Understanding perinatal mental healthcare referral decisions among midwives and health visitors

Joanne Johnson

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Abstract

Introduction: Approximately half of women requiring perinatal mental health (PNMH) care do not receive treatment despite having routine contact with midwives (MWs) and health visitors (HVs). Little attention has been paid to MWs'/HVs' decision-making regarding referring women for secondary PNMH care. In particular, the impact that the level of local specialist PNMH services may have on MWs'/HVs' referral decisions is unexplored.

Aims: To understand MWs'/HVs' decision-making in relation to referring women for secondary PNMH care to identify barriers and facilitators to effective and timely referrals including any impact of having local secondary PNMH service provision.

Methods: Participants were recruited from four NHS Trusts in England, located across two geographical areas, that each provided different levels of PNMH services. One area had PNMH services that met NICE guidelines; the other area had no PNMH services. A sequential mixed methods design was employed comprising three phases. Phase 1: Semi-structured interviews with midwifery managers and health visiting clinical leads (n=5, from all four Trusts) to establish PNMH referral pathways and service provision available to the MWs/HVs working in the two geographical areas. Phase 2: In-depth qualitative semi-structured interviews with clinical MWs/HVs (n=24 consisting of: MWs=16, HVs=8; area with PNMH provision=15, area without PNMH provision=9) to explore their approach to PNMH referral decision-making, analysed using thematic analysis. Phase 3: Bespoke questionnaire, based on the findings from Phase 2, administered to 755 MWs and HVs in the two geographical areas, to measure factors that impact on PNMH referral decision-making among MWs/HVs allowing for statistical comparisons to be made between MWs/HVs, and geographical areas.

Findings: Three overarching themes were identified from the qualitative interviews that reflected MWs and HVs perceived barriers and facilitators to PNMH referral decision-making: identifying need; education, skills and training; and referral pathways.

A total of 99 responses were received for the questionnaire (overall response rate: 13.1%. Response rate for: MWs=11%, HVs=18%; area with PNMH provision=8.72%, area without PNMH provision=38%). There were few significant differences between MWs and HVs and between the two geographical areas on the reported barriers and facilitators to referring women for PNMH care. The most commonly overall reported facilitators to referral decision-making among MWs/HVs were a trusted relationship (97%) and routine enquiry of women's mental health (91%). The most commonly overall reported barriers to referral decision-making were stigma associated with mental ill-health (83%) and the perceived fear by women of losing custody of their child (81%).

Conclusion: Qualitative and quantitative analysis revealed that fundamental to MWs' and HVs' decision-making was the relationship between themselves and women. Furthermore, whilst the provision of PNMH services is important for women in ensuring they receive appropriate and timely PNMH care, it appeared less important to MWs' and HVs' decision-making than the manner in which maternity and health visiting services were delivered. More important factors to MWs and HVs were whether or not they were able to provide continuity of carer and build trusted relationships with women allowing MWs/HVs to identify those women who would benefit from referral for specialist PNMH care.

Awards and presentations resulting from this thesis

Awards:
Awarded first prize in ‘Public Choice Award’ for Images of Research 2017 competition at University of Worcester, Worcester, UK.

Awarded ‘Best Academic Poster Presentation’ for poster entitled: Understanding perinatal mental healthcare referral decisions among midwives and health visitors, at the Community Practitioners and Health Visitors Association Annual Conference, 17th October 2019, Harrogate, UK.

Peer reviewed conferences:

Johnson, J. (2018) Understanding perinatal mental healthcare referral decisions among midwives and health visitors. Oral presentation at the Postgraduate Research Student Conference, University of Worcester 5th July 2018, Worcester, UK.

Johnson, J. (2020) Understanding perinatal mental healthcare referral decisions among midwives and health visitors – qualitative findings. Northern 2020 Maternity and Midwifery online Festival, 23rd June 2020.

Introducing the researcher

Interest in this research is twofold: from a personal perspective as a woman and from a professional perspective as a registered midwife and health visitor. First and foremost, the researcher is a mother and has an interest in perinatal mental health from a personal viewpoint. Having experienced the extremely common, but self-limiting 'baby blues', and although fortunate to not have personally experienced the more severe mental health disorders associated with the perinatal period, the researcher has experienced postpartum depression vicariously through close family members and friends and thus, witnessed the impact that perinatal mental ill-health has on women and wider family.

