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Take-up of community-based perinatal mental health peer support from trained volunteers: a realist-informed study

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ABSTRACT

Aims: To explore mechanisms that lead mothers with perinatal mental health difficulties to take up an offer of face-to-face peer support from trained volunteers, and contextual factors triggering those mechanisms.

Methods: Realist evaluation methods were used to identify context-mechanism-outcome configurations for take-up in a community-based, third sector programme offering one-to-one and group peer support in the UK. Data were from semi-structured interviews with mothers ($n = 20$), peer support volunteers ($n = 27$), and staff ($n = 9$), and baseline quantitative and open-text data about mothers at referral ($n = 260$).

Results: 182/260 mothers (70%) took up peer support, varying between sites with different populations. Twenty context-mechanism-outcome configurations explained take-up, which depended on complex contextual factors. Mechanisms clustered around mothers' expectations of psychological safety; desire for a meaningful reference group for social comparison; beliefs about what they may gain; expectations about how it might compare to professional mental health support; and practical issues such as mode of delivery. The purpose of peer support can be misunderstood. Not all communities see value in talking about emotional distress with peers, and not all mothers trust peers to be non-judgemental. One-to-one and group support may feel safe to different mothers.

Conclusion: Programmes should work with mothers, third sector organisations, and community leaders, to identify how perinatal mental health peer support can be locally offered most appealingly. Accessibility may be increased by offering a choice of group or one-to-one support, and a blend of face-to-face, telephone, and video-conferencing. Publicity material should clearly explain what peer support is and how it can help.

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Background

Perinatal mental health difficulties (PMHD) are common in the UK, affecting approximately one in four pregnant women and new mothers (NHS England [NHS], 2025). They can have a detrimental impact on women's experiences of motherhood (Jones et al., 2014), their physical health, obstetric outcomes, and risk of mortality (Howard & Khalifeh, 2020; Howard et al., 2014; Stein et al., 2014); and on their babies' physical, psychological, mental, emotional, and behavioural development (Howard & Khalifeh, 2020; Howard et al., 2014; Stein et al., 2014). In the UK there has been substantial investment in specialist services for women with severe or complex PMHD (Cantwell, 2023), and in maternal mental health services for women with moderate to severe PMHD related to birth trauma, severe fear of childbirth, or perinatal loss (Maternal Mental Health Alliance, 2024). Mental health peer support – that is, social support from someone with lived experience of a similar mental health difficulty – is an established aspect of mental health services (Cooper et al., 2024) and a growing aspect of perinatal mental health services (Royal College of Psychiatrists, 2021). Peer support from third sector organisations is recommended as an alternative to professional support for women with mild PMHD or as a safety net for women leaving specialist perinatal mental health services (Royal College of Psychiatrists, 2021). A range of third sector programmes offer peer support outside mental health services, in groups or one-to-one from trained peer supporters (Hearts and Minds Partnership, 2024). There is evidence of the effectiveness of peer support in reducing the symptoms of postnatal depression, but the evidence for the impact on other PMHD is mixed (Dennis, 2014; Fang et al., 2022; Huang et al., 2020).

Although community-based peer support has been suggested to be a more acceptable alternative to professional support for people who feel stigmatised by their mental health difficulties (Billsborough et al., 2017), not everyone with mental health difficulties chooses to use peer support if it is offered (Davidson et al., 1999). Take-up rates are often unreported, but in studies in Canada and the UK, only 37% of mothers with PMHD accepted a direct offer of telephone peer support (Letourneau et al., 2015) and 52% of mothers accepted an offer of face-to-face support (Fairbairn & Kitchener, 2020). Where mothers were invited to take part in a trial of telephone peer support, recruitment ranged from 38% (Sembi, 2018) to 72% (Dennis et al., 2009). Across different peer support programmes in the UK, USA, and Canada, when the ethnicity and socio-economic status of supported mothers were reported, they were predominantly White, middle class, and had higher education (Cust, 2016a; Dennis, 2009; Gjerdingen et al., 2013; Letourneau et al., 2015; Prevatt et al., 2018; Rice et al., 2022; Sembi, 2018). This raises the questions of why peer support appeals to some people with PMHD but not to others; which forms of peer support appeal to which people; and why.

A realist review found take-up of community-based perinatal mental health peer support offered face-to-face or by telephone was influenced by multiple factors: mothers' beliefs that it would be beneficial to talk about their problems; their expectations that peer support would offer empathetic understanding and non-judgemental acceptance outside their social circle; their relationships with primary health professionals; their cultural background and perspectives on mental health; their desire for professional support; overcoming barriers of time and money;

preferences for format of the support (group or one-to-one); and the use of volunteers as peer supporters (McLeish et al., 2023). As the evidence in that review was from non-realist sources, there were evidential gaps in linking individual contextual factors (C) and mechanisms (M) leading to the outcome (O) of mothers taking up peer support. A study using realist methods can fill in these gaps by purposefully seeking evidence for underlying causal mechanisms and the contextual factors that trigger them, in order to devise an explanation that is the best fit with the observed data and thus provide evidence to support programmes to more effectively reach mothers who can benefit from peer support (Clark et al., 2008; Sayer, 1992). The aim of this research was therefore to answer the realist question *What is it (M) that leads to take-up (O) of face-to-face peer support from trained volunteers when offered in groups or one-to-one by a community-based programme, for whom (C), in what circumstances (C), and why (M)?* The research reported here is part of a wider evaluation of the pilot of 'Parents in Mind', a third sector community-based perinatal mental health peer support programme. Other aspects of the evaluation are reported separately, including the realist change model for mothers once they were actually using the peer support, covering both positive and negative experiences (McLeish et al., 2024).

