Abstract

Background: Specialist community perinatal mental health teams support women with moderate to severe psychiatric difficulties in pregnancy or postnatally. These teams are being expanded across the UK, and there is considerable international interest in this model of care. However, not all women access these teams, and many are instead supported by community mental health services that do not specialise in the perinatal period.

Aims: To explore perinatal women's experiences of specialist perinatal versus generic non-perinatal community mental health support.

Methods: Semi-structured interviews were conducted with 36 women diagnosed with perinatal mental health difficulties who were supported in the community either by a specialist perinatal or general non-perinatal mental health service. Data were analysed thematically.

Results: Women felt that specialist perinatal and non-perinatal services alike were under-resourced and somewhat too narrow in their remit, but reported positive experiences across both settings. They particularly valued the specialist expertise offered by perinatal teams, but also valued greater continuity of care over a longer period, which some non-perinatal teams provided.

Conclusions: The findings suggest that women with perinatal mental health difficulties value specialist perinatal expertise, but that general, non-perinatal teams may also have advantages for some. Further research into optimal care arrangements is merited.

Declaration of interests: The authors declare that they have no competing interests.

Key words: perinatal, community, mental health, services, women

1. Introduction

Perinatal mental health difficulties during pregnancy and after giving birth are common (Howard et al., 2014) and effective support is considered vital (Bauer, Parsonage, Knapp, Lemmi, & Bayo, 2014). In England it is recommended that all women with serious perinatal mental health difficulties which can be managed in the community should have access to a specialist community perinatal team (Maternal Mental Health Alliance, 2018; National Collaborating Centre for Mental Health, 2018). It is recommended that these should be multidisciplinary teams comprised of perinatal psychiatrists, perinatal mental health nurses and other specialists (e.g. psychologists and social workers) who assess and treat women with moderate to severe difficulties in pregnancy or postnatally. They are expected to offer: assessment of the mother-infant relationship, psychological interventions and medication (via home visits and outpatient appointments), pre-conception advice to women with severe pre-existing mental health difficulties (e.g. bipolar disorder), support for women transitioning to or from a mother and baby unit (MBU), and close liaison with social care, maternity and other psychiatric services (Royal College of Psychiatrists, 2018).

While specialist inpatient MBUs operate across a number of countries (Brockington, Butterworth, & Glangeaud-Freudenthal, 2017) and primary care interventions have been trialled for common perinatal mental health difficulties in both high and low income countries (Harvey, Fisher, & Green, 2012; Rahman et al., 2013), secondary care community perinatal mental health services are, to our knowledge, unique to the UK. There is considerable international interest in replicating this model of care abroad, with countries like Australia beginning to develop similar services. Even in England, although specialist community perinatal mental health teams are now being funded across the country, until recently many regions did not have a perinatal service or had only a part-time perinatal nurse or psychiatrist (Bauer et al., 2014). In areas of the country without perinatal teams, as in other

countries, women with serious perinatal mental health difficulties in the community are seen by non-perinatal or generic mental health services. In the UK, these include secondary care services such as community mental health teams (CMHTs). These multidisciplinary teams include psychiatrists, psychologists, nurses, social workers and occupational therapists and support adults with a range of relatively severe psychiatric problems. Perinatal women with specific diagnoses may also be seen by other non-perinatal secondary care services, such as personality disorder services, or early intervention in psychosis services.

Proposals to increase access to specialist perinatal mental health care have been driven partly by arguments, both from the UK and internationally, that perinatal women require different facilities and responses to those offered by generic, non-perinatal services (Brockington et al., 2017; NHS England, 2016). Women admitted to hospital with acute perinatal mental health difficulties report positive experiences of specialist MBUs compared to general psychiatric wards (Heron et al., 2012; Megnin-Viggars, Symington, Howard, & Pilling, 2015; Robertson & Lyons, 2003), while women accessing primary care services emphasise the need for support to be consistent, non-judgemental and well-tailored to the perinatal context (Megnin-Viggars et al., 2015; Millett et al., 2018). However, to our knowledge, no research has been published exploring women's experiences of secondary care support from either specialist perinatal or non-perinatal community mental health teams. This is clearly a gap in the research and this study set out to explore this qualitatively.