Secondly, the researcher is a registered midwife and health visitor with over 25 years of clinical experience caring for women experiencing perinatal mental health problems. Supporting women with mental health difficulties in the perinatal period has been challenging but rewarding and has given the researcher immense job satisfaction. Furthermore, the researcher has seen first-hand the benefit and impact that accurate and timely mental health care has on the woman, her baby and family. Conversely, the researcher can also attest to the consequences experienced by women who have not received perinatal mental health care in a timely manner. The co-funded studentship offered by the University of Worcester and Midlands Partnership Foundation Trust (MPFT) provided the opportunity to research this area of clinical practice on a full-time basis and on completion of this research, it is hoped that findings will contribute to the current evidence base on perinatal mental health care, enhance the researcher's practice and make a meaningful contribution via recommendations for clinical practice in midwifery and health visiting.

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First and most importantly, I would like to thank my supervisory team: Professor Lisa Jones, Professor Eleanor Bradley and Dr Lucy Hope for their unwavering guidance, support, reassurance and patience. (Special thanks to Lisa for coaching me through the unchartered territory of statistics which helped strengthen my identity as a researcher). I am grateful for their collective encouragement and never failing to remind me that "Doing a PhD is hard; if it was easy, everyone would have one". I have learnt so much about research, the research process, and about myself. I am indebted to you all.

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Grateful thanks to all the midwives and health visitors who generously gave their time to participate in this research and share their experiences and opinions.

Finally, in the words of the ostensible modern-day philosopher and rapper, Snoop Dogg: "Last but not least, I want to thank me. I want to thank me for believing in me. I want to thank me for doing all this hard work. I want to thank me for having no days off. I want to thank me for never quitting".

[1] Please note, Midlands Partnership Foundation Trust, formerly South Staffordshire and Shropshire NHS Foundation Trust (SSSFT) amalgamated with a neighbouring NHS Trust during the period of data collection resulting in a name change. Some appendices bear the SSSFT logo as they were devised prior to the amalgamation.

List of abbreviations

BAME: Black, Asian and Minority Ethnic

CCGs: Clinical Commissioning Groups

CMHTs: Community Mental Health Teams

CMWs: Community Midwives

CNNs: Community Nursery Nurses

EPDS: Edinburgh Postnatal Depression Scale

FYFVMH: Five Year Forward View for Mental Health

GAD: Generalised Anxiety Disorder

GP: General Practitioner

HCPs: Healthcare Professionals

HEE: Health Education England

HVs: Health Visitors

IAPTs: Improving Access to Psychological Therapies

iHV: Institute of Health Visiting

KPIs: Key Performance Indicators

MBU: Mother and Baby Unit

MMHA: Maternal Mental Health Alliance

MMR: Mixed Methods Research

MWs: Midwives

NICE: National Institute for Health and Care Excellence

NMC: Nursing Midwifery Council

ONS: Office for National Statistics

PIS: Participant Information Sheet

PBDU: Parent and Baby Day Unit

PHQ: Patient Health Questionnaire

PIMH: Perinatal Infant Mental Health

PNMH: Perinatal Mental Health

PP: Postpartum Psychosis

PTDS: Post-Traumatic Stress Disorder

RCM: Royal College of Midwives

RCOG: Royal College of Obstetricians and Gynaecologists

RCPsych: Royal College of Psychiatrists

SIGN: Scottish Intercollegiate Guideline Network

TA: Thematic Analysis

WHO: World Health Organisation

Table of Contents

List of Appendices

List of Tables

List of Figures

CHAPTER ONE

Introduction to the research presented in this thesis and outline of the research question and design

1.1 Introduction

Perinatal mental health (PNMH) is a major public health concern, both nationally (Royal College of Obstetricians and Gynaecologists [RCOG] 2017) and internationally (World Health Organisation [WHO] 2008). The perinatal period is defined as the period during pregnancy and the year following childbirth (Austin *et al.* 2008). PNMH disorders include new-onset conditions occurring during pregnancy and after childbirth and pre-existing conditions that relapse or recur (Royal College of Psychiatrists [RCPsych] 2015) such as antenatal and postnatal depression, anxiety disorders, post-traumatic stress disorder (PTSD), obsessive compulsive disorder (OCD), tocophobia, schizophrenia, bipolar disorder and postpartum psychosis (PP) (Austin *et al.* 2008). Depression and anxiety disorders are the most prevalent health problems in the perinatal period (Howard *et al*. 2014) with up to 20% of women reported to experience a depressive episode (Gavin *et al*. 2005; Bauer *et al*. 2014) and an estimated 22% of women affected by perinatal anxiety (Giardinelli *et al*. 2012). In England, this equates to approximately 86,000 women experiencing mild-moderate depressive and anxiety disorders per year and over 1,300 women experiencing the more severe form of mental illness during this time, namely PP (Bauer *et al*. 2014). Annually, it is calculated that 70,000 families in the UK will experience the impact of PNMH disorders (Health Education England [HEE] 2016)

and an estimated 6,600 women will require specialist PNMH services (NHS England 2016). (N.B. Contemporary writing uses the term ‘birthing people’ to reflect a more inclusive descriptor of woman/women; throughout this thesis, woman/women is used but assumes the inclusive descriptor in line with up to date philosophy).