Methods

Setting

The pilot community-based 'Parents in Mind' programme was run by national parenting charity NCT in 2016–19 at three sites in England, for 32 months at site 1, 26 months at site 2, and 21 months at site 3. Site 1 was a relatively affluent, predominantly White, rural area around a relatively deprived city with a third of its population from ethnic minorities, principally Asian communities. Site 2 was a deprived urban area with a 98% White population. Site 3 was a deprived inner-city borough with two thirds of the population from Asian or Black groups. At each site, the programme offered perinatal mental health peer support from trained volunteer (unpaid) peer supporters to pregnant women and mothers with a child under two, who had self-defined PMHD. The peer supporters were local mothers who had past experience of PMHD but were currently well. They received 24 hours of training, and led small, unstructured, weekly face-to-face group meetings or were matched with individual mothers to give one-to-one support for approximately one hour a week. Support was based around non-directive, strengths-based, active listening; sharing ideas for self-care and parenting; and signposting to services. Box 1 shows an example of how the programme described itself in publicity materials aimed at mothers.

Box 1: Example description of the Parents in Mind peer support programme in publicity materials.

Local, friendly group or 1 to 1 support available for women experiencing low mood, anxiety or emotional difficulties during pregnancy and early parenthood. Led by trained volunteers. Parents in Mind is a "mum-to-mum" safe, non-judgemental space to talk, relax, seek information, and gain support. A friendly, warm welcome awaits'.

Data collection

This research used existing programme data and in-depth qualitative interviews, and was guided by the RAMESES II quality and reporting standards for realist evaluations (Wong et al., 2016, 2017). The programme collected anonymised routine baseline data on the mothers who were referred to the programme, including demographic data, the self-report 21-point Hospital Anxiety and Depression Scale (HADS) (Zigmond & Snaith, 1983), and an open question '*What are you hoping to get out of peer support?*'. Interview participants were recruited (1) from mothers who took up peer support, (2) from peer supporters, who could comment on attitudes to peer support in their local communities, plus (3) all programme staff, who had contact with mothers who declined the peer support offered as well as those who took it up. Mothers and peer supporters were invited to participate by their local programme manager, and the contact details of those who agreed were passed to the researcher. Staff were invited directly by the researcher. Participants were offered the choice of being interviewed by telephone or face-to-face; a participant information leaflet was emailed at least 48 hours before the interview; and informed consent was given before the interview began. Interviews covered participants' experiences and views of take-up of peer support and an invitation to comment on developing context-mechanism-outcome configurations (CMOs). Local programme managers and national staff were each interviewed every six months during the pilot, and other participants were interviewed once. Recruitment of mothers and peer supporters continued until no further interviews were required to test the developing CMOs. The researcher had a previous professional relationship with two programme staff but no previous contact with any other interviewees. Interviews were audio-recorded and transcribed. All names used are pseudonyms, with (M) indicating a supported mother and (V) a volunteer peer supporter, while staff are identified only by site (1, 2, or 3).

Data analysis

Descriptive statistics were used to analyse programme data. Open text answers and interview transcripts were analysed using realist coding for contexts, mechanisms, and the single outcome of take-up, as well as the relationships between them, known as context-mechanism-outcome configurations (CMOs) (Wong et al., 2017). This coding process was used to test deductively the initial hypotheses about take-up, which were derived from a realist review of perinatal peer support (McLeish et al., 2023), from the insights of staff gathered during preliminary interviews, and from the views of a project advisory group (Patton, 2010). New CMOs arising from the data were added inductively. Partial CMOs were developed abductively, working backwards from effects to the conditions that would be necessary for those effects to be produced (Jagosh, 2020), and these developing CMOs were explored in subsequent interviews. In every configuration the 'outcome' in the CMO was take-up of the offer of peer support. The finalised CMO configurations were all evidenced by primary data. The CMO configurations that were initially hypothesised and finally evidenced are shown in [Table 4](#).

Results

Participants

Baseline programme data were available for 260 mothers who were in touch with the programme, 30% of whom had self-referred.

Mothers who received peer support ($n = 20$), peer support volunteers ($n = 27$), and all programme staff (local staff ($n = 4$), national staff ($n = 2$), trainers ($n = 3$)) took part in interviews. There were 78.5 hours of interviews; mean lengths were: 37 minutes with mothers (range 20–58 minutes); 54 minutes with volunteers (range 38–82 minutes); 101 minutes with staff (range 36–210 minutes). Ten interviews were face-to-face and the rest were by telephone. The socio-demographic characteristics of interviewed mothers and volunteers are shown in [Table 1](#).

Characteristics of mothers who did or did not take up an offer of peer support

In total 182 mothers (70%) took up the peer support they were offered. Mothers' socio-demographic characteristics and mental health history at the point of referral are shown in [Table 2](#). Mothers who took up support at site 1 were predominantly White first-time mothers, and more socio-economically advantaged than at other sites. Mothers at site 2 were predominantly White, very socio-economically disadvantaged and already had other children. Mothers at site 3 were more ethnically diverse and socio-economically disadvantaged, but they did not fully reflect the ethnic diversity and multiple disadvantage of the borough. Across the three sites, half of mothers who took up support were in touch with a perinatal mental health team at the time of referral, and 75% had a history of mental health difficulties before their current or recent pregnancy.

Table 1. Demographic characteristics of mothers and volunteers interviewed.

	Volunteers ($n = 27$)	Supported mothers ($n = 20$)
Ethnicity		
White British	15 (55.6%)	18 (90%)
White Other	5 (18.5%)	1 (5%)
Asian British	5 (18.5%)	1 (5%)
Black British	1 (3.7%)	0
Black Other	1 (3.7%)	0
Age		
Age 20–30	5 (18.5%)	9 (45%)
Age 31–40	13 (48.2%)	10 (50%)
Age 41–50	7 (25.9%)	1 (5%)
Age 51+	2 (7.4%)	0
Mental health experience (current and/or previous)		
Depression	22 (81.5%)	15 (75%)
Anxiety	10 (37%)	18 (90%)
Post-traumatic stress disorder	5 (18.5%)	3 (15%)
Obsessive compulsive disorder	1 (3.7%)	3 (15%)
Other	2 (7.4%)	2 (10%)
Postcode quintile using Index of Multiple Deprivation		
1 (most deprived)	Not available	6 (30%)
2		4 (20%)
3		3 (15%)
4		3 (15%)
5 (least deprived)		4 (20%)



Table 2. Socio-demographic characteristics and mental health history of mothers who did and did not take up peer support after referral.

