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Nurturing Little Hearts and Minds: Perinatal Mental Health and Parent-Infant Relationships Strategy for Kent, 2024 - 2029

Public Consultation Report

April 2024

Contents

Executive Summary

This report sets out the findings to the public consultation of the Nurturing Little Hearts and Minds: Perinatal Mental Health and Parent-Infant Relationships Strategy for Kent.

There was broad consensus that the strategy will support perinatal mental health and parent-infant relationships:

- 61 consultees took part in this consultation, 56 of whom completed the online consultation form. Of these, 41 were residents and 14 were professionals.
- Most consultees found the strategy easy to read (74%).
- Most consultees thought that the strategy sets out what is important to improve perinatal mental health and parent-infant relationships across Kent (59%).
- Most consultees agreed with the action areas identified in the strategy (78% strongly agreed or tended to agree).

Action Area 1 - Relating with warmth: Developing relationship-based support
On average, 80% of consultees strongly agreed or tended to agree with Action Area 1. Consultees shared personal experiences that supported the need for these actions. Some consultees also expressed concerns about how this action can be implemented given the pressures on services and professionals.

Action Area 2 - Thriving together: Improving equity of support
On average, 74% of consultees strongly agreed or tended to agree with Action Area 2. There was consensus that inclusion was important, and that support should be available to a diverse range of families. However, there were some different views on how this strategy can be inclusive of both mothers and fathers.

Action Area 3 - Leading collaboratively: Nurturing a system of support
On average, 79% of consultees strongly agreed or tended to agree with Action Area 3. Consultees expressed the importance of joining up services and support. However, there were concerns about the funding that will be available to deliver this well.

Other comments
There were two themes from the additional comments that consultees provided. First, there were concerns about the use of gender additive language such as 'Mums, Dads, and Co-parents'. Second, there were concerns about the affordability of implementing this strategy. In particular, some consultees questioned whether Kent County Council should be delivering this strategy rather than other local authority duties, such as waste and transport services.

Background

This strategy is an opportunity to support parents and carers to give their babies the best start for life.

Our earliest years of life shape the adults we become. It is a time of rapid brain development and our experiences lay the foundations for a wide range of future health and mental health outcomes. For parents and carers, having a baby can be a time of real joy and a time of challenge. It is important to support parents and carers to give their babies the best start for life.

This Nurturing Little Hearts and Minds: Perinatal Mental Health and Parent-Infant Relationships strategy is a five-year commitment to improving support for babies and their families across Kent. It sets out Kent County Council's ambition to work across sectors and services to improve perinatal menta health and parent-infant relationship support. It is in-line with the scope of the perinatal mental health and parent-infant relationship strand of the Family Hubs and Start for Life programme, focusing on early intervention and prevention.

The strategy was co-produced with parents, carers, and professionals.

The draft strategy was co-produced with more than 300 parents, carers, and professionals.

In terms of parent and carer engagement, a total of 130 parents and carers contributed to the strategy.

- 46 parents and carers completed an online survey.
- 27 parents and carers completed in-depth interviews – lasting more than 1.5 hours each.
- 46 took part in outreach activities in children's centres and other public spaces in Kent.
- 11 parents and carers joined two co-production workshops where the themes and actions were reviewed.

Parents and carers were from diverse backgrounds.

- One in ten of the parents engaged were Dads.
- Nearly one in four parents or carers engaged were from a non-White ethnicity (77.9%).
- The number of single parent households engaged was proportionate to the national average (14%, 15% respectively).
- Most parents and carers had one baby (51.6%). In total, more than one in ten were expecting a baby (12.7%) or had three or more children (11.8%).
- Nearly half of parents and carers reported they were worried about money problems or financial stress 'very often' or 'often' (49.1%).

In terms of professional engagement, a total of 180 professionals contributed to the strategy.

- 107 professionals joined two webinars, representing 38 different organisations across all sectors in Kent.
- 44 professionals completed an online survey, with 34 different roles, representing 17 different organisations.
- 29 senior leaders joined one-to-ones or roundtables, representing 13 different organisations.
- Used social media and emailed 180 professionals directly to encourage engagement.

A full list of organisations that supported the development of the strategy can be found in Appendix 1.

Formal Public Consultation

Consultation process

On 8 February 2024 an eight-week consultation was launched and ran until 5 April 2024. The consultation provided parents, carers, and professionals with the opportunity to find out more about the strategy and provide feedback. The public consultation for this strategy – Nurturing Little Hearts and Minds – was launched alongside the consultation for the Nourishing Our Next Generation strategy.

Feedback was captured via a consultation questionnaire, which was available on the Kent County Council website. Hard copies of the questionnaire were also available upon request.

A consultation stage Equality Impact Assessment (EqIA) was carried out to assess the impact the proposals could have on those with protected characteristics. The EqIA was available as one of the consultation documents and the questionnaire invited respondents to comment on the assessment that had been carried out.

Consultation engagement

There were several activities to promote engagement in the consultation process:

- Staff were available at activity events throughout the consultation period (9 events across the county and one online evening event to support engagement from parents with very young children) to engage with participants about the proposals, answer queries and encourage participation.
- Across the period of the consultation many multi-agency partnership meetings were attended to raise awareness of the consultation and share information.
- Young people were engaged directly and had the option of how they participated (for example, questionnaires, group discussions etc).

To raise awareness of the consultation and encourage participation, the following activities were undertaken:

- Promotional material sent to Health Visiting service and community-based midwifery.
- Social media and paid Facebook advertising.
- Posters and promotional postcards in Children’s Centres / Family Hubs, Youth Hubs, Kent Libraries, and Gateways.
- Emails to stakeholder organisations, including email to all early years and childcare providers that operate within the Kent Local Authority (over 1700).
- Invite to people registered on Let’s talk Kent who had asked to be kept informed about new consultations.
- e-bulletin for Early Years and Childcare professionals throughout Kent.
- Media release issued at the launch of the consultation.

- Articles on Kent County Council's staff intranet and e-newsletters and email to staff groups.
- Social media campaign was implemented with different / repeated messaging over the consultation period.
- Email to stakeholders in the two weeks before the consultation closed to remind/prompt those who had not yet responded.
- The consultation website contained a short introduction and all the consultation information (the full document, summary document, Equality Impact Assessment, questionnaires, other background information, and easy read and large print documents. A Word version of the questionnaire was available for those that did not want to complete the online form. Promotional materials (and the website) included details of how to request alternative formats. A telephone number and email address were available for queries and feedback.

The consultation webpage had a total of 9,530 visits. Of these:

- 7,832 visited at least one page.
- 1516 visited multiple pages and / or downloaded documents.
- Most visits were direct (4,617) or from social media posts (3,263).

Points to note:

- Consultees completing the online survey were given the choice of which questions they wanted to answer or comment upon.
- Where consultees did not respond to a question this was recorded as 'not disclosed', where a question was not relevant to a consultee this was recorded as not applicable ('N/A').
- This report includes feedback from residents and professionals. Qualitative analysis for each stakeholder group has been reported separately.
- Consultees were given a number of opportunities to provide feedback in their own words throughout the questionnaire. This report includes thematic feedback across consultee responses.
- Feedback received by the Kent County Council team via email has been reviewed for the purpose of analysis and free text comments have been included where applicable in this report.
- Participation in consultations is self-selecting and this needs to be considered when interpreting responses.
- Kent County Council was responsible for the design, promotion, and collection of the consultation responses. Barnardo's was appointed to analyse the feedback and write this consultation report.

Overview of Consultees

Analysis of consultees that shared their feedback

A total of 61 consultees took part in this consultation:

- 56 completed the online survey.
- One resident provided feedback by email.
- One organisation provided feedback by email.
- One infant feeding support worker provided feedback by email.
- One young person provided feedback by email.
- One response was received from a group of young parents following an event at a targeted forum.

Breakdown of survey consultees

A total of 41 residents completed the survey, one of whom did not live in Kent. A total of 14 professionals completed the survey. One respondent reported that they were providing a response on behalf of Kent County Council, however, Kent County Council has confirmed that it did not submit a formal response and so this response was coded as 'other' (see Table 1).

Table 1 'How are you responding to this consultation?'

Response	Total
As a Kent resident	40
As a professional working with parents and families in Kent	14
As a resident of somewhere else, such as Medway or further afield	1
Other	1
Grand Total	**56**

Demographic overview of consultees responding to the consultation as professionals.

Several different professions completed the survey (see Table 2). Those recorded as 'Other' include an infant feeding specialist midwife, and two consultees who have more than one role.

Table 2 Profession

Response	Total
Children's Centre / Family Hub staff	5
Other	3
Breastfeeding support staff	3
Perinatal Mental Health Worker	1
Midwife or student midwife	1
Health Visitor	1
Grand Total	**14**

Demographic overview of consultees responding to the consultation as residents. Consultees were asked if they were a parent or carer (anyone who cares for a baby regularly). Most consultees were a parent, carer, or an expectant parent (73%, see Table 3).

Table 3 "Are you…?"

Response	Percentage of respondents
A parent or carer	71%
Neither of these	27%
Pregnant or an expectant parent	2%
Grand Total	**100%**

Two thirds of resident consultees were Mums, with one response from a Dad. More than a quarter of consultees did not disclose their role as a parent or carer (see Table 4).

Table 4 Role as a parent or carer

Response	Percentage
Mum	66%
Not Disclosed	27%
Auntie	2%
Grandparent	2%
Dad	2%
Grand Total	**100%**

More than two thirds of parents and carers who responded to the survey reported that they were the primary parent or carer (68%; see Table 5).

Table 5 'Are you the primary parent or carer?'