2. Method

2.1 Participants

This study was part of a wider qualitative research study (the 'STACEY' study) exploring experiences of a range of services supporting women with perinatal mental health difficulties. Altogether, 52 women were recruited purposively for the wider study. Women were initially

approached by a clinician from their mental health team and those interested in participating were contacted by a researcher who provided them with further information about the study. A sub-sample of 36 women was selected from the wider study, who had all accessed secondary care treatment in the community for a perinatal mental health difficulty (defined as a new mental health difficulty or relapse/exacerbation of a pre-existing difficulty occurring during or after their most recent pregnancy). Treatment was either from a multidisciplinary, specialist perinatal community mental health team, or from a non-perinatal community mental health service offering continuing care. Women were *not* included if they had only received input from e.g. a local perinatal specialist (i.e. not a full multidisciplinary perinatal team) *unless* they had also accessed a relevant multidisciplinary service. Community services offering acute care only were excluded (i.e. crisis teams), as were primary care services supporting women with milder difficulties. Non-perinatal services included CMHTs, recovery teams, early intervention services and complex needs or personality disorder services.

Additional inclusion criteria required that women had to be 16+ and have a baby aged 6-9 months old.

The 36 participating women came from eight diverse National Health Service (NHS) healthcare providers in England. At the time of data collection, three of these had full multidisciplinary perinatal community mental health services while five did not. Interviews normally took place in participants' homes. NHS ethical approval was obtained (reference: 13/LO/1855). Participation was voluntary and women's care was not affected if they declined to take part. Women were told that their contributions would be kept confidential with identifying details removed, but that the researcher would pass on information if he/she had major concerns about their safety or that of others. All participants gave informed written consent.

2.2 Data collection

A qualitative interview guide was developed by the research team with input from a service user and carer advisory panel. Semi-structured interviews lasting approximately one hour were carried out between June 2015 and March 2017. Women were asked about their access to services, experiences of care, relationships with professionals, and involvement in decision making. They were also asked about information provision and family inclusion and support. Interviews, covered women's experiences of their entire care pathway, but only data relating to relevant services were analysed for this study. Thirty-three of the thirty-six interviews were conducted by the first author (who is a clinical psychologist and researcher), while two were conducted by an MSc student and one by a service user researcher who had herself accessed support for a perinatal mental health difficulty.

2.3 Analysis

Interviews were audio-recorded, anonymised, transcribed and imported into NVivo 11[1]. Thematic analysis (Braun & Clarke, 2006) was carried out by the first and second author (an MSc student). Initial codes were generated using line-by-line coding, after which relationships between codes were explored to develop key themes in an iterative process. A third researcher (also an MSc student) separately coded four interviews to increase validity and disparities between the researchers were resolved through discussion. In qualitative research, reflexivity is considered vital. Throughout the research process, the researchers were therefore mindful of how their own positioning, backgrounds and experiences (e.g. of working in or accessing services) could have influenced their interactions with participants and/or interpretations of the data.

[1] One additional interview was accidentally not recorded and was therefore excluded.

3. Results

3.1 Participant characteristics

Fourteen women had accessed a specialist multidisciplinary perinatal mental health team, eighteen had accessed a non-perinatal mental health team in a secondary care setting, and four had used both during the perinatal period. Twelve women who accessed non-perinatal teams also had some form of specialist perinatal input, but not from a multidisciplinary community perinatal team (e.g. from a local perinatal specialist or specialist mental health midwife). Women's characteristics are shown in Table 1.

[Table 1 here]

3.2 Key themes

3.2.1 Value of perinatal expertise and tailoring

Women in the study experienced a range of difficulties and had diverse needs. Some wanted professionals to offer them emotional support to help them cope with motherhood and the impact on their mental health of having a new baby. Others wanted support caring for their infants and several were struggling with interpersonal conflict. Fifteen women had stayed either on an MBU (n=6) or an acute psychiatric ward/crisis house (n=6), or both (n=3), and wanted help continuing their recovery in the community. A number of women were keen for advice about taking medication in the perinatal period.

For women who accessed specialist perinatal teams, a key theme was the high quality of expertise offered. Women reported that clinicians had "real insight" (Mother-14[2]) into

[2] Mothers were given ID codes (1-36) and verbatim comments are labelled using these.

perinatal mental health and were able confidently to reassure them that "people do come out through it" (Mother-3). They felt specialist perinatal practitioners were able to answer their questions (e.g. about taking medication during pregnancy/while breastfeeding), tailor their support to the perinatal context, and inform women about other local services that might be of value.