	Mothers who took up support (n = 182)					Mothers who did not take up support (n = 78)				
	All sites (n = 182)	Site 1 (n = 95)	Site 2 (n = 53)	Site 3 (n = 34)	All sites (n = 78)	Site 1 (n = 44)	Site 2 (n = 13)	Site 3 (n = 21)		
Ethnicity										
Asian	11 (6%)	4 (4%)	0	7 (21%)	4 (5%)	1 (2%)	0	3 (14%)		
Black	9 (5%)	4 (4%)	0	5 (15%)	7 (9%)	1 (2%)	0	6 (29%)		
White	152 (83%)	82 (86%)	51 (97%)	19 (56%)	43 (55%)	30 (67%)	10 (77%)	3 (14%)		
Other	2 (1%)	0	1 (2%)	1 (3%)	7 (9%)	3 (7%)	1 (8%)	3 (14%)		
Not recorded	8 (4%)	5(5%)	1 (2%)	2 (6%)	17 (22%)	9 (20%)	2 (15%)	6 (29%)		
Postcode quintile*										
1 (most deprived)	50 (28%)	10 (11%)	34 (64%)	6 (18%)	24 (31%)	6 (18%)	10 (77%)	4 (19%)		
2	37 (20%)	12 (13%)	3 (6%)	22 (65%)	19 (24%)	22 (65%)	0	10 (48%)		
3	34 (19%)	28 (29%)	2 (4%)	4 (12%)	14 (18%)	4 (12%)	1 (8%)	1 (5%)		
4	34 (19%)	24 (25%)	10 (19%)	0	8 (10%)	0	1 (8%)	0		
5 (least deprived)	24 (13%)	20 (21%)	4 (8%)	0	3 (4%)	0	0	0		
Not recorded	3 (2%)	1 (1%)	0	2 (6%)	10 (13%)	2 (6%)	1 (8%)	6 (29%)		
First time parent										
Yes	106 (58%)	61 (64%)	26 (49%)	19 (56%)	23 (29%)	13 (30%)	5 (38%)	5 (24%)		
No	76 (42%)	34 (36%)	27 (51%)	15 (44%)	47 (60%)	30 (68%)	6 (46%)	11 (52%)		
Not recorded	0	0	0	0	8 (10%)	1 (2%)	2 (15%)	5 (24%)		
Perinatal stage										
Pregnant	46 (25%)	20 (21%)	21 (40%)	5 (15%)	30 (38%)	16 (36%)	7 (54%)	7 (33%)		
Postnatal	138 (75%)	75 (79%)	32 (60%)	29 (85%)	33 (42%)	21 (48%)	4 (31%)	8 (38%)		
Not recorded	0	0	0	0	15 (19%)	7 (16%)	2 (15%)	6 (29%)		
Previous mental health difficulties										
Yes	136 (75%)	74 (78%)	44 (83%)	18 (53%)	38 (49%)	24 (55%)	9 (69%)	5 (24%)		
No	46 (25%)	21 (22%)	9 (17%)	16 (47%)	25 (32%)	15 (34%)	2 (15%)	8 (38%)		
Not recorded	0	0	0	0	15 (19%)	5 (11%)	2 (15%)	8 (38%)		
Mental health support**										
Receiving psychological therapy	34 (19%)	24 (25%)	4 (7%)	6 (18%)	6 (8%)	2 (5%)	3 (23%)	1 (5%)		
In touch with perinatal mental health team	90 (50%)	54 (57%)	20 (38%)	16 (47%)	23 (29%)	16 (36%)	3 (23%)	4 (19%)		

*Using the Index of Multiple Deprivation.

**Respondents could choose more than one option for this question.

Table 3. Baseline Hospital Anxiety and Depression Scale (HADS) anxiety and depression scores for supported mothers.

	All sites (n = 161)	Site 1 (n = 81)	Site 2 (n = 52)	Site 3 (n = 28)
Baseline depression scores				
Non-clinical < 8	60 (37.3%)	36 (44.4%)	15 (28.9%)	9 (32.1%)
Mild (8–10)	53 (32.9%)	24 (29.6%)	18 (34.6%)	11 (39.3%)
Moderate (11–14)	30 (18.6%)	13 (16.1%)	11 (21.2%)	6 (21.4%)
Severe (15–21)	18 (11.2%)	8 (9.9%)	8 (15.4%)	2 (7.1%)
Baseline anxiety scores				
Non-clinical < 8	19 (12.0%)	9 (11.1%)	3 (5.8%)	7 (25.0%)
Mild (8–10)	29 (18.0%)	18 (22.2%)	5 (9.6%)	6 (21.2%)
Moderate (11–14)	58 (36.0%)	31 (38.3%)	17 (32.7%)	10 (35.7%)
Severe (15–21)	55 (34.2%)	23 (28.4%)	27 (51.9%)	5 (17.9%)

There were substantial gaps in the data available for mothers who did not take up support after referral, but available data suggest that a higher proportion overall were currently pregnant, already had older children, and were not receiving other mental health support.

Baseline Hospital Anxiety and Depression Scale (HADS) scores were available for 161 mothers who took up peer support, shown in Table 3. Although Parents in Mind was originally intended to be for mothers with mild-to-moderate PMHD, a third of mothers who took up support had HADS scores suggesting severe anxiety, and almost a third had scores suggesting moderate to severe depression. Both anxiety and depression scores were highest in site 2, where half of mothers had scores suggesting severe anxiety.