Response	Percentage
Yes	68%
Not Disclosed	27%
No	5%
Grand Total	**100%**

Consultees had experience of caring for a wide age range of children, with 40% of parents and carers currently expecting a baby or caring for a baby under the age of two (see Table 6). Consultees were not asked how many children they cared for.

Table 6 'Please select the age of the child(ren) that you regularly care for?'

Response	Percentage
Expecting a baby	7%
0-2 months of age	2%
3-6 months of age	5%
7-12 months of age	5%
13-24 months of age	22%
3-4 years old	17%
5-10 years old	22%
11-19 years old	3%
Not Disclosed	18%
Grand Total	**100%**

Consultees reported that they lived across five different Districts in Kent (see Table 7). Nearly a third of consultees came from Canterbury (30%). No responses were received from residents living in Gravesham, Sevenoaks, Tunbridge Wells, Swale, Ashford, Folkestone & Hythe, Dover, nor Thanet.

Table 7 Districts (based on the first five characters of the post code)

Response	Percentage
Canterbury	30%
Tonbridge & Malling	29%
Maidstone	23%
Dartford	13%
Not Disclosed	4%
Swanley	2%
Grand Total	**100%**

Use of services

Consultees were asked about their use of the following services:

- Children's Centres / Family Hubs
- Health Visiting
- Specialist perinatal mental health (PMH) services e.g. support from a specialist community Perinatal Mental Health nurse / midwife
- Perinatal mental health advice / support e.g. accessed a local helpline or talked to staff in the health visiting service

How often did consultees use services?

Most consultees had accessed a children’s centre / family hub at some point (80%) with one in four using this service once a month or more frequently (25%). One third of consultees had accessed perinatal mental health support (33%, see Table 8). Other people in the household were reported to use services less. For example, only 7% use a children’s centre / family hub once per month or more frequently, and 16% accessing perinatal mental health support (see Table 9).

How did consultees use these services?

Of those who did use services, most accessed support in person in a building. A small proportion of consultees reported using services online (2% for health visiting and 5% perinatal mental health advice; see Table 10). This pattern was comparable with how other people in the household used services (see Table 11).

Table 8 How often have you used the services below?

Response	Children's Centres / Family Hubs	Health Visiting	Specialist PMH services e.g. support from a specialist midwife	PMH advice / support e.g. accessed a local helpline
At least once a week	10%	0%	0%	0%
Once a fortnight	5%	0%	2%	2%
Once a month	10%	7%	5%	0%
Twice a year	5%	7%	0%	0%
Less regularly	17%	27%	12%	15%
Used it in the past	34%	46%	10%	15%
Never used this service	20%	12%	68%	66%
Not disclosed	0%	0%	2%	2%
Grand Total	**100%**	**100%**	**100%**	**100%**

Table 9 How often have others in your household used the services below?

Response	Children's Centres / Family Hubs	Health Visiting	Specialist PMH services e.g. support from a specialist midwife	PMH advice / support e.g. accessed a local helpline
At least once a week	2%	0%	0%	0%
Once a fortnight	0%	0%	0%	0%
Once a month	5%	2%	2%	2%
Twice a year	7%	2%	0%	0%
Less regularly	15%	24%	15%	7%
Used it in the past	12%	22%	2%	2%
Never used this service	56%	46%	78%	73%
Not disclosed	2%	2%	2%	15%
Grand Total	**100%**	**100%**	**100%**	**100%**

Table 10 How do you use the services below?

Response	Children's Centres / Family Hubs	Health Visiting	Specialist PMH services e.g. support from a specialist midwife	PMH advice / support e.g. accessed a local helpline
I don't use this service	44%	39%	83%	83%
In person at a building	51%	54%	10%	7%
Both	5%	5%	7%	5%
Online	0%	2%	0%	5%
Not disclosed	0%	0%	0%	0%
Grand Total	**100%**	**100%**	**100%**	**100%**

Table 11 How do others in your household use the services below?

Response	Children's Centres / Family Hubs	Health Visiting	Specialist PMH services e.g. support from a specialist midwife	PMH advice / support e.g. accessed a local helpline
I don't use this service	73%	73%	91%	88%
In person at a building	27%	24%	3%	0%
Both	0%	3%	6%	9%
Online	0%	0%	0%	0%
Not disclosed	0%	0%	0%	3%
Grand Total	**100%**	**100%**	**100%**	**100%**

Assessment of Equality and Diversity

Two thirds of consultees were willing to support an equality and diversity assessment (66%). A total of 34% of consultees did not wish to respond to these questions. Of these, 25% said ‘No’ and a small proportion (9%) reported that they were responding on behalf of an organisation questions (see Table 12). Those that did not provide equality and diversity responses were recorded as ‘Not Disclosed’.

Table 12 Willingness to support the equality and diversity assessment

Response	Percentage
Yes	66%
No	25%
Responding on behalf of an organisation	9%
Grand Total	**100%**

Most consultees reported identifying as female (64%). All consultees who reported a gender also reported having the same gender as at birth (66%; see Tables 13 & 14).

Table 13 Are you…?

Response	Percentage
Female	64%
Not Disclosed	34%
Male	2%
Grand Total	**100%**

Table 14 Is your gender the same as at birth?

Response	Percentage
Yes	66%
Not Disclosed	34%
Grand Total	**100%**

Most consultees were under the age of 50 (51%), with 11% of consultees being over the age of 60 (see Table 15).

Table 15 Age group

Response	Percentage
25-34	21%
35-49	30%
50-59	2%
60-64	2%
65-74	5%
75-84	4%
Not Disclosed	36%
Grand Total	**100%**

Just over a fifth of consultees reported belonging to a particular religion or having a religious belief (21%), all of whom reported to be Christian or chose not to disclose which religion or religious belief they hold (see Tables 16 and 17).

Table 16 Do you belong to a particular religion or hold a religious belief?

Response	Percentage
No	45%
Not Disclosed	34%
Yes	21%
Grand Total	**100%**

Table 17 Type of religion

Response	Percentage
Christian	21%
Not Disclosed	34%
N/A	45%
Grand Total	**100%**

Consultees were given a definition of the Equality Act 2010 and asked if they considered themselves to be disabled, as set out in the Equality Act 2010. Most consultees reported that they did not have a disability (55%), while 9% reported that they do (n=5, see Table 18).

Of the five respondents that considered themselves to have a disability:

- three reported learning disability (including neurodivergence),
- one reported a mental health condition, and
- one reported multiple disabilities;
    - Physical impairment,

  - Sensory impairment (hearing, sight or both),
  - Longstanding illness or health condition, such as cancer, HIV/AIDS, heart disease, diabetes or epilepsy,
  - Mental health condition,
  - Learning disability.

Table 18 Disability as set out in Equality Action 2010?

Response	Percentage
No	55%
Not Disclosed	34%
Yes	9%
I prefer not to say	2%
Grand Total	**100%**

A total of six different ethnicities were reported, with most consultees reporting their ethnicity as ‘White English’ (55%; see Table 19).

Table 19 Ethnicity

Response	Percentage
White English	55%
Not Disclosed	34%
Other - White European	4%
Mixed White & Asian	2%
White British	2%
Other - White	2%
Other - Eastern European	2%
Grand Total	**100%**

Consultees were asked if they considered themselves to be a carer – defined as anyone who provides unpaid care for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support. A total of 18% of consultees considered themselves to be a carer (see Table 20).

Table 20 Do you consider yourself to be a carer?

Response	Percentage
No	48%
Not Disclosed	34%
Yes	18%
Grand Total	**100%**

A total of four different sexualities were reported, with most consultees reporting their sexuality to be heterosexual / straight (54%; see Table 21).

Table 21 Are you…?

Response	Percentage
Heterosexual/Straight	54%
Not Disclosed	34%
Gay woman/Lesbian	5%
Bi/Bisexual	4%
Other	2%
I prefer not to say	2%
Grand Total	**100%**

Consultation Findings

In this section, we present an overview of the findings from the public consultation. Analysis of each question is presented in turn. Where a written response did not directly answer a question, it was analysed along with 'any other comments.' A selection of quotes from written responses are included here to highlight important points, all written responses are reported in full in the appendices.

Is the strategy easy to understand?

Consultees were asked if they found the strategy easy to understand. Nearly three quarters of consultees answered 'Yes' (74%), with professionals finding the report easier to understand than residents (80% and 68% respectively, see Tables 22 and 23).

Table 22 Residents - Is the strategy easy to understand?

Residents (n=41)	
Response	**Percentage**
Yes	68%
No	24%
Not disclosed	5%
Don't know	2%
Grand Total	**100%**

Table 23 Professionals – Is the strategy easy to understand?

Professionals (n=15)	
Response	**Percentage**
Yes	80%
No	13%
Not disclosed	7%
Don't know	0%
Grand Total	**100%**

Consultees were asked for suggestions about what could make the strategy easier to understand. A total of 15 comments were received; 12 from residents and three from professionals (see Appendix 2). A common theme was that the strategy should be made shorter. However, it is likely that most consultees did not see the easy read version, with only 14 downloads of the easy read document.

“It is probably easy to ready for you but for the general public this is too complex. Please create simple 2-page document to say what you are planning to do practically.” (Personal)

“It's a lengthy document for people to read through with a lot of information to absorb which is unavoidable but perhaps could put people off reading.” (Professional)

Does the strategy clearly set out what is important to improve perinatal mental health and parent-infant relationships across Kent?

Most consultees reported that the strategy did clearly set out what was important to improve perinatal mental health and parent-infant relationships across Kent (59%). Residents reported more agreement than professionals (65% and 53% respectively; see Tables 24 and 25).

Table 24 Resident – ‘How much do you agree or disagree that the strategy clearly sets out what is important?’