During appointments, women valued it when specialist perinatal clinicians seemed "used to having babies there" (Mother-4) or even arranged for an extra staff member to "play with them" (Mother-2). In some cases, women said that perinatal mental health clinicians also advocated on their behalf, for example ensuring that staff in maternity services understood the implications of having a perinatal mental health problem and acted accordingly.

> I'm grateful, thankful to [my perinatal psychiatrist] for making the doctor induce me, though because the, you know, the hospital was making it very difficult.
>
> Mother-10

By contrast, several women under the care of non-perinatal teams felt there was a lack of perinatal expertise among clinicians, and a few women believed practitioners underestimated the likelihood of them experiencing perinatal mental health difficulties or did not take their perinatal struggles seriously enough.

> I don't think that they see enough pregnant women to really know what they're, you know, to keep up to date with what they're saying. I don't think that the psychiatrists, the general psychiatrists that I've seen have shown much understanding of it.
>
> Mother-22

When women experienced general mental health practitioners as insensitive, or unaware of their needs as mothers, they could feel unsupported and struggle to engage.

> [The CMHT psychiatrists] said that I wasn't really cooperating. Well it's because I had [my baby] and I wanted to keep breastfeeding her. That's what I wanted to do.
>
> Mother-29

> "When, you know, you're not able to breastfeed…you feel awful…I don't think that was ever addressed by-, we never talked about it…and we never had that chance…to discuss it."
>
> Mother-26

Where women had both specialist perinatal and non-perinatal input, there were examples of perinatal practitioners being supportive when women found clinicians in non-perinatal services insensitive. Often, this seemed to be because they felt specialist perinatal clinicians treated them like ordinary mothers, while non-perinatal clinicians were more likely to judge them or view them as a risk to their babies. There were indications (though only tentative due to the small numbers) that this was particularly true of women diagnosed with personality disorders, who sometimes valued perinatal mental health specialists, while struggling to feel accepted by others.

> [The personality disorder service] were horrible with me at the beginning, they were really horrible. I wouldn't have kept going if my perinatal mental health nurse wouldn't have said like, 'You do this'…She was very clear, 'Just a horrible assessment, yes. And if they say something to you that offends you, then you need to still go…and they need feedback'…She was basically holding it together.
>
> Mother-34

There were exceptions, where women felt non-perinatal practitioners showed a good level of understanding and expertise. It was also clear that women could still benefit from non-

perinatal mental health support, especially when practitioners had experience with other perinatal women, shared their own experiences of parenthood, or researched perinatal issues.

> [My CMHT care coordinator has] come up with loads of different things to do with the kids and me in terms of getting back out in the community…She's gone out and done her research and come back.
>
> Mother-16

It was common across specialist perinatal and non-perinatal services alike for women to say they valued clinicians sharing their own experiences of having a baby and appearing almost like peers. There were also examples across both settings of practitioners arranging appointments around family schedules or offering home visits so women didn't have to travel or arrange childcare.

> [My perinatal nurse] has children of her own. She's come from, she's a single mother. She's actually come from a place of, like, she's experienced it and…she just really understands me.
>
> Mother-8

> [The early intervention service] don't make me go into the hospital unless it's absolutely necessary, because they know I've got children and it's difficult to get out, car, get the pushchair out, get upstairs.
>
> Mother-19

3.2.2 Importance of coordination between services

As shown in Table 1, most participating women had previously accessed mental health support. Some had longstanding difficulties and were already in contact with non-perinatal mental health teams prior to becoming pregnant. There were examples of clinicians in non-

perinatal services ‘stepping up’ women’s care when they became pregnant and liaising well with maternity services, contacting them with any concerns, and in one case carrying out joint visits with health visitors. This was highly valued.

> [The early intervention team were] very quick off the mark to…[check that] the few doses [of medication] that I did have while I was pregnant didn’t affect him. So doctors were contacted, scans were done, and so I think [that] was done very efficiently.
>
> Mother-30

There were also examples of women being referred by non-perinatal services for specialist advice (e.g. around medication), either from perinatal community mental health teams or from local practitioners with perinatal expertise. In some cases, staff in non-perinatal teams were praised for making rapid contact with perinatal services.