CMO configurations

There were a range of factors that influenced mothers' take-up of the peer support when they were offered it, reflecting the complexity of mothers' expectations, needs, and backgrounds. Table 4 shows the individual CMOs with supporting illustrative quotations and indicates the difference between the initial and the final CMOs.

When a mother was affected by cultural narratives of idealised motherhood and the internalised, experienced or expected stigma of mental illness, she might assume that she was uniquely failing at motherhood where others apparently succeeded (C), hide her feelings from family and friends (C), and avoid new parent groups (C). These mothers were motivated to take up peer support (O) if they wanted emotional support (C) and believed that mental health peers would be non-judgementally accepting (M) and empathetically understanding (M), if they believed that talking to peers would make them feel 'normal' (M), or if they felt safe talking to someone outside their normal social circle so that the disclosure of difficult feelings would not have any social repercussions (M) (CMOs 1–4). However, there were also contrary examples where mothers said they did *not* assume that they would be accepted by peers, but expected to be judged by them for being a bad mother or for being weak. When a mother was worried about her prospects of recovery (C), she might take up peer support (O) if she believed that meeting others who had recovered from perinatal mental health difficulties would give her hope (M) (CMO 5). When a mother did not feel able to cope with her mental health or parenting (C), she might turn to peers looking for tips on self-care and looking after her baby (M) (CMO 6).



Table 4. Context-mechanism-outcome (CMO) configurations for take-up of perinatal mental health peer support, with supporting quotations.

CMO #	Context		Mechanism leading to outcome of take-up of peer support		Outcome	Illustrative quotation
	Initial CMOs (hypothesised)	Final CMOs (evidenced)	What circumstances/for whom	Resources provided by programme		
1	✓	✓	<p>Mother wants emotional support but:</p> <ul style="list-style-type: none"> - Feels internalised stigma: negative self-labelling as an abnormal 'bad' mother - Experiences or expects stigma from others - Avoids new parent groups as these make her feel worse 	<p>Offer of peer support</p> <p>Mother believes peers will be non-judgemental so she can speak about mental health freely</p>	<p>Mother takes up offer of peer support</p>	<p>C = context M = mechanism (M) = mother (V) = volunteer peer supporter</p> <p>C 'I felt intensely guilty that I'd been given what we'd been wanting for years, and why wasn't I happy? ... I felt like a complete failure'. Grace (M)</p> <p>C 'You see things on Facebook with mums saying stupid stuff that I believed, like "Oh I loved doing the night feeds" ... and how blessed they are. You know, #blessed ... It is taboo, postnatal depression ... people think of it as, you don't love your baby'. Paige (M)</p> <p>C 'If I went to any other mums' groups, sometimes it feels as though there is an element of judgement, and I couldn't communicate how I was feeling as a parent openly. I felt so ashamed of how I was feeling'. Natalie (M)</p> <p>COUNTER: M 'I was afraid that the baby would start screaming [at the peer support group], and that everybody would hate me, and that I would panic when he was crying and I couldn't stop him'. Vicki (M)</p>
2	✓	✓	<p>Mother feels internalised stigma and wants to normalise her experiences and feelings</p>	<p>Offer of peer support</p> <p>Mother believes peers will make her feel 'normal'</p>	<p>Mother takes up offer of peer support</p>	<p>C-M 'When you're feeling low, you think, "How come it's perfect for everyone else?" When I saw this leaflet and it was about like-minded people who had been through it themselves, that was the key part for me because I thought they're not going to look at me like I'm some sort of weirdo, I'm a normal person'. Hema (M)</p>

(Continued)

Table 4. (Continued).

		Context		Mechanism leading to outcome of take-up of peer support		Illustrative quotation	
CMO #	Initial CMOs (hypothesised)	Final CMOs (evidenced)	What circumstances/for whom	Resources provided by programme	Reasoning or reaction leading to use of peer support	Outcome	
3	✓	✓	Mother feels stigma and hides feelings from partner, family, and friends	Offer of peer support	Mother feels safe to attend because peers are outside normal social circle	Mother takes up offer of peer support	C-M 'What appealed to me about the group was that it was people who were in a similar situation and I felt safe to talk about it in a way that I couldn't with some of my closest friends and family, because I wanted to put on this front that everything was okay and that I was coping with it all and motherhood was wonderful'. Di (M)
4	✓	✓	Mother has disclosed feelings to partner, family, and friends but they don't understand	Offer of peer support	Mother believes peers will understand	Mother takes up offer of peer support	C-M 'My husband doesn't understand. He's seen me have two panic attacks and he's like, "You should just calm down"... I wanted to ask other girls that have had babies what their experience was and there's no point talking to a bloke about that, isn't there? They cannot make sense of it'. Brooke (M)
5	x	✓	Mother worries she may never recover	Offer of peer support	Mother believes peers will give her hope of recovery	Mother takes up offer of peer support	C-M 'I was a bit negative, thinking, "It's probably going to be the same [as therapy]. They'll tell me to use the same techniques, and I'll try it and it won't work". [But once I knew] it was mums that had been through something similar themselves... I thought, that'd be quite nice, speaking to a mum that feels better now and can be like, "Don't worry, you've got this. I'm okay now, I've got this". Annie (M)
6	✓	✓	Mother feels unable to cope with her mental health and parenting	Offer of peer support	Mother believes peers will give her tips on self-care and coping	Mother takes up offer of peer support	C-M 'Learning from other people – both in terms of mental health and babies (very little contact with babies/other mums)'. (Open text)

(Continued)



Table 4. (Continued).