Resident (n=41)	
Response	**Percentage**
Strongly agree	35%
Tend to agree	30%
Neither agree nor disagree	8%
Tend to disagree	10%
Strongly disagree	8%
Not Disclosed	8%
Don't know	3%
Grand Total	**100%**

Table 25 Professionals – ‘How much do you agree or disagree that the strategy clearly sets out what is important?’

Professional (n=15)	
Clearly Set Out What is Important?	**Percentage**
Strongly agree	13%
Tend to agree	40%
Neither agree nor disagree	13%
Tend to disagree	20%
Strongly disagree	7%
Not Disclosed	7%
Grand Total	**100%**

A total of 25 written comments were received for this question, with 19 from residents and six from professionals (see Appendix 3). Written comments expressed a diversity of views about whether the strategy sets out what is important. Of those who expressed more negative sentiment, this often related to how this strategy connects with other services, such as family hubs / children's centres, midwives, education, or the NHS.

"I completely agree with the approach to focus on the mild to moderate support needs of families in pregnancy and newborns, as this is where a great impact can be made to ensuring the family thrive in what can be very difficult first days and is likely to reduce the need for more robust interventions." Professional

"I am not sure you need to offer so much and nanny people so much. Friends, parents and family, professionals e.g. midwife/clinic nurse, doctor, charities." Parent

"You[r] plan is great and much needed. Make sure that people know about the services and where to look for help. Many people with mental health problems prefer online communication so maybe create some discussion groups in the social media where people can find information and reach out to other parents." Parent

"It focuses on the main areas of concern." Parent

"Identifies specific findings from parents / families with clear action points on how to address them." Parent

Action Area 1 - Relating with warmth: Developing relationship-based support

The actions in this area are:
1.1 Training for professionals to improve trauma informed care;
1.2 Campaigning to break the stigma of perinatal mental health and parent-infant relationship support; and
1.3 Identifying opportunities for earlier support.

There was broad support for all actions, with an average 80% of consultees strongly agreeing or tending to agree (see Table 26). This was the action that received the most agreement from consultees.

Table 26 Action Area 1: How much do you agree or disagree that the below actions will help improve perinatal mental health and parent-infant relationships across Kent?

	Action Area 1		
Response	**1.1**	**1.2**	**1.3**
Strongly Agree	59%	64%	67%
Tend to Agree	21%	14%	15%
Neither Agree nor Disagree	2%	4%	2%
Tend to Disagree	4%	4%	2%
Strongly Disagree	5%	7%	4%
Don't Know	4%	2%	4%
Not Disclosed	5%	5%	7%
Grand Total	**100%**	**100%**	**100%**

A total of 22 written comments were received for this action area, with 18 from residents and four from professionals (see Appendix 4 for all responses).

Two consultees described the importance of any training including the voice of parents and carers and being an opportunity to challenge and prejudice. This was reinforced by a response received by email from a resident.

> “Please ensure training includes the voice of parents/carers, is action based and is not simply awareness based - all the research shows that awareness training has (at best) only a time limited superficial impact.” Resident
>
> “There needs to be a level of staff training that surpasses any prejudice about the age and educational level of parents.” Resident

Two consultees reported concerns about the capacity of professionals to attend training and deliver care in a more relationship-centred way.

“Training HCPs is important but the issue is these professionals are already over worked and appointment times are already stretched and clinics full. Unless you can reduce the workload so that we have time to review and address issues raised by patients how can we offer personalised care for PNMH?” Resident

“Healthcare professionals need to have adequate time and work within an organisational culture that supports them in approaching their patients with empathy. The key messages from the training need to be voiced from the top down so it’s not a tick box exercise and outcomes can be maximised.” Resident

Finally, some consultees shared their personal experiences of services to reinforce the need for this action area.

“You are discharged from midwifery services that make contact with you early on, and then don’t have any contact with the health visitor until much later. I really struggled at around 6 months and didn't really know who to contact, and felt worried and embarrassed about contacting anyone in case it was viewed as I was failing.” Resident

“Having experienced birth trauma my treatment and the care/ support I received in [District of Kent] was abysmal. Complete lack of support and undiagnosed PTSD. Whereas my experience of living in [Different County outside Kent] I cannot fault the incredible HV team with all the support they gave me.” Resident

Action Area 2 - Thriving together: Improving equity of support

The actions in this area are:
2.1 Harnessing data and insight to improve equity;
2.2 Supporting perinatal mental health of Dads universally; and
2.3 Reviewing the inclusivity of all perinatal mental health and parent-infant relationship service offers.

There was broad support for all actions, with an average 74% of consultees strongly agreeing or tending to agree (see Table 27).

Table 27 Action Area 2: How much do you agree or disagree that the below actions will help improve perinatal mental health and parent-infant relationships across Kent?

	Action Area 2		
Response	**2.1**	**2.2**	**2.3**
Strongly Agree	45%	48%	64%
Tend to Agree	29%	23%	13%
Neither Agree nor Disagree	5%	5%	4%
Tend to Disagree	5%	11%	7%
Strongly Disagree	7%	5%	7%
Don't Know	5%	2%	2%
Not Disclosed	4%	5%	4%
Grand Total	**100%**	**100%**	**100%**

A total of 22 written comments were received for this action area, with 18 from residents and four from professionals (see Appendix 5).

There was strong recognition of the importance of inclusivity. Consultees shared examples about how they have experienced discrimination or prejudice.

“Everyone needs to feel included in the process: children, mums and dads, and also grandparents and childminders.” Resident

“As a non-birth mother in a two-mum family, I have found it hard to access support for mental health.” Resident

“Dads are just as important as Mums and usually need support based of what their partners are going through. Having support for them will also encourage their partners to seek help as well.” Resident

“At a basic level, dads / co-parents should be encouraged to be involved in the universal touch points with families. My husband taking the kids to development reviews or other appointments alone or even attending past the first few weeks of our children's' lives has been met with surprise. To make inroads to dealing with partners' mental health and parenting confidence etc., there needs to be a culture change.” Resident

However, there was some tension between views that being inclusive of both fathers and mothers.

“Male parents and carers are notoriously hard to engage and may not want to identify as struggling with perinatal mental health difficulties. Alternative wording may be needed to enable you to offer support to make carers as intended.” Professional

“2.1 The strategy discriminates against mothers (the largest and most vulnerable marginalised group in our patriarchal culture) as they have been excluded. 2.2 The definition of peri-natal means around pregnancy. Dads cannot be pregnant, therefore this language is misleading and inaccurate. I do support emotional support for fathers - but it is different to perinatal support. 2.3 The danger is that in trying to be inclusive to all, women and mothers and their unique and vital role has been excluded.” Professional

Action Area 3 - Leading collaboratively: Nurturing a system of support

The actions in this area are:
3.1 Developing commissioning principles;
3.2 Building a relational pathway of support for parent-infant relationships; and
3.3 Establishing a community of practice for perinatal mental health and parent-infant relationships.

There was broad support for all actions, with an average 79% of consultees strongly agreeing or tending to agree (see Table 28).

Table 28 Action Area 3: How much do you agree or disagree that the below actions will help improve perinatal mental health and parent-infant relationships across Kent?

	Action Area 3		
Response	**3.1**	**3.2**	**3.3**
Strongly Agree	52%	57%	63%
Tend to Agree	25%	21%	18%
Neither Agree nor Disagree	5%	5%	7%
Tend to Disagree	7%	4%	4%
Strongly Disagree	5%	5%	4%
Don't Know	2%	2%	2%
Not Disclosed	4%	5%	4%
Grand Total	**100%**	**100%**	**100%**

A total of 21 written comments were received for this action area, with 16 from residents and five from professionals (see Appendix 6).

The need to join up services and support was emphasised in the written responses.

“Nothing is joined up currently.” Resident

“I agree that commissioning needs to be effective, but the collaborative element is most important. We need the different parts of the system to work well together and for existing services and professionals to work as partners for families.” Resident

“Absolutely agree. Make good use of VCS!” Resident

“More joined up working is very much needed like it used to be but was stripped away over the last 20 years due to funding.” Professional

Funding and workforce shortages were expressed as barriers to enabling this action area to be successful.

“These are great suggestions - but how on earth will they be resourced by a council in a severe deficit?” Resident

“Again, it is staffing time and availability. We want the best for families but without the resources and staff we cannot offer these.” Resident

Making this strategy a success

Consultees were asked to comment on the section of the strategy about making the strategy a success (see Appendix 7). A total of 13 comments were received, of which 11 were from residents and two were from professionals. These comments were varied, but a theme around raising awareness of services and promoting good, evidence-based practice did emerge.

“Increasing awareness across various communities, using different channels of communication (online social groups, GPs, etc).” Resident

“Individual professionals, like all people, have individual experiences and biases but I do wish that going forward NO professionals would even contemplate providing sleep training advice that is developmentally inappropriate. I have heard many examples of this still happening today and I am always shocked. It is not evidence-based and it undermines what this strategy aims to achieve (strong parent-child attachment, nurturing relationships).” Resident

“Extending training to the voluntary sector is essential so that there is a joined-up approach. Voluntary sector needs to be given correct funding to ensure security of provision.” Resident

Any other comments

This section was an opportunity for consultees to share any other comments in addition to their responses to the more specific questions they were asked. Cross-cutting responses from other questions were also included in this section. A total of 25 responses were received, of which 18 were from residents and five were from professionals (see Appendix 8).

There were two main themes to these comments:

1. Concerns about gender additive language.

Although there was positive feedback from some consultees about the inclusion of Dads and other parents and carers, there were calls for a greater focus on mothers. This was also reflected in comments on the equality and diversity impact assessment (see Appendix 9) and in an email response (see Appendix 10).

