB staff do everything they can to find free services.

The figure below shows how changes in women's feelings and emotions about themselves improves their confidence and ability to manage their everyday lives. The mechanisms of change signify self-respect and arose out of the mentoring and staff relationships. They are evidence of women feeling that being a mother is worthwhile and they are more confident about being a mother. Further, despair is replaced with hope to give women added motivation to improve their situation.

 Figure 6.3.   Improved coping strategies and confidence to make better informed decisions

Issues
- anxieties & feelings of inadequacy
- times when feel overwhelmed and in despair

Mechanisms of change
- feel better about self (82%)
- more confident will be a better mother (83%)
- more able to value myself as a mother (80%)

BB outcomes
- better understand and deal with my situation (75%)
- more confident about making better decisions (83%)
- more able to solve own problems (84%)
- More hopeful about future (83%)

Possible future outcomes
- women's improved quality of life
- enhanced child development & improved life trajectory

Although this study can only assess the immediate outcomes of the BB programme, data were collected as indicators to assess the likelihood of improvements continuing. Over three quarters (76%) said that they felt more able to plan for their future and in interviews women talked about the courses they were going to attend and their future plans with satisfaction and pride. These plans offered them self-assurance and gave them some certainty. Like others, the plans of this woman illustrate how new motherhood offers an opportunity to make career changes and BB staff assist women to make the most of this possibility by encouraging them to consider their future. This woman explained:

They talked about what I hope to do after, career-wise, and after talking to [name of staff] I did go away and think… maybe this is a good time to do what I love. So next September I will be going to study childcare and hopefully become a childminder… I love being in a children's environment… because of [name of staff] encouragement it made me think let's look at this differently, let's not just do what I've always done which is just earn money. (Woman)

Women also talked about the importance of giving their child a 'good start' to life. Just under three-quarters (71%) said they were better able to enjoy being with their infant and this pleasure gave them a foundation for forming a constructive relationship and having aspirations for their future.
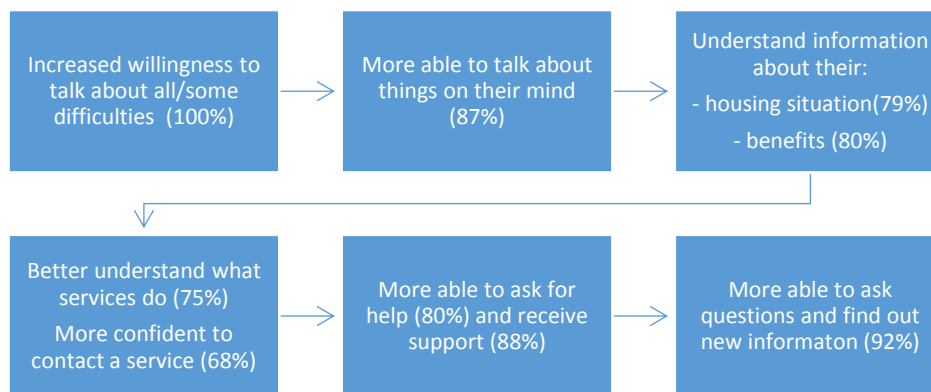
6.3 *Increased use of services*

Characteristics of the problem include: poor knowledge of health and community services, what is available, what they do, and how to find out about them; erratic attendance at health clinics and other services; unwillingness to discuss their anxieties and concerns with services; fractious and abrupt relationships with service providers. A partner agency characterised women's issues with services as follows:

They are frightened to engage with other services and professionals… they have had bad experience in the past, have been involved with mental health services… they are worried about how Social Care will view their parenting. (Partner Agency)

As the characterisation of the problem described above suggests there are certain preconditions that need to occur before an increased use of services can be expected. The findings summarised in the diagram below show that the BB programme has contributed to these preconditions being met for the majority of women. The findings also give us some certainty that women will continue to use services in the future and it is reasonable to expect that this uptake of services will improve outcomes for the women and their infant.

Figure 6.4. Changes that precede an increased use of services

Increased willingness to talk about all/some difficulties (100%)	→	More able to talk about things on their mind (87%)	→	Understand information about their: - housing situation(79%) - benefits (80%)
Better understand what services do (75%) More confident to contact a service (68%)	→	More able to ask for help (80%) and receive support (88%)	→	More able to ask questions and find out new informaton (92%)

A more detailed analysis of the findings presented above show that almost half (48%) of the women chose to keep some of their problems and concerns private and that they included, for example: 'family problems' (3), 'other problems' (2), 'housing' (1), and 'benefits' (1). This finding may be expected from a group of women who are distrustful of services.