> I think [my CMHT care-coordinator] could see that my mood had really deteriorated. So she tried again [to contact the MBU] and then managed to find me a bed…So it was pretty good going…
>
> …And then the handover back to the local team I think was quite good because my care-coordinator came several times to [the MBU] and so she was very much in the loop.
>
> Mother-11

> I was referred [to a perinatal specialist]. And I had seen him a couple of times before pregnancy because I was trying to decide whether to stay on or off medication.
>
> Mother-17

Joined up working between services was key, as women described feeling overwhelmed when professionals from different services saw them in an uncoordinated way, or when referrals between services felt disorderly. Also, while in some cases women got access to perinatal teams quickly, and links between MBUs and community perinatal teams seemed

generally good, others felt that clinicians in non-perinatal mental health services, as well as GPs (family doctors), and maternity clinicians (e.g. midwives and health visitors), lacked knowledge of specialist perinatal services, causing delays and mix-ups. It is possible that this related partly to the fact that some areas were in the midst of setting up new specialist services or expanding existing ones; certainly, it was compounded by the fact that, although most areas at least had a local perinatal specialist, there often was no full perinatal service to which to refer women.

Occasionally, women cared for by non-perinatal services also expressed concerns that this may have restricted their ability to access more specialist perinatal support.

> I think a lot of people were too scared to do anything [to help me with my baby] because it was therapy interfering. I'm thinking I should do [the personality disorder treatment] because it's the best thing…whereas actually no…Maybe if I hadn't been [under the personality disorder service] I would have got…more specialist [perinatal support].
>
> Mother-26

3.2.3 Available, consistent clinicians

Across both specialist perinatal and non-perinatal mental health teams, women generally felt staff were accessible, with several noting that clinicians were "always available at the end of a phone" (Mother-30). Early intervention teams were particularly well liked in this regard.

Both perinatal and non-perinatal teams also mostly arranged for women to see the same clinicians consistently. This was seen as especially important in the perinatal context, where some women feared opening up about their difficulties to unfamiliar people (e.g. in case their babies were taken away), and where general maternity care often lacked continuity.

> I just think [my perinatal mental health nurse] was massively reassuring…You have a troop of miscellaneous midwives, it's a different one each time…So [my perinatal nurse] was like a constant…a sort of counterpoint to all of that.
>
> Mother-1

Indeed, a particular strength of non-perinatal teams was continuity of care. Although a few women reported high staff turnover, and one said the complex needs team she was under discharged women if they became pregnant, others emphasised that they had been under their team's care prior to pregnancy and had been able to retain the same care-coordinator during pregnancy and postnatally. This was usually highly valued.

> I've spent so long with [my CMHT care coordinator] you know, I've got to know her now…She's been brilliant. She's been an absolute, I couldn't, I couldn't fault her.
>
> Mother-16

Not only this, whereas women under the care of specialist perinatal teams could usually only be seen for up to one year postnatally, non-perinatal teams were often able to offer longer-term care over several years.

> [My early intervention care-coordinator] said, 'I'll just keep seeing you for as long as you need me.'
>
> Mother-19

There were a small number of cases across both settings where women complained that clinicians judged them unfairly to be a potential risk to their babies, or did not allow them enough autonomy over their care. However, the majority found clinicians non-judgemental, collaborative and supportive.

3.2.4 Inadequate resourcing and a narrow focus

Notwithstanding these positive aspects of care, both perinatal and non-perinatal mental health teams were described as under-resourced. Although, as outlined, women generally found clinicians available and consistent, some women commented that clinicians initially took a long time to see them (especially psychiatrists and psychologists), did not arrange regular appointments, appeared unprepared and performed quick, perfunctory appointments.

> I was discharged [from the MBU] and passed over to somebody called a care-coordinator, care I have yet to receive six months after leaving hospital. I have not seen the [CMHT] psychiatrist that is apparently in charge of my wellbeing.
>
> Mother-33

> I think that the impression I got is that…the perinatal team are very, very busy. And I saw one of the representatives, but it took me quite a few weeks for her to get in contact with me.
>
> Mother-7

Women also reported that practitioners sometimes lost contact with them unexpectedly, leaving them feeling forgotten and struggling with ongoing difficulties.