“Women have babies. Breasts produce milk. Let’s not mess with science and the absolute honour and privilege but otherworldly experience it is to carry and feed a baby (do not conform to the minority).” Professional

“It is a great shame that we have finally got funding for a long-overdue service to support mothers when they are at their most vulnerable, yet the word mother is not being used. This is unprecedented, deeply concerning and inaccurate because only mothers (and birthing people) can be pregnant - not other carers.” Professional

2. Concerns about affordability.

There were concerns that delivering this strategy will be costly, and there were calls for greater focus on other local authority services.

“My best suggestion (to prevent money being wasted) is to look for the one or two achievable actions that can make a positive difference for new mothers and babies. We cannot fix everything here - that’s like pretending we can fix the whole of society!” Resident

“Unfortunately, we cannot afford these side services. Our community charges and taxes are not being used to repair our infrastructure. We should spend money on resurfacing roads and providing schools we cannot afford these ‘luxury’ ideals.” Resident

“If KCC is broke why are they even developing this strategy - why are they involved in pre-natal care? surely this is a role for NHS - stick to emptying the bins and fixing potholes - I know it is not glamorous but we cannot AFFORD anything else.” Resident

Comments about the equality and diversity impact assessment

Consultees were given the opportunity to comment on the equality and diversity impact assessment. A total of 16 responses were received, of which 12 were from residents and 4 from professionals.

Comments were varied, highlighting a diverse range of perspectives on equality and diversity (see Appendix 9).

> “Everyone should already have the same opportunities to access these helps - no postcode lottery, no language barrier!” Resident
>
> “Intersectionality needs to be considered a lot of people have multiple factors. E.g. those who are LGBTQ+ that struggle with their mental health due to fertility treatment not working and then becoming pregnant. Or ethnic minorities that have Autism etc.” Resident
>
> “Surely equality should include all parents regardless of income. Without this integration, a "poor" and "rich" community is created, and most people end up on SMP at some point during their maternity leave, which is more tough to the people that are losing a significant amount of income.” Resident

Next Steps

This report will be shared with Kent County Council, where it will be analysed and a ‘You Said, We Did’ summary will be published highlighting any actions or changes emerging from the consultation.

Appendices

Appendix 1 – Organisations engaged in co-producing the strategy

Appendix 2 – Suggestions to make the strategy easier to read

Appendix 3 – Consultation feedback ‘Does the strategy clearly set out the ambition?’

Appendix 4 – Consultation feedback ‘Action Area 1: Relating with Warmth’

Appendix 5 – Consultation feedback ‘Action Area 2: Thriving Together’

Appendix 6 – Consultation feedback ‘Action Area 3: Leading Collaboratively’

Appendix 7 – Consultation feedback ‘Making this strategy a success’

Appendix 8 – Consultation feedback ‘Any other comments / cross cutting comments

Appendix 9 – Consultation feedback ‘Comments about the equality and diversity impact assessment’

Appendix 10 – Consultation feedback received by email

Appendix 1 – Organisations engaged in co-producing the strategy

Organisations that attended one of two online webinars

Ashford Rural Medical Services
Ashford Rural Primary Care Network
Children and Families Ltd
Children's Centre
Childrens Families Ltd
Dartford & Gravesham NHS Trust
Drapers Mills Primary Academy
East Kent Hospitals University
NHS Foundation Trust
East Kent Mind
Family Action
Folkestone & Hythe Children's Centre
Folkestone and Hythe Children'S Centre
Home-Start Dover District
Kent and Medway Integrated
Care Board
Kent and Medway NHS and Social Care
Partnership Trust
Kent Community Health
NHS Foundation Trust
Kent County Council
Kent Parents
Kent Surrey & Sussex Academic Health
Science Network
Kent Surrey & Sussex
Operational Delivery Network
Maidstone and Tunbridge Wells
NHS Trust
Mama to Mama
Mind in Bexley and East Kent
NHS
North Kent college
Open Access Children's Centre
OXPIP
Porchlight
Red Zebra
Rising Sun
Save the Children UK
Seashells Children's Centre
Swale Children's Centre
Thanet Children's Centre
The Education People
The Piggybank Day Nursery Ltd
Unknown
Wokingham Local Authority

Organisations that responded to our online survey for professionals

Ashford Borough Council
Ashford Rural Medical services
Dartford and Gravesham NHS Trust
East Kent Hospitals University NHS
Foundation Trust
East Kent Mind
Home-Start
Kent and Medway Integrated Care
Board
Kent and Medway NHS and Social Care
Partnership Trust
Kent Community NHS Foundation Trust
Kent County Council
Kent Safeguarding Children Multi-Agency Partnership
Kent, Surrey and Sussex Neonatal ODN
Mama to Mama
My Birth Support CIC
Porchlight
Rising Sun Domestic Violence and
Abuse Charity
Save the Children UK

Organisations attending roundtables and one-to-one meetings

Baby Umbrella
Better Breastfeeding
East Kent Hospitals NHS Foundation Trust
Involve Kent
Kent and Medway ICB
Kent and Medway Integrated Care Board
Kent and Medway NHS and Social Care Partnership Trust
Kent Community Health NHS Foundation Trust
Kent County Council
Medway NHS Foundation Trust
PorchLight
Seashells Children's Centre
University of Kent

Appendix 2 – Suggestions to make the strategy easier to read

Residents:

- It depends who you want to understand it. It's a bureaucratic document full of bureaucratese terminology. It's fine for other civil servants and NGO people but normal humans won't find it straight forward.

- It’s too long.

- I don't understand why this enormous, beautifully created policy document is pertinent to the county council. This is a matter for the health service. The council's only job is to facilitate the Childrens Centres, managing them effectively and ensuring they are vfm.

- Problems are not the route to solutions, witness their tendency to morph into a plethora of kindred problems in the blink of an eye. There ought to be a single STRATEGY involving all sections of society, of all ages. Advocacy of LOCAL ECONOMIES is the way forward. The benefits are immediate, and tangible. A country without local economies is a failed country.

- It is probably easy to ready for you but for the general public this is too complex. Please create simple 2-page document to say what you are planning to do practically. This is all that people need to know. No one has time to read through many pages and in reality many people will not even understand even if they read them.

- I am a professional copywriter and I am completely bamboozled by this document.1) Who is it for? Because it is NOT for parents. This is a long, intense, dense, academic document that is not suitable or usable for the public. Establish exactly who this document is for and what you want them to do with it. Currently, someone doing a Masters in Health and Social Care would find this useful for their research. A professional working in the council would find this very difficult to read, but might glean some useful tid-bits to help inform their practise. A nurse or health visitor would struggle to understand how this information impacts their day-to-day. A parent looking for support wouldn't even manage to get past the first page.2) Reading age. The UK national reading age is 9 (Entry Level 3 according to the National Literacy Trust.) A quick assessment of this document shows it is at the Level 4, possibly Level 5 reading age (National Literacy Trust.) People at this reading level tend to be academics. It is unacceptable and renders this document useless if it is not at an accessible reading age for the target audience. If the target audience is the British public, it should aim for Entry Level 3. If it's for professionals, it should aim for Level 2 or Level 3. Being over Level 4 honestly makes this document useless except for academic purposes.3) 130 parents and carers were used in your research. It doesn't take a genius to tell you that this is a remarkably small sample size, rendering your findings very limited. You're basing strategy in the whole of Kent off of only 130 parents? I can't even begin to say how limiting and silly this is. This research would simply never fly in any scientific setting.

- Executive summary does not adequately summarise the content and excludes the voice of parents. Develop accessible summaries too, for those unable to engage with a complicated written document.

- Make it shorter and clearer as to what will actually be done. There is too much waffle.

- Could be shorter so not as much to read.

- Not everyone can access it in the formats it is. People with disabilities struggle with the access to reply and read the documents. Website is black on white with no way of changing the screen for Irens syndrome

- My suggestion would be to have the Strategy and Feedback be translated in various languages for Dartford Igbo, Yoruba, Hausa, Twi, Krio, Creole, would be particularly useful for the black community. Also, to be able to provide feedback without having to register anonymously would be helpful for those concerned leaving their details. Many black and ethnic minority women I know believe that infant feeding is a family and cultural decision rather than something that authority should be part of conversationally and therefore they may disregard consultations like this as they do not believe it applies to them. This could be a potential barrier for them getting solutions to issues they may face when requiring your services. Also, the language could be a barrier having translations available helps reach black and ethnic minorities engage. Igbo and Yoruba are two Nigerian languages commonly used in the Dartford area and Twi is a Ghanian language. Krio is the language of Sierra Leone as there are many Sierra Leoneans living in Kent. Creole is a Caribbean language. Also, where I live in Gravesend, Punjabi is predominately used by the Indian community which many parents and grandparents tend to speak as we have one of the largest Gurdwaras here. Having resources translated to Punjabi and other ethnic minority languages could help those family members with influence such as mothers and grandmothers help to spread the KCC messages to those in need of your services.

- It is easy for me to understand, but I have experience of reading/being involved in consultations and also work in this sector. I don't think it would be easy to understand if I were outside of this.

Professionals:

- Possibly by using more images and slightly less text. Will the strategy be available in alternative formats and BSL.

- From a lay point of view, this is wordy and too full of technical information and data for a significant proportion of families to understand and comment on. In order to engage more parents in this consultation, consideration could be given to a much shorter outline, using bullet points, giving facts on what the new service intends to deliver and what it will look like.

- It's a lengthy document for people to read through with a lot of information to absorb which is unavoidable but perhaps could put people off reading.

Appendix 3 – Consultation feedback 'Does the strategy clearly set out the ambition?'