We also found that BB staff problematise issues where there is ignorance; for example, they explain that FGM is a criminal offence. Staff also anticipate potential problems and discuss them; for example, that some women need to decide if the father is going to be named on the birth certificate of their baby. These practices demonstrate the commitment and skills of staff not to 'side-step' difficult issues. This finding is an example of a characteristic of a quality relationship and is likely to be a factor in explaining outcomes. The findings also show that giving some women the confidence to disclose private troubles remains a challenge for staff and mentors.

The findings presented above show that the mentors and staff have good communication skills that facilitate change and are another constituent of quality relationships. Staff and mentors also mentioned that confidence to contact services includes confidence not to contact a service if a woman does not wish to. Confidence also includes telling someone if they are receiving a poor service. Both staff and mentors expressed their frustrations about women lying and how this made it particularly difficult to form respectful and trusting relationships, and gives some indication of the depth of the shame and inadequacies women must feel as well as the challenges involved working with these women.

All the data show that women increased their use of services. Mentors found that women might not be accessing maternal services, have a limited knowledge about immunisations and have no knowledge of activities available for their infants. Some women may have accessed these services without the support of mentors, however, several women

commented on the impact of attending activities in Children's Centres on their lives and how they have becomes socially integrated:

I attend play group twice a week… through the playgroups I go for walks with other mothers and we meet in their houses. (Woman)

I was very isolated but now I have friends that I have met at groups. (Woman)

6.4 *Contributing to the local community*

Outcomes for each of the four aspects of contributing to the community are described in this section as follows:

6.4.1. *Mentors: increasing social skills and knowledge in local community*

Findings from the self-completion questionnaire show that the mentors improved their knowledge about their local area and about those who lived in local communities by:

- Being more knowledgeable about local services (100%)
- Improved their understanding of women from different cultures, ethnicities and faiths (86%)

Found personal satisfaction from being able to help by:

- Feeling good about being able to support other women (100%)
- Feeling good about contributing to the local community (86%)

Gained personally from mentoring by:

- Having a better understanding of their own life experiences (86%)
- Actively listen to others more often (71%)
- Feeling more confident, better about themselves, having a better understanding of 'healthy' relationships, and more confidence to find paid work (57%)

The mentors said that they still use the skills or knowledge they acquired whilst mentoring and the majority agreed that they continue to use their knowledge about services, their relationship building skills, skills to work as a team, and all the mentors still feel proud of what they achieved volunteering at BB. Some explained how their experience directly led to them getting paid employment.

I applied for [name of job] because of the advert sent by BB, the only reason I heard about it and the experience of BB gave me the skills to apply to it. (Mentor)

6.4.2. *Increasing participation of mothers in community-based activities*

Almost all questionnaire respondents (96%) said that they have either attended, or would like to attend mother and baby activities.

In interviews with women they talked about how they valued attending Children's Centres:

That's my saving grace… It helps him socialise and it helps me to meet people and he enjoys himself… It's been a really positive life-changing experience. (Woman)

6.4.3. *BB Staff: contributing to community capacity to care and quality of services*

These outcomes are not well-documented in this report, rather data on some outcomes have been gathered whilst others emerged during the course of the research and have not been sufficiently well captured. Nevertheless the available information illustrates how the BB programme has acquired a key role as a collaborative partner amongst those with responsibilities for delivering services to vulnerable pregnant women and those in early motherhood.

This role has been adopted in part because:

They are well-known and well-respected. (Partner Agency)

As a consequence an informal network has organically grown amongst women workers that is a practical response to their situation. They have set up an accountable system as one partner explained:

We have protocols for confidentiality [and] these egroups so we do not duplicate referrals and do not ask women the same questions. (Partner Agency)

Staff across agencies also jointly problem-solve, 'off-load' in ways that relieves their emotional toil and creates space for them to offer care and support, and which seeks solutions for women in a complex system that is 'slow moving' and can be unhelpful.