CMO #	Initial CMOs (hypothesised)	Final CMOs (evidenced)	Context		Mechanism leading to outcome of take-up of peer support		Outcome	Illustrative quotation
			What circumstances/for whom	What circumstances/for whom	Resources provided by programme	Reasoning or reaction leading to use of peer support		
7	✓	✓	Mother has preference for cultural homogeneity or heterogeneity	Mother has social anxiety or low social confidence	Programme is able to offer a choice about cultural matching	Resources provided by programme Mother feels safe to attend because cultural similarity or difference matches her needs	Mother takes up offer of peer support	C = context M = mechanism (M) = mother (V) = volunteer peer supporter C-M 'There's an Asian lady who has come for the past three weeks, but she initially only came because she wanted to see a Muslim mother'. Vani (V) C-M 'Women do not want to be seen by other women in their same community talking about an issue like this, because they feel embarrassed'. Uma (V) C-M 'It was just me and two volunteers. It wasn't this big daunting task walking into a room of people where I didn't know anybody ... I'd find that really intimidating to walk into the room like that'. Natalie (M) C-M 'I definitely thought about not going, because I would have to sit in a one-to-one situation with someone and I was scared ... there's nowhere to hide. And so if you're not feeling brave that day, you might cancel and then you might feel like you couldn't ask to go again because you feel like you'd let everyone down because you'd cancelled'. Vicki (M)
8	✓	✓	Mother has social anxiety or low social confidence	Mother has social anxiety or low social confidence	Programme offers choice of one-to-one or group support	Resources provided by programme Mother feels safe to talk 1:one-to-one to a peer supporter although she would not feel safe in a peer support group, or vice versa.	Mother takes up offer of peer support	C-M 'Coming from an Asian background, I think that depression is not recognised. People think that you don't get depressed if you're Muslim ... If you are feeling depressed you don't always recognise it in yourself, so how can you go and seek help?' Quirat (V)
9	x	✓	Mother recognises her thoughts and feelings as mental health difficulties	Mother recognises her thoughts and feelings as mental health difficulties	Offer of peer support for mental health difficulties	Resources provided by programme Mother feels the offer is aimed at people like her	Mother takes up offer of peer support	C-M 'Coming from an Asian background, I think that depression is not recognised. People think that you don't get depressed if you're Muslim ... If you are feeling depressed you don't always recognise it in yourself, so how can you go and seek help?' Quirat (V)

(Continued)

Table 4. (Continued).

		Context		Mechanism leading to outcome of take-up of peer support		Illustrative quotation	
CMO #	Initial CMOs (hypothesised)	Final CMOs (evidenced)	What circumstances/for whom	Resources provided by programme	Reasoning or reaction leading to use of peer support	Outcome	
10	✓	✓	Mother believes it is useful and acceptable to talk about mental health difficulties	Offer of peer support based on talking and listening	Mother wants to talk about her mental health	Mother takes up offer of peer support	C-M 'It was so geared towards White, middle class women: "sit face-to-face and talk"... It would be good to combine it with other activities because for many cultures that face-to-face does not work'. (Staff, site 3). C-M 'Any of BME [Black and minority ethnic] community that were coming in, anyone with multiple disadvantage, were not staying in the service ... The very small groups that I have are White British, and yes we're supporting them, but that's not OK because my community is only 16% White British ... The service model doesn't work for the demographic that I'm in'. (Staff, site 3) C-M 'I don't really have any friends or family ... I just felt really alone, and I was hoping to make some friends'. Morgan (M) COUNTER: M 'I didn't really want to make friends, I didn't want to bond with anybody'. Hema (M). C-M 'I just wanted a reason to leave the house once a week, even if everything else was crap'. Erin (M).
11	x	✓	Mother is socially isolated or first in her circle to have a baby	Offer of peer support	Mother believes peer support will provide friendship	Mother takes up offer of peer support	C-M 'The service is because her midwife thinks it will help her. She's not sure what to expect out of the service.' (Open text: written by staff on mother's behalf).
12	x	✓	Mother experiences life with a baby as chaotic and wants structure	Offer of regular peer support	Mother believes regular peer support will help to structure her time and give her a reason to leave the house	Mother takes up offer of peer support	
13	✓	✓	Mother trusts professionals	Programme has good relationship with local professionals	Mother trusts peer support programme because she is referred by a professional she trusts	Mother takes up offer of peer support	

(Continued)

Table 4. (Continued).

CMO #	Initial CMOs (hypothesised)	Final CMOs (evidenced)	Context		Mechanism leading to outcome of take-up of peer support		Outcome	Illustrative quotation
			What circumstances/for whom	Resources provided by programme	Reasoning or reaction leading to use of peer support			
14	x	✓	Mother has mild perinatal mental health difficulties	Offer of peer support	Mother believes peer support will help her recover	Mother takes up offer of peer support	M 'Hope to feel less anxious and depressed'. (Open text) M 'I'd like to stop taking medication and hopefully cope well without it'. (Open text) M 'To reduce my anxiety and any lasting impact of birth trauma' (Open text) M 'Improve agoraphobia'. (Open text) C-M 'I've done a few lots of person-centred therapy. I have been over and over all of the bad stuff that's happened in my past, I don't feel I need to keep doing that. So I wanted to learn new ways to deal with my emotions ... and work out strategies.' Oona (M)	C = context M = mechanism (M) = mother (V) = volunteer peer supporter
15	x	✓	Mother has positive current or previous experience of professional mental health support	Offer of peer support	Mother believes peer support will offer something different from professional mental health support	Mother takes up offer of peer support	COUNTER: C-M '[My friend's] psychologist from the mental health team at the hospital had spoken about Parents in Mind ... Because she was having [professional] one-to-one support at that point she didn't use it'. Di (M) C-M 'I wanted it to be some sort of stop gap ... I didn't have any thoughts that it would be a cure, but I thought it would potentially tide me over or help me not to deteriorate'. Natalie (M) C-M 'I thought it would have more of a counselling session than it actually is'. (Open text)	
16	✓	✓	Mother wants professional mental health support	Programme has wider criteria than professional support or is available without waiting list	Mother believes peer support will be similar to professional support or can be a holding position while waiting for professional support	Mother takes up offer of peer support	C-M 'Leaving the perinatal mental health team to the community team and think this group will be helpful during that transition'. (Open text)	
17	x	✓	Mother has been discharged from specialist perinatal mental health service	Offer of peer support	Mother believes peer support will help as a 'step-down' service	Mother takes up offer of peer support		

(Continued)

Table 4. (Continued).