Residents:

- It sets out SOME of what's important, but it only pays lip service to the critical role of father involvement. In Dr Warren Farrell's book "The Boy Crisis" he details 85 physiological, physical and psychological effects on children that a lack of fathers has. Children without fathers in the home die younger. Boys are twice as likely to be diagnosed with autism or ADHD. Girls start puberty up to 18 months earlier. And so on. And yet fathers are relegated to a few short paragraphs on page 23.I understand WHY this is. Men are not considered to be important, particularly by the female-dominated civil service. I would suggest that the problem of solving children's misery starts with a stable family unit, a father, and a mother, married and in a home. I don't think you address that issue in any depth.

- It's important to raise various issues that parents and families face whilst raising children. Being aware of the challenges someone is facing increases the chance of people feeling listened and cared for. Offering information to families in a preventive manner can make a huge difference in the wellbeing of their families.

- As stated above words are cheap - it's resources and the proper funding of adequate numbers of professionals that is needed.

- PNMH & PIR are so important so I must ask why children's centres are closing and therefore putting another barrier to parents/carers to receive support. Why is there no increase in staff either for these services if the drive for this is so important. Reduction in staff means higher caseloads, more stressed-out staff and therefore impacting those they are working with.

- It is clear once you are able to find the information as the document is so long.

- I am not sure you need to offer so much and nanny people so much. Friends, parents and family, professionals e.g. midwife/clinic nurse, doctor, charities. Surely you can put money elsewhere whilst we are in the state we are in.

- It's all very ambiguous.

- All this work should have already been happening via Community Midwives and Health Visitors.

- As above, problems fester. Imagine if your draft and strategy started in a different way. MY EDUCATIONAL PROGRAMME IMAGINE Imagine your child … who would push seeds down in the soft ground, cover them with soil, and all the while watch plants grow. Child will harvest the crops in the fullness of time; crops are brought to the table where meals are prepared and consumed. Rounding this off, the same process is repeated time and over again by placing what is left over back on to the ground to nourish the soil … the educational value of all this would be immense. One seed at a time, one step at the time, one word at the time … and you unfurl the world. THIS IS THE MOTHER OF ALL LEARNING.

- It focuses on the main arears of concern.

- You plan is great and much needed. Make sure that people know about the services and where to look for help. Many people with mental health problems prefer online communication so maybe create some discussion groups in the social media where people can find information and reach out to other parents. It is great to have a physical place they can go to but these services could be part of the library and not necessarily separate facilities.

- Because if people want babies it is not for council taxpayers to support them - at best this is NHS or get a book as we do as young parents.

- Identifies specific findings from parents / families with clear action points on how to address them.

- Read the feedback from the professionals. What do they say time and time again? They need FUNDING. Page 45 and 46 gives NO indication of increased funding. The professionals (who are mostly underpaid or volunteers for charities) are the experts on this. Your research means nothing unless you speak to the ACTUAL experts. They know what they need, they know where the money should go, and they know how to do it. With Kent County Council empower these incredible people to actually DO the work they are trained to do?

- There are not enough support on perinatal mental health across East Kent.

- The devil is always in the detail of implementation and given the political and financial context it is hard to see how this strategy can be properly resourced and implemented. Organisational culture change is also inherently difficult and too often strategies such as this fail due to lack of consideration of the wider context (e.g. pressure on services which means less time to fully support mental health of parents amongst the many other competing demands).

- I felt that post partum care was super poor. Looking back I was clearly struggling with breastfeeding and my mental health because of this but didn’t have any help or support. Midwives visiting seemed aloof with a checklist, not really offering any support.

- It is not clear.

- It does not explain how it is actually going to implement this improvement to perinatal mental health. How are you going to reduce waiting times? How are you going to offer this to more people? How are you going to offer care for people that are suffering with perinatal mental health mildly, at the moment it seems only if you are deemed "high risk" with pre-existing mental health concerns that you get the input and support, people that are ok but mildly struggling are overlooked. How are you going to make this accessible for people who can't drive or afford the bus? How are you going to have more staff to reduce the waiting time?

Professionals:

- I read the easy read version, and how it is bullet pointed makes it clear to see the plans.

- Kent has very good infant and baby services, but these should be extended further.

- Building relationships with those professionals who have the knowledge to help with support cannot always be done on the first meeting leaving some parents/carers afraid to talk, informal groups are some of the best places for parents to open up for instance in baby massage parents often open up about how they are feeling but there is no mention of such services being offered.

- I am really pleased to discover this initiative, it is a huge positive in my missions as a professional to support parent and infant relationships and promote positive attachments, optimal brain development and better outcomes for the future. However, from what I can tell of the strategy it would be targeting particular families, demographics, those in need etc. I'm not disputing this in itself but believe that there is even more potential to reach desired outcomes through a united approach across all health professionals in all interactions with parents. I understand time and budget restrictions, but I genuinely believe that if we could even manage a short training session, e learning, online webinar etc. even just 1 hour! On normal infant behaviour (feeding, sleep, needs and all the whys) attachment and how this is fostered and the impact of a positive attachment - I think this could make a huge difference in the advice that is given and language that is used. I myself, every friend, every client has experienced at some point in their contact with midwifery or health visiting services, some kind of advice that promotes unresponsive parenting. This comes from outdated literature and societal expectations that our children need to learn to 'self-settle', shouldn't need us through the night from a young age, shouldn't be held continuously, need to be independent etc. Often this advice is unsolicited, perhaps in response to a tired mother who just needs reassurance and a listening ear, not to be told she needs to put her baby down more, stop feeding to sleep and attempt cry it out strategies. This really is such common advice in my personal and professional experience. I would love to offer my support and expertise in providing this underpinning knowledge in anyway I can. I hold a BA Honours degree in social work, 9 years' experience working with children and families. I also hold a Level 6 OCN qualification as a holistic sleep consultant which covers child development, attachment, biological norms, feeding etc. I would be happy to provide a digital resource, offer short talks with local teams, a downloadable webinar, parent drop in group etc. I am so passionate about your goals and this is the driving force behind my current business. I genuinely believe that many of societies unrealistic expectations on the parent-child relationship are significantly contributing to future mental health and relational difficulties.

- As above - too much data and information that obfuscates the important messages and intended service delivery.

- I would love to be able to build stronger relationships with my clients so that they feel safe to discuss how they are feeling emotionally, however when you only offer 3 contacts, sometimes only two if an antenatal is not offered if is very difficult to build a relationship. The amount of contacts offered by Family Nurse Partnership is best practice and allows those practitioners to build that connection with their clients, but these is offered to a very small proportion of the community and it is a shame it can not be offered to more parents. The service we provide is Monday - Friday 9-5 and I feel this excludes Dads as they are often working.

Appendix 4 – Consultation feedback ‘Action Area 1: Relating with Warmth’

Residents:

- Training needs to provide safe places for staff to speak about their experiences. Sometimes staff come across as terse/indifferent, they are experiencing overload. The safe places need to be ongoing.

- Your system is too large and cumbersome for any of this to work effectively.

- There needs to be a level of staff training that surpasses any prejudice about the age and educational level of parents.

- Opportunity for earlier support - more opportunities to build relationships between professionals and parents through groups.

- The necessity for all these things is the result of the legacy of the breakdown of strong families. New parents find themselves struggling when they never had normal attachments when they were tiny babies; they may now be alone with a new baby; they may have suffered domestic abuse; they may have lost their family support.

- This is pie in the sky. All services are stretched to the limit and it is still the case that communication between different services is poor. What is the point of this and why is it the business of KCC? This is a health / SS matter.

- The answers we seek reside within learning. Learning is easy. Learning is a joy. It is interactive, collaborative, organic… it’s a simple fact that learning is all embracing, multi-faceted, and we can but rejoice at the endless opportunities offered by it. There is "no" limit to what we can learn.

- As I said this is a really great initiative and will help families.

- Yes - just stop this nonsense - we cannot afford it!!!!!

- Healthcare professionals need to have adequate time and work within an organisational culture that supports them in approaching their patients with empathy. The key messages from the training need to be voiced from the top down so it’s not a tick box exercise and outcomes can be maximised.

- It will be great if all these supports are free of charge and no special requirements need to meet to get the free services.

- Please ensure training includes the voice of parents/carers, is action based and is not simply awareness based - all the research shows that awareness training has (at best) only a time limited superficial impact.

- Asking questions is not enough. More needs to be done before a baby arrives to help on the journey to parenthood.

- Training HCPs is important but the issue is these professionals are already over worked and appointment times are already stretched and clinics full. Unless you can reduce the workload so that we have time to review and address issues raised by patients how can we offer personalised care for PNMH? Yes that lady needs a longer discussion and input about her health but I also have a clinic of 12 women and only a 30 minute slot per person. I can't go another or longer clinic because the GPs are kicking midwives out to bring in outside services and the children's centres are closing. So how can I offer women and their families longer appointments to discuss and look after their mental health with nowhere to see them?

- You are discharged from midwifery services that make contact with you early on, and then don't have any contact with the health visitor until much later. I really struggled at around 6 months and didn't really know who to contact, and felt worried and embarrassed about contacting anyone in case it was viewed as I was failing. Maybe a team needs to contacting new mums around this time to see if they can provide any support.

- More funding and centres like waterside in Gravesend should be set up in other areas following this model.

- Absolutely agree with this but I don't think it should come from statutory bodies i.e. health and social care. The VCS is exceptionally well placed as it is far more trusted by vulnerable people. Women experiencing poor PMH are not likely to trust a HV or similar if they feel (for example) intrusive thoughts because they are afraid of how it will impact their care/consequences for them as a parent. Care offered should be personalised and accessible, not just a one size fits all with some online only resources. Offer support in pregnancy so women know where to get it when they have their babies.