> We were due a call [from the perinatal mental health nurse] and then didn't hear from her again…I know that, you know, they're probably very stretched…But I have been thinking about, you know, counselling…There's a shadow that hangs over me.
>
> Mother-5

It was conspicuous that several women said they wanted psychological therapy but found this hard to access, across both perinatal and non-perinatal settings, usually because of long

waiting lists, though occasionally also where psychologists felt unable to allow babies in sessions or to offer home visits (even in perinatal services).

Additionally, it was notable that some women were parenting in challenging circumstances, often with little support, and in the context of turbulent relationships. Twelve women were not living with a partner and these mothers seemed particularly likely to be younger or from a Black African or Caribbean background. Some women said they would have valued help with the wider issues and lack of support they faced but found community teams, both perinatal and non-perinatal, somewhat narrow in their focus. For example, a few women would have liked more practical support and advice with infant-care. One woman - a young, single mother from a Black Caribbean background - accessed a specialist perinatal community team after discharge from an MBU, but struggled again once back at home. She suggested that a community-based equivalent of an MBU would have been valuable "where mums can have appointments, just to do all the [MBU] activities, you know, but not have to stay" (Mother-8). Others suggested services may benefit from offering more parenting support, night nurses, crèches or even small amounts of childcare to allow mothers respite.

Although there were exceptions, there also appeared to be relatively little family involvement in women's care, or provision for couples or families, across both settings. Involvement of families was not always straightforward. For example, some women wanted confidentiality from their partners and families (e.g. due to perceived stigma around mental health reported by some women from Asian, Muslim and Black African backgrounds). However, while there were examples of practitioners being sensitive to women's family contexts, on the whole families and interpersonal contexts seemed overlooked. A few women also wanted couples therapy but said this was not available.

Finally, three women had lost custody of their babies and felt there was little support available to help them cope with the aftermath of this. One woman was discharged by her perinatal mental health team to a general, non-perinatal service once she lost custody as she was no longer considered 'perinatal'; she felt almost completely unsupported emotionally with her loss.

4. Discussion

To our knowledge, this study is the first to explore women's experiences of support for perinatal mental health difficulties from secondary care perinatal and non-perinatal community mental health services. As such it fills a clear gap in the research literature, helping to develop a knowledge base around the support needs of women with moderate to severe perinatal mental health difficulties. We found that women reported generally positive experiences of support from both specialist perinatal and non-perinatal mental health services in the community. Although they experienced both types of service as stretched and under-resourced, they generally found clinicians available and consistent. Building on the findings of previous research in primary care (Megnin-Viggars et al., 2015; Millett et al., 2018) and inpatient (Heron et al., 2012; Megnin-Viggars et al., 2015; Wright et al., 2018) settings, women placed a high value on services offering them specialist perinatal expertise and tailoring. This suggests there may be benefit in trialling specialist secondary care models internationally and offers support to the UK's expansion of perinatal services. As recommended in other research, our findings suggest that general mental health (and maternity) clinicians may benefit from training to improve their perinatal expertise and confidence referring women to specialist services (Myors, Schmied, Johnson, & Cleary, 2013).

While specialist expertise was more readily available from perinatal services, it was notable that women reported positive experiences of support from non-perinatal community mental health services too, particularly when practitioners researched perinatal issues, drew on their own experiences of motherhood, stepped up women's care in the perinatal period, and liaised effectively with perinatal services/specialists when needed. Some women also praised the continuity of care that non-perinatal mental health services could provide, , as these teams could see women before, during and after pregnancy and were sometimes able to offer longer-term support than perinatal teams (which generally only offered treatment for up to one year postnatally). While we interviewed women 6-9 months postnatally, when they were still eligible for specialist perinatal support, we identified a potential tension for some women, wherein specialist teams did not usually offer them long-term continuity of care, while non-perinatal teams offered greater continuity but lacked specialist expertise.

Continuity of care has been identified as vital during the perinatal period, as this is a time when women particularly fear discussing their difficulties with professionals (Megnin-Viggars et al., 2015). Our findings suggest that general community mental health services should not discharge women simply because they become pregnant; that some women accessing specialist perinatal teams may wish to be seen for longer than the current 12-month cut-off point; and that both perinatal and non-perinatal teams need to follow-up women proactively to avoid care being terminated without warning. It would be valuable to conduct further research, both in the UK and internationally, to evaluate optimal care arrangements: while it appears that women value specialist perinatal expertise highly, there may be questions about whether they should be transferred fully to a specialist perinatal team during the perinatal period, or whether some form of shared or joint working between perinatal and non-perinatal services would be preferable in some cases.