CMO #	Initial CMOs (hypothesised)	Final CMOs (evidenced)	Context		Mechanism leading to outcome of take-up of peer support		Outcome	Illustrative quotation
			What circumstances/for whom	Resources provided by programme	Reasoning or reaction leading to use of peer support	Peer support		
18	✓	✓	Mother has had negative experience of professional support Mother conceals symptoms from professionals – fear of judgement and/or children being taken into care	Peer support is available by self-referral and with minimal self-disclosure	Mother believes community-based peer support is a safe or better alternative	Mother takes up offer of peer support	<p>C = context M = mechanism (M) = mother (V) = volunteer peer supporter</p> <p>C 'I had counselling but it was not great ... some of the things she said, it made me feel worse'. Lena (M)</p> <p>C-M 'We have the rumour that if you are mentally ill, in my society they say, "if you mention this to a professional, your children will be taken away" ... But if it's just a [volunteer peer supporter] who you meet and it's not written or any paper filling, you just talk and are friendly, I find that this give everyone the confidence to speak to the stranger'. Yasmin (V)</p> <p>C-M 'It's that whole feeling of being judged and I was feeling quite proud, and I didn't want to feel embarrassed having to go back to the doctors and go through that process'. Hema (M).</p> <p>COUNTER: 'The last woman said, "You can say it's confidential, but I've just been through the court case where they've taken my three children, and the therapist said the same, but it was used". And what can you say to her?' (Staff, site 3)</p>	

(Continued)



Table 4. (Continued).

CMO #	Initial CMOs (hypothesised)	Final CMOs (evidenced)	Context		Mechanism leading to outcome of take-up of peer support		Illustrative quotation
			What circumstances/for whom	Resources provided by programme	Reasoning or reaction leading to use of peer support	Outcome	
19	✓	✓	Mother has resources of time, money, and energy to invest in meeting her own needs, and access to transport	Programme offers support requiring less commitment e.g. by telephone or drop-in group	Mother can use peer support in ways that do not exceed her resources	Mother takes up offer of peer support	<p>C = context M = mechanism (M) = mother (V) = volunteer peer supporter</p> <p>C-M 'A lot of our complex women don't have time to be coming out to things so they want one service not three services, or they've got three kids or they're coming too far . . . I realised very quick the service is not for [those] women.' (Staff, site 3)</p> <p>C-M 'In the deepest darkest November, when you've got a four day old baby and you've been up all night, and you can't get yourself out to a children's centre – that could be a phone call. It's the reality of being there for these women when they actually need us'. (Staff, site 2)</p>
20	x	✓	Mother has autonomy within family	Offer of peer support (potentially with another activity)	Mother is able to make her own decision to attend	Mother takes up offer of peer support	<p>C-M 'If the family know that you're going because of mental health, it would be like, "Why should you be?" I think mainly it is the family that prevents women going out and seeking help'. Xami (V)</p>

Some CMOs were dependent on the specifics of the peer support that was available. Some mothers wanted to experience 'peerness' from someone with a shared cultural and language background (C) but others did not trust people from a shared background to preserve confidentiality (C), so their feelings of safety (M) leading to take-up (O) were affected by the programme's ability to match their cultural preference (CMO 7). Some mothers with low social confidence (C) said they took up peer support (O) because they felt safe talking to an individual peer supporter or a very small group (M) but would not have attended a big group. Others believed that talking to an individual would create uncomfortable pressure for self-disclosure, so they might only take up peer support if they could feel relatively anonymous by dropping into a bigger group where they would feel more in control of what they shared (M) (CMO 8).

Some mothers had reasons for taking up peer support which were less directly related to their beliefs about 'peers'. Mothers who were socially isolated (for example because of migration, rehousing policies following domestic abuse, or being the first in a social circle to have a baby) (C) might turn to peer support (O) because they were looking for friendship (M), whereas other mothers were clear that they did not want to make new friends through peer support (CMO 11). Mothers who experienced their lives with a new baby as chaotic (C) might take up peer support (O) if they believed it would give them a structure to their week and a reason to leave the house (M) (CMO 12).

Several CMOs related to the influence of mothers' experiences of support from mental health professionals and other health and social care professionals. Being referred by a health professional they trusted (C) could lead mothers to trust the peer support programme (M) (CMO 13). They might use peer support (O) if their symptoms were mild (C) and they believed peer support would be enough to help them recover (M) (CMO 14). Some mothers who had a successful past or current experience of psychological therapy (C) chose to use peer support (O) because they saw it as offering something valuable in a different way, for example coping strategies (M) (CMO 15). They might also use peer support (O) if they had been professionally assessed for mental health services (C) and believed peer support would help as a holding position while waiting for therapy (M) to start; or had been turned down as not meeting the professional service criteria (C) and believed peer support would be similar to a talking therapy (M) (CMO 16). Alternatively they might choose to use peer support (O) as a 'step down' service to maintain recovery (M) after discharge from perinatal mental health treatment (C) (CMO 17). However, mothers who feared a judgemental response from professionals (C) or had a disappointing past experience of professional support (C), might take up peer support (O) through self-referral in the belief that peer support would be a better or safer alternative (M) (CMO 18). Access to Parents in Mind required the filling out of forms with personal details and an informal mental health assessment, and at site 3 it was reported that this self-disclosure could feel unsafe to mothers who feared the involvement of social services (C) and did not trust the confidentiality of peer support (M). On the other hand, several mothers at sites 1 and 2 who took up support (O) were experiencing multiple disadvantages, including domestic abuse, but were already working with social services (C), so using peer support did not create an additional concern about disclosure (M).