- Having experienced birth trauma my treatment and the care/ support I received in [District of Kent] was abysmal. Complete lack of support and undiagnosed PTSD. Whereas my experience of living in [Different County outside Kent] I cannot fault the incredible HV team with all the support they gave me.

Professionals:

- Health and Care professionals are not always the ones parents want to speak to it will take more than five years to change this.

- Ensure that the Actions within the strategy are implemented at the earliest stage, to give pregnant parents the time to absorb, learn, reflect and process the information available to them, instead of leaving it until when baby has arrived. Helps to prepare and then remind again what's available once baby is born.

- Again, really pro all of these actions. But keen to see a general shift in approach to all families, not just those outwardly struggling or expressing concern, but just a shift in the type of advice and information that is given from day 1. This is so often about unsolicited advice, comments made about normal infant behaviour such as 'they're just using you for comfort now' 'try to make sure they're having some time out of your arms' 'they know what they're doing'. An underlying tone that we need to encourage independence, we shouldn't just support our children for comfort only a physical need and that our children are manipulating us.

- 1.1.Trauma has to be in relation to women specifically. Sexual trauma can have a profound effect on birth and breastfeeding. Trauma of other carers is not going to have the same effect on the child and/or mother-infant dyad. 1.2 It is deeply ironic that this strategy is unwittingly perpetuating the stigma of perinatal mental health by literally erasing the words mother and women from it. 75% of women feel invisible when they become mothers. Not mentioning the word mother, or implying that a mother is interchangeable with another carer, exacerbates the problem for women. Rather than making it seem like this strategy is for everyone, it might be more appropriate to have one service for mothers and birthing people, and a different mental health service for other parents and carers whose needs for safety and support will look different. 1.3 The authors are happy to use the word dad in points 1.2 and 1.3, but they have not used the word mother. This does not feel right at all.

Appendix 5 – Consultation feedback 'Action Area 2: Thriving Together'

Residents:

- Your problem here is not 'equity' or 'inclusivity'. It is social breakdown. You can make some improvements but not like this. This is a data collecting exercise which will make jobs for bureaucrats and solve nothing.

- Everyone needs to feel included in the process: children, mums and dads, and also grandparents and childminders.

- How can you measure discrimination? Action 2 seems to be a "hollow promise" to me. How are you going to get absent fathers to engage with all this?

- Who will provide data? Can we afford this?   Action at a local level (where we have staff) would make for easier to identify areas of need.

- I'm in favour of reviewing, but what does "equity" mean? To put things in terms of agreeing or disagreeing is not helpful.

- I think there is no issue with inclusion and access to services but it is more of an issue of different ethnical groups not knowing about them due to poor IT skills or poor language skills. Maybe translated materials spread into the communities will increase the reach out.

- As a non-birth mother in a two-mum family, I have found it hard to access support for mental health.

- 1 Harnessing data and insight to improve equity. - Get some Masters students to tell you how to do this. Because they'll do a much better job than is currently being done.

- It will be great if all these supports are free of charge and no special requirements need to meet to get the free services.

- Dads are just as important as Mums and usually need support based of what their partners are going through. Having support for them will also encourage their partners to seek help as well.

- It is not clear what “equity” means in this sense. It is not clear what will actually be done beyond management speak. The services offered are already often open to all (expect bookable activities).

- This needs to be an accessible service and lots of people struggle with access to a central hub. They do not drive, they do not have money for bus fare or the bus routes have now reduced

- If services are online how will the most vulnerable families be supported?

- The school curriculum needs to include more health promotion and education, so that future parents are prepared for family life experiences

- Parents to be is not clear language. There is a lot of mental health support for men locally (Mentalk, campaigns for male mental health etc) but no women’s safe spaces.

- There is very limited support for Dads at present my partner suffered with postnatal depression which made live very difficult at the start. We need to talk about the emotional changes and what’s parenthood is really like in pregnancy.

- At a basic level, dads / co-parents should be encouraged to be involved in the universal touch points with families. My husband taking the kids to development reviews or other appointments alone or even attending past the first few weeks of our children's' lives has been met with surprise. To make inroads to dealing with partners' mental health and parenting confidence etc., there needs to be a culture change.

- There is lots of targeted mental health support for men. Everything that seems to be coming out that women can access is aimed at 'parents'. So women need their own specific support.

Professionals:

- Ensure services are welcoming and available to young parents, and those with protected characteristics. Ensure that DA data is included if appropriate as this can link strongly to MH and well-being

- Male parents and carers are notoriously hard to engage and may not want to identify as struggling with perinatal mental health difficulties. Alternative wording may be needed to enable you to offer support to make carers as intended.

- The local perinatal service has stringent / discriminatory boundaries on the access to their service. This has been going unaddressed for years now.

- 2.1 The strategy discriminates against mothers (the largest and most vulnerable marginalised group in our patriarchal culture) as they have been excluded. 2.2 The definition of peri-natal means around pregnancy. Dads cannot be pregnant, therefore this language is misleading and inaccurate. I do support emotional support for fathers - but it is different to perinatal support. 2.3 The danger is that in trying to be inclusive to all, women and mothers and their unique and vital role has been excluded.

Appendix 6 – Consultation feedback ‘Action Area 3: Leading Collaboratively’

Residents:

- Balint groups were common in the 1960's 1970's why do we always reinvent the wheel.

- Nothing is joined up currently.

- Not just having services inside hubs! Town and Village centres are a very good place as these often have the best transport links.

- I agree that commissioning needs to be effective, but the collaborative element is most important. We need the different parts of the system to work well together and for existing services and professionals to work as partners for families.

- Absolutely agree. Make good use of VCS!

- 3.3 is the only one which might be useful. I would suggest starting it in a single town and a single maternity hospital area to test it.

- Bring back Children's Centres - I have long believed that Kent is all too often a market leader in service provision and then abandons good practice after deciding something isn't working without giving enough time for benefits to be seen, or deciding that it isn't providing 'value for money' ... only to see the rest of the country following some years later and leaving us behind.

- Who are these “partners” you refer to repeatedly? If it’s the NHS staff, they honestly cannot take on any extra work right now!!

- Surely best practices already exist. Is this really necessary? How many expensive committees are going to be involved? and Nurturing a System of Support - what does that mean? Management speak.

- Don't forget to include the communities in the support process as they are the main ones that can support young parents.

- Literally none of this can happen without proper funding. Are you expecting volunteers or under-paid experts to do this? It's too important to be underfunded.

- It will be great if all these supports are free of charge and no special requirements need to meet to get the free services.

- These are great suggestions - but how on earth will they be resourced by a council in a severe deficit?

- There are lots of great breastfeeding charities that are not supported enough. It is not clear who else local partners refers to. The strategy needs to be much more specific.

- Again, it is staffing time and availability. We want the best for families but without the resources and staff we cannot offer these.

- Options for private EYFS, mental health, wellbeing professionals to collaborate and tender.

Professionals:

- More joined up working is very much needed like it used to be but was stripped away over the last 20 years due to funding.

- Ensure that commissioned services are accessible. 3.2 Ensure links to DA support are included within the pathways. A COP is a great idea, these are always a great way to network share expertise and so much more.

- As I have offered - I would LOVE to be able to support on this initiative in any way I can. I believe I have a huge breadth of knowledge and experience in the parent and child relationship, its importance, the norms and how to foster this. I would love to support in the wider and long term goals and to support parents to feel less pressure in what is already such a difficult time.

- When are professionals supposed to fit in this additional training?!

- As an infant feeding practitioner I feel that the language on this page does not recognise the importance of the mother-infant bond for the optimum development of the child.

Appendix 7 – Consultation feedback ‘Making this strategy a success’

Residents:

- Increasing awareness across various communities, using different channels of communication (online social groups, GPs, etc).

- Give things TIME - before making those decisions!

- What’s really needed in the long term is to build community - this takes time! Without improvements in family life, it is unlikely to be effective in the long term. Fixing mental health problems also takes a long time to fix, but identifying them early is surely an essential part of a midwife’s work?

- Leave it to the health service and provide what support they ask for.

- What type of "Strategy"? What type of "Success"? My overall approach is based on a tested notion of KNOWLEDGEFood is the Source of all KnowledgeWater is the Source of all KnowledgeEnergy is the Source of all Knowledge.

- "offering training" is so vague. Who is training? What's their background? How will you measure success and outcomes? When will this training start? Will participants in this training be paid for taking time out of their working schedule to do it?

- You are discharged from midwifery services that make contact with you early on, and then dont have any contact with the health visitor until much later. I really struggled at around 6 months and didn't really know who to contact and felt worried and embarrassed about contacting anyone in case it was viewed as I was failing. Maybe a team needs to contacting new mums around this time to see if they can provide any support - this removes the embarrassment/shame aspect. I was engaging with children's centres and struggling with poor sleep. The lady in charge of the group promised to send me some information on methods to use for sleep that didn't involve 'cry it out', every week for 6 weeks. I also emailed her twice. The information never transpired and would have really helped in my moment of need. Being sleep deprived for 6 months is tough and is going to negatively affect your mental wellbeing.

- More face-to-face opportunities. Early interventions through designated midwife, health visitors, face to face, in person ASQ checks, 6 week checks better, professionals joined up and information sharing, early interventions from community therapies, maintenance and investment in children’s centre sites not closures. Reduction in online services - most vulnerable and EAL families find these inaccessible.

- I think health staff going into schools to teach "what is normal behaviour in a baby" would be useful. Especially the schools with the greatest level of deprivation.

- Extending training to the voluntary sector is essential so that there is a joined up approach. Voluntary sector needs to be given correct funding to ensure security of provision.