Access to psychological treatments that meet the specific needs of perinatal women (e.g. their need to bring babies to sessions) appears also to require improvement. As identified by other research too (Lever Taylor et al., 2019), our findings suggest that such interventions should additionally include couples therapy and support for women's partners. Greater practical support and advice with infant care would also appear to be of value, particularly for mothers with limited support networks around them, including exploration of the possibility of a community-based equivalent of an MBU. Finally, it is important to give greater consideration to the needs of women who lose their babies and how are they offered support.

4.1 Limitations

While this study was novel and unique, it also had a number of limitations.

Firstly, the study was carried out during a period of rapid expansion of perinatal mental health services in England. This means that its findings are, to some extent, time-specific and women's experiences may vary as services change. Even so, the study can still inform future service development by drawing attention to women's needs and priorities.

Because of regional variations in the distribution of specialist perinatal teams, women who accessed them were generally recruited from different areas of the country to those accessing non-perinatal teams. This could have resulted in biases (e.g. if the views of women accessing perinatal versus non-perinatal teams differed for reasons unrelated to service type). Future research should include more balanced, regionally diverse sample, especially as specialist perinatal teams are now being expanded nationally. This research was also limited to women accessing services in England. As outlined, secondary care community perinatal mental health teams are currently unique to the UK. Nevertheless, it would be valuable to carry out international research to explore and compare perinatal women's needs and experiences of

secondary care community mental health provision across different contexts.

Women were recruited by clinicians with whom they had worked. It is possible that clinicians referred women with whom they had a good relationship and that this may have made participants' views unrepresentatively positive.

As this study was part of wider research, women were asked about all aspects of their care, including about other mental health services not relevant to this study (e.g. acute/inpatient services). While women provided useful insights, future research may benefit from focussing exclusively on views of community multidisciplinary services to provide greater depth. It may also be beneficial for future research to include the views of women who accessed general primary care services, since differing criteria for access between perinatal and non-perinatal secondary care teams could mean we excluded some women who would have accessed a specialist team had one been available.

Finally, as women were interviewed when their babies were 6-9 months old they were still eligible for support from perinatal teams at this point. As these services usually only offer support for up to one year postnatally (though there are plans to extend this to two years), it would be valuable for future research to interview women later on to explore experiences of the length of care offered.

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Declarations

Ethics approval and consent to participate

All procedures contributing to this work complied with the ethical standards of the English National Health Service. Ethical approval was obtained from the Camberwell St Giles London Research Ethics Committee (REC reference: 13/LO/1855). Informed written consent was obtained from all individual participants included in the study.

The datasets generated and/or analysed during the current study are not publicly available due to them containing information that could compromise research participant privacy/consent but are available from the corresponding author on reasonable request.

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Table 1: Characteristics of women (N=36)

Characteristics		**Category**	**Respondents n (%)**
Age		Mean age	33 years
		≤ 25	6 (17%)
		26 - 29	5 (14%)
		30 - 39	22 (61%)
		40+	3 (8%)
Ethnicity		White British	19 (53%)
		White Other	3 (8%)
		Black Caribbean	5 (14%)
		Black African	3 (8%)
		Asian	3 (8%)
		Mixed Race	2 (6%)
		Other	1 (3%)
Primary diagnosis		Depression	12 (33%)
		Anxiety	3 (8%)
		Personality disorder	9 (25%)
		Bipolar disorder/psychosis/schizophrenia	12 (33%)
Eligible service used	Perinatal	Perinatal mental health team (PMHT)	14 (39%)
	Non-perinatal	Community mental health team (CMHT)	12 (33%)
		Early intervention service	3 (8%)
		Recovery service	1 (3%)
		Personality disorder (PD)/complex needs service	1 (3%)
		CMHT and PD service	1 (3%)
	Both	PMHT & CMHT	2 (6%)
		PMHT & PD service	2 (6%)
Level of education		No formal qualifications	7 (19%)
		Secondary education	13 (36%)
		Undergraduate	7 (19%)
		Postgraduate	9 (25%)
Living with partner		Yes	24 (67%)
		No	12 (33%)
Previous mental health service use		Yes	30 (83%)
		No	6 (17%)
Location		London	18 (50%)
		South of England	17 (47%)
		North of England	1 (3%)