There were also practical issues, for example, a mother needed to have the time and resources to invest in meeting her own needs (C), and access to affordable transport (C), in

order not to experience peer support as adding to her burden (M) (CMO 19). Parents in Mind only offered daytime face-to-face support in public locations with no option for support by telephone, online, or at home, and this limited some mothers' ability to use it (O). This particularly affected pregnant women who were working during the day, and mothers who were not able to travel to a meeting, for example because of a lack of public transport, disability, or at crucial periods in late pregnancy or recovering from birth (C). Some homeless mothers with multiple social disadvantages (C) at site 3 were offered peer support in partnership with a third sector organisation offering them other services, but had turned down peer support (O) because they were overwhelmed with other challenges and so did not have the material and psychological resources to make use of it (M). The fact that mothers at all sites who had other children were less likely to take up peer support when referred also suggests that childcare responsibilities (C) may have also limited some mothers' access (O).

It was clear that a mother's recognition of her thoughts and feelings as a mental health difficulty (C) and her belief that it is useful and acceptable to talk about mental health difficulties (C) were essential preconditions of taking up peer support based on talking and listening (CMOs 9–10). These issues had particular salience at site 3, where Parents in Mind was less successful than had been hoped in reaching mothers from Black, Asian, and other minority ethnic backgrounds who were the majority population; staff reported that mothers from these communities generally did not continue with the support even if they accessed it once. The programme at site 3 had tried to make itself attractive to mothers of all backgrounds: the peer supporters reflected the local ethnic and linguistic diversity, and local publicity for the programme was adapted to the local cultural context by avoiding any mention of 'mental health' and featuring an Asian mother wearing a hijab. Staff and peer supporters suggested that some mothers in their local communities might be unable to admit their distress even to themselves if their religious culture did not legitimise their feelings (C). Alternatively a mother's desire to seek help might be obstructed (O) by gatekeepers within the family who did not accept the legitimacy of the mother's needs (C), opposed her talking to outsiders (C), or imposed extensive domestic responsibilities that prevented her from prioritising her own needs (C) (CMOs 19–20).

Discussion

This research explored the reasons why some mothers with PMHD take up peer support from trained volunteers while others do not. Seventy per cent of the 260 mothers who were referred to Parents in Mind used the peer support, which compares favourably to reported take-up in other community-based perinatal peer support interventions (McLeish et al., 2023). Perinatal mental health peer support is a complex intervention (Moore et al., 2015), and the mechanisms underlying mothers' reactions to the offer of peer support were also complex and depended on a range of contextual factors which could trigger or obstruct the mechanisms leading to take-up. Mechanisms were clustered around psychological safety (Edmondson, 1999) based on mothers' perceptions of how peers would respond to them; their desire for a meaningful reference group for social comparison (Festinger, 1954); their beliefs about what would happen at peer support and what they may gain from it; their expectations about how peer support might be similar to or different from professional mental health support; and practical issues. This

complexity suggests that publicity for peer support programmes should explicitly state the range of ways in which it may help. The relatively high take-up rate for Parents in Mind may be related to the programme's unusual offer of both one-to-one and group support, which addressed the needs of different mothers including those with social anxiety or low confidence (McLeish et al., 2023).

Many of the final evidenced CMOs had been anticipated in the hypothesised CMOs based on the literature and stakeholder consultation, but eight new CMO configurations were added, along with evidence of how contrary mechanisms might be triggered. The final CMOs showed that some mothers had a sophisticated understanding of how peer support might benefit them, as their expectations were in line with what they themselves went on to experience as impacts, which are reported separately (McLeish et al., 2024), and the impacts reported in previous studies (Anderson, 2013; Carter et al., 2018, 2019; Chen et al., 2000; Dennis, 2003, 2010, 2013; Duskin, 2005; Eastwood, 1995; Montgomery et al., 2012; Pitts, 1995; Prevatt et al., 2018; Sembi, 2018; Shorey & Ng, 2019). On the other hand, some mothers expected that peer support would be similar to professional talking therapies (CMO 15), which could lead to disappointment (McLeish et al., 2024); and some hoped it be a 'cure' for their mental health difficulties (CMO 14), which might be the case for mothers with mild depression (Royal College of Psychiatrists, 2021), but would be unlikely to happen for other mental health difficulties, or more serious or chronic difficulties (Dennis, 2014; Fang et al., 2022; Huang et al., 2020).

The CMOs that show how current or previous experiences of professional support can shape mothers' expectations about peer support have not been identified in previous studies, although aspects of CMOs 13 (trusting professional recommendation) and 15 (wanting but being unable to access professional support) have been previously reported (Carter et al., 2019; Chen et al., 2000; Dennis, 2009; Letourneau et al., 2015; Shorey & Ng, 2019). This may be because 75% of Parents in Mind mothers had a history of perinatal mental health difficulties before their current pregnancy and 50% were in touch with specialist perinatal mental health services at the time of referral. This contrasts with some earlier perinatal mental health peer support interventions which have specifically excluded mothers with a history of mental health difficulties (Carter et al., 2019; Cust, 2016b; Dennis, 2003; Field et al., 2013a, 2013b; Shorey et al., 2019).