- Individual professionals, like all people, have individual experiences and biases but I do wish that going forward NO professionals would even contemplate providing sleep training advice that is developmentally inappropriate. I have heard many examples of this still happening today and I am always shocked. It is not evidence-based and it undermines what this strategy aims to achieve (strong parent-child attachment, nurturing relationships). In fact, leaving a child to cry or expect them to regulate themselves prematurely would be considered an adverse childhood experience at any other time of the day, but it appears to be accepted by many as normal if it's when parents need/ want to sleep. We really need to adjust expectations around infant sleep within this broader aim and support parents through the challenges that come with what is developmentally normal and appropriate. I notice a strong emphasis on attachment in this strategy, which I think is essential. I feel that professionals should be brought up to speed on this to enable them to support attachment parenting styles; parents are often looking for coping strategies or to be told everything is normal, but it is hard. They do not want to be met with "just let your baby cry; they'll learn how to sleep". It's horrifying that this is still fairly commonplace.

Professionals:

- Groups where parents can meet other parents feeling the same way so they no longer feel alone.

- I would be interested to know exactly what interventions organisations are offering as there are some named who are not offering mental health support in reality.

Appendix 8 – Consultation feedback 'Any other comments / cross cutting comments

Residents:

- My best suggestion (to prevent money being wasted) is to look for the one or two achievable actions that can make a positive difference for new mothers and babies. We cannot fix everything here - that's like pretending we can fix the whole of society!

- Honestly, just get someone to simplify the whole thing. I would be surprised if anyone reads it.

- Keen on the notion of "start" as in "start with food", which is my trademark. Let's get started, then!

- Went to see GP about being stressed out due to feeding issues and moving home. It wasn't really resolved.

- Scrap it.

- Unfortunately, we cannot afford these side services. Our community charges and taxes are not being used to repair our infrastructure. We should spend money on resurfacing roads and providing schools we cannot afford these 'luxury' ideals.

- KCC should not be involved - scrap the whole thing and stick to core services which you are struggling to meet.

- Cancel the whole thing a waste of TAXPAYER money.

- It needs to be more than just well-intentioned words. To be honest we've all heard before what needs to and should be done. Now we need to see effective identification of need followed by effective interventions which will require more than words. In 2003 my own daughter's HUGE MH needs (postnatal psychosis which had built up over 3 pregnancies) were eventually identified almost by accident by an observant EY practitioner while she and my granddaughter were attending a Kent Children Centre - we need MORE not less of those. In 2023 my step-daughter needed to resort to privately-funded interventions to address her MH issues related to a very traumatic ectopic pregnancy and the loss of her much wanted baby. I don't feel like much has changed in the intervening years except the closure of services.

- Too many mention of parent and not mother when that is what should be used in the context. It leaves it unclear.

- If KCC is broke why are they even developing this strategy - why are they involved in pre-natal care? surely this is a role for NHS - stick to emptying the bins and fixing potholes - I know it is not glamorous but we cannot AFFORD anything else.

- I am particularly confused as to why you are referencing UNICEF as a target or aspiration. The UN is NOT our government! UNICEF has no jurisdiction in Kent. They are not the model you should be following. Listen down, not up!

- Why do we spend money on this kind of thing - I should think you could fund a couple of social workers out of the costs of this initiative.

- I have one final comment on breast feeding. It is time to normalise formula feeding too and tell mothers that the most important part is their child to be fed. I remember that not been able to breastfeed caused a major distress to me and affected my mental health. I was convinced that every mother can breast feed and it is a matter of choice. However, this turned out not to be the case.

- One min u say you are broke and then you come up wit this - if u want a baby deal with NHS not KCC.

- It will be great that all these supports are easily accessible across the whole Kent for free of charge.

- We have several prisons in the county. The young men in them are very often fathers. Their mental health needs to be considered too.

- Whilst I agree it is incredibly important that infants need strong relationships with their mothers and other parents, there are other important reasons to improve perinatal mental health. This strategy is very infant-focused and comes across as though the only reason to improve PMH is for the sake of the infant, not to help the mother. Some focus on this would also be nice.

Professionals:

- There is absolutely no mention of groups and courses that are, and have been available for ALL families with children and young people 0-19 yrs over the last 10-15 yrs that have massively helped to reduce isolation and depression, increased confidence in their parenting abilities and given parents and children the opportunity to interact with other parents/carers, babies and children/young people and access peer support through building friendships within the groups and courses. The strategy constantly reminds everyone that it takes a village to raise a child, well KCC have just cut services that have been doing just this over the past years. As for all Health Visitors being Solihull trained, this is correct, however the HV's are so busy that the children's centres run the parenting workshops and drop-in sessions (which are now the Kent Parenting Programme as Solihull was not allowed to be rolled out anymore thanks to KCC!!!!!)

- Women have babies. Breasts produce milk. Let's not mess with science and the absolute honour and privilege but otherworldly experience it is to carry and feed a baby (do not conform to the minority)

- It is confusing to read as the words parents and carers are used instead of mother. This makes it inaccurate in places.

- These 3 actions are essential to: embed knowledgeable, well-informed services based on: caring and listening, patient centred, accessible without barriers, to all of those families who need it most and robust information sharing among families and professionals, informed consent, communications and liaison, which is key to developing expertise, safe practice and trust. Consensus Statement 2014 advises breaching of confidentiality when a client is at risk of harm, and must be used to avoid serious consequences of ill mental health, suicide, and the lives of families who become victims of it.

- It is a great shame that we have finally got funding for a long-overdue service to support mothers when they are at their most vulnerable, yet the word mother is not being used. This is unprecedented, deeply concerning and inaccurate because only mothers (and birthing people) can be pregnant - not other carers.

- Recognise women and babies and breastfeeding (not birthing person or chest feeding).

- Please reinstate the word mother in this strategy e.g. mothers, parents and carers.

Appendix 9 – Consultation feedback 'Comments about the equality and diversity impact assessment'

Residents:

- You should consider scrapping it entirely. I know you won't but one day you're complaining about not having enough money and the next you're hiring more DEI people! It's a grift. It's snake oil.
- Shouldn't this already be in existence?
- Everyone should already have the same opportunities to access these helps - no postcode lottery, no language barrier!
- Please use sex-based language. Desexed language in health communications is likely adversely impacting the most vulnerable women the most, including those with learning difficulties, low literacy or low health literacy and low English proficiency. There needs to be an impact assessment for language used.
- The strategy is very careful to mention co-parents / carers but still include the word Dad. I think explicitly stating all these elements are all important. Thank you.
- Intersectionality needs to be considered a lot of people have multiple factors. Eg. those who are LGBTQ+ that struggle with their mental health due to fertility treatment not working and then becoming pregnant. Or ethnic minorities that have Autism etc.
- Very good to be inclusive and adhere to E&D principles, however, don't do it to the expense of women. Pregnancy and motherhood is exclusively experienced by women so don't erase or alienate them with additive language.
- Excluding the word mother from a peri-natal mental health strategy is unprecedented and does not reflect inclusion.
- Please stop marginalising women. Removing reference of breastfeeding, women, mother from literature and posters is going too far. All parent relationships should be respected but not at the cost of removing women to do this
- Who is paying for this nonsense? The taxpayer.
- Surely equality should include all parents regardless of income. Without this integration, a "poor" and "rich" community is created, and most people end up on SMP at some point during their maternity leave, which is more tough to the people that are losing a significant amount of income.

- Stop being so wet, let talent shine not tribal differences. The best person should get the job

Professionals:

- Within the EqIA ' Details of Negative Impacts for Sex' would there be relevance for the inclusion of women's maternal MH as a person experienced or experiencing DA. https://www.rcm.org.uk/media/4522/rcm-and-rcog-joint-statement-on-domestic-abuse.pdf#:~:text=Domestic%20abuse%20doubles%20the%20risk%20of%20preterm%20birth,the%20way%20a%20mother%20bonds%20with%20her%20child.

- Remember the majority not minority.

- Excluding the word mother from a peri-natal mental health strategy is unprecedented and does not reflect inclusion.

- Sadly the word mother has been erase from all sections.

Appendix 10 – Consultation feedback received by email

Summary from focus group with young mums:

- Negative impact on mother’s mental health of social service practises around assessing safety for the (at the time) unborn child.

- Professionals reviewing a young person’s history of trauma before each meeting and referencing it, can be very triggering for young people.

- Lack of confidentiality in speaking to mental health professionals, as they would pass info back to social workers, who would bring it up in meetings – meant that she stopped confiding in mental health workers, and her mental health declined as a result.

- Lack of housing support after leaving mother and baby unit, tenancy ended because she was in hospital, etc. Re-housed with no furniture, told by social worker that she should be able to cope with life now, slept on floor on blankets with 3-month-old. Eventually sourced furniture herself on Facebook.

- Felt that there is a discrimination against families with social services involvement.

- All young people referenced a lack of kindness and respect from maternity professionals, including no respect for consent. For example, undressing a young person while she was saying “no”, rude manner, interrupting skin-on-skin bonding to change the bed, etc.

- One young person had a late-stage miscarriage, which ended in medical emergency. Again, there was no consent, no privacy screen, and they were taken to children's ward because they were under 18. The young person felt there is a need for MH support after miscarriage.

- Another young person said it would be helpful to have positive information during ante-natal period, particularly to how to bond with the baby (PIR), how to read baby's body language. not just warnings and anxiety-inducing info.

Summary of feedback from one resident (potentially identifiable information has been removed):

I completely agree with the approach to focus on the mild to moderate support needs of families in pregnancy and newborns, as this is where a great impact can be made to ensuring the family thrive in what can be very difficult first days and is likely to reduce the need for more robust interventions.