Partner agencies talked about how BB staff were always helpful, positive and offered practical solutions. This reduced the pressure on these workers and telephone conversations offered an opportunity to share concerns and we gained a strong impression that BB has a leadership role in this network. During partner interviews frontline staff seemed tired, sometimes overwhelmed with their increasingly complex caseloads and higher workloads. BB staff observed the emotional toil of their own work and that of their colleagues in other agencies and that everyone was a woman, sometimes on low pay and suffering in similar ways to those who they were supporting. One interviewee explained how she was 'emotionally full up' and it is recognised in therapeutically-informed services that frontline staff absorb the pain and anxiety of those who they are helping unless they are well supported emotionally. When a person becomes emotionally full up their emotions 'spill over' and they suffer empathy fatigue and can project their own anxieties onto those they are supporting. In these situations reflective groups are used for staff to think about their own feelings, to express their distress and to relieve some of the strain and stress of their work.

BB's leadership role is reinforced by their role as facilitators at conferences, multi-agency meeting that they host, and events that promote their service and show promotional videos. These gatherings strengthen informal networks and enable women workers to feel valued and that their work is of value. These are occasions where good practice is shared and information about organisations disseminated.

6.4.4. *Outreach work*

The purpose of outreach work is to reinforce the importance of women using maternity services and to disseminate information to women in early pregnancy, but these activities

were not assessed in this study. Mentors were also recruited through outreach and the shortage of mentors suggests the significance of outreach for the sustainability of BB.

7. Discussion

Many findings presented in this report can be used to address some of the gaps in our knowledge about how to facilitate change that leads to positive outcomes for disadvantaged and vulnerable pregnant women. They can be used to learn more about how a community-based organisation can lead an integrated response amongst statutory and voluntary agencies that benefits women frontline workers and the recipients of their services. The findings can also be used for training purposes and to reflect on how to improve practices particularly for those who are hard to help.[31]

Although we should be cautious about drawing firm conclusions from this small study, the findings highlight a number of issues where there is scope for further debate and possibly changes in decision-making, using a collective approach. Some of these issues are discussed below.

7.1. *Making judgements about the complexity of cases*

The wisdom of investing in schemes for pregnant women and women in early motherhood who experience adversity and poverty was recognised by all partner agencies who participated in the research. These interviewees were fulsome in their praise of BB and describe the programme's role as fulfilling an invaluable 'gap' in services that statutory services are unable to provide and as a 'catalyst' that facilitates many improvements for women. Interviewees unanimously wished that the BB programme was open to all women irrespective of the complexities of their situation. There is a strong sense amongst these practitioners that it is 'unfair' that no community-based initiatives are available for those women in the most desperate of circumstances. Further there is consensus that an increasing number of women are presenting with more complex issues and as a consequence fewer women will be given an opportunity to benefit from the BB programme.

There may be scope for an informal free-flowing seminar amongst all the relevant agencies to gain a deeper understanding of which cases are too complex for community-based organisations and how best to assess them. Questions include; when are cases 'too hot to handle'? Are mentors being protected too much? Would accepting more complex cases make it even harder to recruit mentors? Are BB staff being too cautious, can they take on more challenging cases? How could additional services be integrated into the joined-up service provision to provide the extra support required?

7.2. *Recruiting mentors*

At the time of the research agencies said that they would prefer more women to be supported by the BB programme and at the same time recruiting mentors is becoming more difficult. The equitable relationships at the heart of peer mentoring at BB opens up

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[31] Reder, P., and Fedman, G. (1996) The relationship to help: Interacting beliefs about the treatment process, *Clinical Child Psychology and Psychiatry*, 1,3: 457-467.

mentoring opportunities for all local mothers irrespective of their class, ethnicity, faith or no faith, or age. In theory, there are a large number of local women who could become involved. Understanding more about reluctances to become a peer mentor may improve recruitment strategies for new volunteers.

7.3. *Similar interventions: what works best for women living with adversity?*

Another issue that has emerged from this study is making decisions about what type of programmes, services and additional support are most suitable for women living in poverty and facing adversity. Choosing between different between types of counselling programmes, approaches to depression, and parenting courses are choices practitioners need to make when referring women to services. Making these decisions is not necessarily easy and opinions vary amongst professionals about what works best.