Although it is sometimes assumed that peer support is intrinsically more appealing than professional support for people who have had a negative experience of professional support (Billsborough et al., 2017), in fact some of the findings about reasons why mothers choose *not* to take up peer support echo the reasons why mothers may be reluctant to disclose their mental health to professionals or use professional mental health support when offered (Fisher et al., 2024; Hadfield & Wittkowski, 2017; Webb et al., 2023). These include not recognising their own experience as a mental health problem, shame and fear of being judged (by peers), fears that disclosing mental health difficulties could lead to child removal, and the practical problems of lack of time and transport. Practical problems of paying for childcare and transport were overcome in a pair of studies in the USA, where participants in trials comparing interpersonal therapy or yoga to peer support were paid \$20–30 for each 20-minute session of peer support they attended (Field et al., 2013a, 2013b); most participants in these trials were described as African American or Hispanic and having a low income. Parents in Mind was successful in reaching mothers in the two most deprived socio-

economic quintiles at sites 2 and 3, but was unable to overcome the issues facing mothers living with multiple disadvantages in site 3. A higher proportion of women who were referred to Parents in Mind when pregnant did not take up peer support, which underlines the importance of flexible delivery to reach mothers at different stages of the perinatal period. Alternative modes of delivery may appeal to some mothers but not others, as evidenced by previous studies where uptake varied between 37–75% when one-to-one peer support was offered exclusively by telephone to mothers with postnatal depression in Canada and the UK (Dennis et al., 2009; Letourneau et al., 2015; Sembi, 2018). Video-conferencing technology is now also used in peer support (2020), but there is as yet no evidence about how this new option for mode of delivery affects take-up of one-to-one and group peer support for PMHD. It is possible that a blended offer of face-to-face, telephone, and videoconferencing support will make organised peer support accessible to more mothers in the perinatal period, reflecting mothers' preference for blended treatment delivery when accessing professional support, provided they had access to resources such as mobile data and WiFi (Royal College of Psychiatrists, 2021).

Like most other reported PMHD peer support interventions in the UK, USA and Canada (McLeish et al., 2023), the great majority of mothers (83%) who took up Parents in Mind peer support were White, but this varied from 97% at site 2 (an area with an almost entirely White population) to 56% at site 3 (where the majority of the population were from Asian, Black, and other minority ethnic communities). A number of CMOs related to the obstacles that might specifically prevent mothers from some cultural backgrounds from taking up peer support, very similar to the issues that can deter them from taking up professional support (Conneely et al., 2023; Fisher et al., 2024). These related to mothers' understanding of the meaning of mental health difficulties (CMO 9), the acceptability of talking about mental health to outsiders (CMO 10), mothers' autonomy within the family (CMO 20), and their sense that 'peers' should share their religion, culture, or language or alternatively not feeling safe with people from the same community for fear of judgement and gossip (CMO 7). These contradictory preferences pose challenges for a peer support programme that has to decide who to recruit as peer supporters and whether or not to organise groups on the basis of shared language and culture. For communities with a tradition of helping each other through practical support rather than talking about emotions, mental health peer support based on listening may be less attractive than a group based around an activity, at which peer support could also take place informally.

The experience across the three sites highlights the importance of understanding what local communities want and need, before establishing a peer support programme. At the end of the pilot, continuation funding had been secured at sites 1 and 2. At site 3, instead of continuing Parents in Mind, NCT joined a partnership of community organisations with a new service for mothers from migrant communities and/or those experiencing socio-economic disadvantage, offering pregnancy information sessions, drop-in groups, counselling, and one-to-one social, emotional, and practical peer support (NCT, undated). This is in line with research suggesting that volunteer support programmes not focused on mental health, or which have a more practical remit, can successfully support mothers from Black, Asian, and other minority ethnic communities and those living with multiple disadvantages, and can have a positive impact on their self-reported emotional wellbeing (Lederer, 2009; McLeish

& Redshaw, 2017). Future research could explore how mothers from diverse backgrounds can most effectively be enabled to benefit from peer support *mechanisms* even if they do not access perinatal mental health peer support *programmes*.

Strengths and limitations

This study drew on the Parents in Mind programme data and the experiences of mothers, peer supporters, and staff in three very different communities, providing insights into similarities and differences. Using a realist approach throughout the study has enabled CMOs leading to take-up to be explored and fully evidenced, building on a realist review of non-realist studies where there was abundant evidence for contexts related to take-up but mechanisms were not usually explicit (McLeish et al., 2023).

A limitation of this research is that it was not possible to interview mothers who did not take up peer support, and there were gaps in the demographic data available about them, so some mechanisms may have been missed. This research instead explored the reasons why some mothers decline an offer of peer support through the second-hand accounts of staff who had spoken to many of these mothers, explanations from volunteers who described the reasoning prevalent in their communities, and the experiences of mothers who did take up peer support but only after initial ambivalence, who were able to describe their own reasoning. It would be beneficial to include the direct perspectives of mothers who decline peer support in future research if feasible. Realist methodology may be considered to have an in-built risk of confirmation bias, insofar as initial hypotheses are used as a heuristic to guide data analysis. This was mitigated by inviting interviewees to comment on developing CMOs, and by the use of open coding and inductive and abductive data analysis, leading to the development of eight out of the final evidenced twenty CMOs which had not been previously hypothesised.

Conclusions

Understanding mothers' complex motivations and expectations related to peer support can help those implementing perinatal peer support programmes to design and describe the peer support in ways that will increase mothers' desire to use it. Mothers with varied PMHD and from diverse backgrounds (including very socio-economically disadvantaged mothers) make use of organised peer support if they believe it will help them in the ways they need, and it is available in a format which makes them feel safe and able to attend. However, not all communities see the value of talking about emotional distress with peers, and not all mothers trust mental health peers to be non-judgemental. Local programmes should work with mothers, other third sector organisations, and community leaders, to identify how perinatal mental health peer support can be offered most appealingly in their area. Offering a choice of group or one-to-one support may encourage more mothers to make use of peer support, and a blend of face-to-face, telephone, and video-conferencing support may increase accessibility. The purpose of peer support can be misunderstood, leading to disappointment, so publicity material for mothers and professional referrers should clearly explain what it is and how it can help.

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Authors' contributions

All authors contributed to the development of the research question and methodology. JM carried out the interviews and data analysis. JM drafted the manuscript and all authors read and approved the final manuscript.

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Data availability statement

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