You mention training around trauma-based care and this is absolutely needed, and there is reference to the fact that this should be in its widest form… I don't think that training and educating the professionals in the services should be limited to trauma-related concerns, but to the general perinatal offer. In the last few weeks of pregnancy when a mum is tired, heavy, suffering insomnia and anxiety around the birth and during the period of the 'fourth trimester' mums and their partners can be pushed to feeling the lowest mood of their life and are at this time very vulnerable to perceived criticism. Therefore, it is so key that a passing comment or harsh word not given with the best intention can send families into mental health crisis. I have several examples of situations such as this, both from my own parenting journey and from those around me and would like to share these with you for context in relation to the vulnerability we were all in at the time.

- In the hospital setting following a difficult 5-day labour mum rang her bell on the ward to ask what she should do with her newborn as she needed to use the loo, after half an hour with no response she carried her baby to the toilet where she was promptly stopped by a midwife in front of other mums and was told sternly that she cannot carry her baby on the ward and "to leave her in her cot, there is enough people around to keep an eye on her".

- On first visit from health visitor mum was asked if she had been exercising, on reply that they hadn't really was told "maternity leave is not just an excuse to sit around".

- Midwife appointment in the first week after birth mum was told "you can get that cardigan off, it's far too hot for that for baby today".

- Midwife criticised mum for allowing grandparent to hold baby in the first two-week period and told to take baby back from them to ensure bonding and establish breastfeeding, when this was one of the first breaks mum had had from holding her newborn.

- Midwife arriving late appearing flustered and refused seat, asked mum to quickly take babies clothes off to be weighed and patting the countertop in the kitchen, when mum feeling flustered laid baby down where she had patted was quickly told “not on there, that is far too hard for them”.

- After hospitalisation for psychosis mum was asked how she was feeling during first health visitor appointment following return from hospital, to which mum replied they weren’t great, the HV returned to looking at her paperwork and asked if they had been doing tummy time with their child with no acknowledgement of her mood or considering what additional pressure the follow-up question may result.

- In isolation and kindly delivered, these instances may have a positive effect on mum, but in the condescending and scathing tone experienced they have all contributed to feelings of inadequacy as a new mum. These examples highlight the difficulty these individuals may have in approaching professionals about their mental health, as it was caused in part by those individuals themselves.

I fully support the section on page 20 that invites more sensitive and meaningful questions around mental health, as my experience was similar around being asked several times about it without feeling like I could mention anything (like intrusive thoughts) unless I was wanting serious intervention. Any professional supporting a new family should know the basics on ‘usual’ and ‘significant’ mental health concerns to put parents minds at ease and help them identify when further intervention may be helpful. The confidence to have these conversations is what’s needed with professionals and could help to reduce the cost of further services.

Relating to action 2.2, although we would like to believe a pandemic to the scale as we witnessed in 2021 is unlikely, I would like to see reference to the acknowledgement that partners cannot be excluded from the birth journey, as this put significant strain on mothers and their partners. Rules around limiting access to only mothers, whilst understandable, put a heavy burden on the mental health of both parties, especially in instances where there were complications or devastating news. The risk to the future generation and the cost to mental health services following this time must outweigh the risk to the service, who was already dealing with a mother from the household.

When scan-reading through the document and reading the “one-minute interaction’ for dads I assumed this was feedback from dads that all they received from the system was a one-minute interaction considering their own mental health or concerns, so was surprised to read this is the name of part of the strategy moving forward. I understand the concept that is trying to be achieved here, but I feel this could be negative to the approach adopted by professions ("let's get dad out of the way with his one-minute interaction") and make dads feel insignificant in the journey.

Something my friends' husband was told by a midwife when she was in labour was "your job is to look after mum, hers is to look after baby. Make sure she's eating, showering, not doing too much round the house, try to make her life just about looking after baby". I don't know if this can be included in the approach, but this was such a helpful thing for him to hear, as it gave him purpose and useful instruction and he definitely took it seriously.

Approaches to mental health are so important, but often physical health and nutrition play a part in our mental health. When supporting a newborn baby, parents often neglect their own physical needs and, in the case of mothers, understanding body changes following labour. I had an undiagnosed double-prolapse following the birth of my son and this was minimised by professionals who told me to expect changes in that region, but could have had significant impact on the birth of my second child if it remained undiagnosed. Following advise that it could be a 7 month wait to have any physical examination of the area I was forced to go private as it was having a significant impact on my mental health. Parents need to be listened to and fully supported in their physical health in a timely manner.

Action 3 is missing the continued interaction with people supported by all systems. This is the first time I am feeding back on my experience (other than informally with my midwife in my second pregnancy) as I was acutely aware that any failings I found were cross-system and would lose significance when divided into its parts (i.e. hospital maternity unit, community midwife, specialist support services, health visiting). Joint training and shared knowledge is hugely beneficial to all services on a regular basis, but to understand the part that each team plays in someone's journey you need those individuals giving feedback to them directly. Sweden have an excellent system-approach to supporting individuals in social care called 'Esther', which was adopted in Kent Adult Social Care as a café interaction. At these events, professionals were able to hear directly from people who had positive and negative experiences in the system and were able to work together to improve and maintain the standard of service, with each area taking responsibility for its own role. Something like this would be really positive in perinatal care.

Feedback received from one organisation:

Overall, we welcome the plan and the detail it contains. We welcome anything that helps support families (whole, extended families, not just the parents) and without going through every single paragraph, we can say we are broadly happy with what is proposed.

However, we want to concentrate on our area of expertise, and that relates to baby loss, whether miscarriages, stillbirth, or infant deaths. The only references we could see (and, to be fair, we have not read every page) is in the tables describing existing services which lists:

- Short-term therapies, support, and advice to people and their families for moderate / severe mental health difficulties as a result of birth trauma and / or birth loss. Parents must have accessed support from other NHS therapy services first, such as NHS Talking Therapies, and

- Counselling for women who have experienced a range of difficulties, including the loss of a pregnancy at any stage, traumatic birth, caring for a baby on the Neonatal Intensive Care Unit, and fertility issues.

These are both important, but our understanding is that accessing these support services is pretty difficult with very limited criteria for that access and, again we understand, support is offered to mothers only, and not fathers, nor other relatives. Through our baby loss charity we support around 500 people who have lost babies, at any stage of pregnancy or after, in any circumstances, and at any time, and anecdotally we have been told by so many people that counselling, in particular, is just not available for a variety of reasons. We would encourage these services to be developed with far more fluid access criteria.

We appreciate that Baby loss relates to a minority of families, but our estimate is that there are around 1,600 babies dying each year in East Kent alone, through miscarriage, stillbirth, perinatally, or as infants. That is a massive number, equating to around one in five of all the births. It is disappointing that the plan does not really address this large, and very important group.

We do appreciate that the emphasis in the plan is around supporting babies as they start life, but that just cannot ignore all the babies who do not survive.

Setting aside the circumstances surrounding the baby deaths addressed in the Kirkup Report (and we are supporting a significant number of those families) we do hear anecdotally about poor services received by families following the loss of a baby and much of this relates to poor communication, both within maternity units and between them and other health professionals, including GPs and health visitors. We also have a real concern around the level of training and awareness around baby loss offered to staff, both within the NHS and in other agencies, including KCC and local councils. This lack of awareness is something that can be addressed and improved relatively easily, and we this is something we would encourage.

We do appreciate the implied focus on babies who survive, but we cannot forget those who do not, and their families.

Feedback received from one infant feeding support worker:

I have read the full policy and in, what I'm sure is a well-intentioned attempt to be inclusive, the words mother and woman have been largely avoided. I am very concerned that this will lead to mothers not realising that this service is for them. Especially when in this period of a woman's life (known as 'Matrescence') they are right brain and often sleep-deprived, it is very confusing language. The words 'parents and carers' have largely replaced the word 'mother'. I cannot emphasise enough that the word 'parent and carer' is not interchangeable with the word 'mother'.

p.9 "When babies receive warm and sensitive care, they develop a secure attachment relationship." It is great that the attachment needs of babies are finally being recognised more widely (it's something mothers have always known), but if we obscure the fact that babies need to form a secure attachment with their mother as the primary care giver (apart from in very rare cases where the mother is not available), we are putting babies at higher risk of neglect and abuse.
Due to the hormones of pregnancy and lactation, the mother also has specific attachment needs in relation to her baby, which no other carer (father, grandparent) has. No other carer is interchangeable with the mother - even if a baby is looked after by a great adopted mother or grandmother, they will not be able to replace the mother and this will always be missing in the babies life. It is this importance of the mother role which is the reason why perinatal mental health services are so important in the first place. e.g. p.11 - "Perinatal mental health means the way a parent or carer may think or feel" this obscures the fact that only women/those born female can get pregnant (not other carers - i.e. fathers, foster carers or grandparents). Mothers go through a massive physical and hormonal change, which is why they need support specific to them. Other carers don't.
p.13 "If a parent or carer is struggling with their mental health, it can make it more difficult to breastfeed." This language obscures the fact that only the mother, the female who birthed the child can breastfeed. Mothers will not be able to relate to this kind of language, so it is excluding to them.
p.13 "Support for parent mental health" - this obscures the fact that mothers postnatally have specific requirements for support that other carers don't have e.g. they will be recovering from pregnancy and childbirth. They will likely be sleep deprived, possibly still bleeding and recovering from scars and/or stitches depending on how old their baby is.

Women should surely be at the centre of this service, but the language reflects a blind spot towards them. We must not undervalue the importance and uniqueness of the female maternal role by using obscuring language. As with all other mammalian species, babies have in inborn need to be with their mother to ensure their survival and healthy development.