One example is parenting courses. Poor parenting exists across all classes but has less impact on better off children.[32] Stress has been found to disrupt parenting and lack of money is a major source of stress and conflict for those who living in poverty.[33] Some also argue that maternal instincts recede when women are highly stressed and anxious, placing a greater emphasis on the importance of selecting the most appropriate type of parenting courses.[34] Staff and mentors offer advice about parenting and often refer women to parenting classes. According to BB staff two types of courses are available; those that advocate routines and consistency that are imposed by the mother to 'fix' problems and use instrumental star systems to praise a child, for example, and other courses which recognise that babies are always changing and it is best that parents learn to find different solutions that suits the child, to tolerate different parenting styles without feeling threatened by them, and to encourage women to have confidence in themselves. But which is most suitable for women living with adversity?

7.4. *Achieving outcomes*

Those who make referrals to BB consider that women facing particular multiple challenges will be unable to cope well with their pregnancy, birth, and early motherhood unless they have support above and beyond 'usual care'. The majority of women who participate in the BB programme find stability in their lives, form supportive relationships, value themselves as mothers and have increased motivation and capacity to care for their infant. Many also gain knowledge and create space to consider the development of their infant by attending children's centres and activities for young children.

The findings from this study show however that achieving these improvements is not always straight forward. We noted that a woman was 'pressured', maybe 'cajoled' against her wishes and some may feel that such actions contravene women's rights to choose. Other may argue that women sometimes need to be 'pushed' as their reluctance to participate or

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[32] Field, F. (2010) *The Foundation Years: preventing poor children becoming poor adults*. London: HM Government.

[33] Field, F. (2010) *The Foundation Years: preventing poor children becoming poor adults*. London: HM Government.

[34] Blaffer Hrdy, S (1999) *Mother Nature*. London: Chatto & WIndus.

take particular actions is due to their lack of confidence and if priority is given to the infant's interests then women sometimes need to be persuaded to do things differently. The findings from this study support this latter approach, although in practice this requires a fine judgement about when 'pushing' may become harmful.

We also found that even when women have indifferent or negative experiences of the BB programme some improvements can happen that are likely to bring benefits to their infants. These findings indicate that there is scope for improving how the problems and challenges experienced by these women are conceptualised to develop stronger theories about how to bring about changes for this group of women. This would, for example, assist practitioners make judgements about when to 'put pressure' on women and how to reduce poor experiences arising from participating on the programme. Building stronger theories to improve how to respond better is unlikely to be easy as many of these women live with deep-seated multiple problems that affect their everyday lives.

7.4. *Partnership work*

One area that can be improved is partnership working. Poor services limit the realisation of positive outcomes and can cause women further harm particularly where there is racism and practices are discriminatory.[35] Gaps in services and a lack of consistency between organisations also reduce the possibilities of achieving positive outcomes. Other services are oversubscribed and often unavailable when a woman needs them. Partner interviewees were dismayed by the closure of some key local and high quality services for these women, as well as some national provisions. These closures impinge on their ability to support women effectively.

Locally we found co-operative, mutually supportive relations across agencies that contribute to achieving better outcomes for all agencies. 'What works' and good practice are shared between frontline staff across agencies amongst women workers, often in an informal setting.

It makes sense to build on what is already successful but how can partnership working be improved in the interests of supporting pregnant women and women their early motherhood? In what ways can health managers and local authority managers adopt a facilitating and enabling role without disturbing what works well informally? Our findings suggest that there are different ways to consider commissioning and to devise support systems for frontline workers across agencies to remedy these issues.

7.5. *Role of BB programme*

The organisational arrangements, procedures, and ethos accounts for the well-implemented programme and organisational synergy gives rise to and sustains practices which bring about positive outcomes for the majority of women. BB is well positioned within a highly regarded voluntary organisation, Shoreditch Trust, and is a well-respected programme.

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[35] Samele, C., Clewett, N., and V. Pinfold (2015) *Birth Companions commissioned literature review: Supporting vulnerable pregnant women and new mothers in the community*, report by Informed Thinking and McPin Foundation.

These circumstances offer possibilities for the BB programme to give greater consideration to its role within the sector in Hackney. Pregnant women and new mothers are situated at a critical juncture where co-ordinated support or 'systems of help' can be mobilised to prevent the escalation of social and psychological problems and can contribute to improving the life trajectories of infants. Many of the findings presented in this study discuss 'avoidable social inequalities'[36] and how BB staff are well positioned to take a greater leadership role.

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[36] Lindquist, A., Kurinczuk, J., Redshaw, M., and M. Knight (2014) Experiences, utilisation and outcomes of maternity care in England among women from different socio-economic groups: findings from the 2010 National Maternity Survey, *International Journal of Obstetrics and Gynaecology*, 1610-1617.