The perinatal period provides healthcare professionals (HCPs) with the opportunity in which to assess a woman’s emotional wellbeing and risk of PNMH disorders due to the frequency of contacts during this time (Howard *et al*. 2014; NICE 2014). Midwives (MWs) and Health Visitors (HVs) play a key role in assessing and referring women for specialist PNMH care (NICE 2014) due to the routine care such services offer to women in the perinatal period. However, despite women having routine contact with MWs and HVs throughout this time, an estimated 50% of PNMH cases go undetected and untreated (Redshaw and Henderson 2016). Of those that are detected, only 40% receive appropriate treatment (Bauer *et al*. 2014). Previous research suggests MWs and HVs may lack knowledge and confidence in recognising and managing mental illness, and lack expertise in screening women for PNMH disorders and referring women in need of PNMH care (Rothera and Oates 2011; Jomeen *et al*. 2013; Hauck *et al*. 2015; Noonan *et al*. 2017) which may go some way to explain why many women with PNMH difficulties go undetected or fail to receive appropriate treatment.

National Institute for Health and Care Excellence (NICE) (2014) guidance recommend that clinical organisations provide specialist multidisciplinary perinatal services in each locality with clear referral and management protocols for services.

In accordance with NICE (2014), Scottish Intercollegiate Guideline Network (2012) guidance and the Joint Commissioning Panel for Mental Health (2012), pregnant and postnatal women requiring mental health care should have access to care and treatment from specialist Mother and Baby Units (MBU), specialist PNMH Community Mental Health Teams (CMHTs) (RCPsych 2015), a specialist PNMH MW (Royal College of Midwives [RCM] 2014) and a specialist PNMH HV (Health Education England [HEE] 2016). In addition, Klimowicz and Lignum (2016) recommend that women should have access to Parent and Infant Mental Health (PIMH) Services. PIMH services are important as they offer direct clinical interventions to specialist caseloads addressing problems such as the care-giving relationship between parent and infant (HEE 2016). However, UK service provision for PNMH is variable in both coverage and quality (NHS England 2016) and an estimated 40% of women in England do not have access to specialist PNMH service provision (Bauer *et al*. 2014). Current literature states that PNMH services are inadequate to meet the needs of women in the UK and internationally where frequent references are made regarding the lack of specialist PNMH services and/or disparity of PNMH services (Battle and Howard 2014; Castro *et al*. 2015; Brockington *et al*. 2017a). A UK survey of Heads of Midwifery found that 37 (48%) of the 77 NHS Trusts surveyed, did not have a specialist MW for mental health (RCM 2014) and an estimated 85% of Acute Trusts either had no specialist PNMH services or services that did not meet NICE recommendations (NHS 2017).

Previous research has also suggested that in addition to a lack of PNMH service provision, HCPs such as MWs and HVs lack policy direction and referral criteria to guide their practice when managing women with PNMH problems (Rothera and

Oates 2011; Higgins *et al*. 2018). This raises the question of what the alternative management and referral protocols are that guide MWs' and HVs' practice in the absence of such policies. Furthermore, there is a dearth of literature concerning what influence having a specialist PNMH service has on MWs' and HVs' decisions about whether or not to refer women for PNMH care.

1.2 Common perinatal mental health problems:

1.2.1 Depression

Depression and anxiety are the most prevalent health problems in the perinatal period (Howard *et al*. 2014; Howard and Khalifeh 2020). Typically, perinatal depression is defined as a non-psychotic, depressive episode of mild to major severity that occurs during the perinatal period (Gelaye *et al*. 2016). Symptoms include a sense of morbid unhappiness, feelings of helplessness and hopelessness, irritability, fatigue, interpersonal hypersensitivity, insomnia, anxiety and tearfulness (O'Hara 2009; Benoit *et al*. 2007; Oates *et al.* 2004). There is a wide body of evidence that suggests depression can result in impaired functioning and impact on how a woman responds to her baby's cues (Beck 1995; Perfetti *et al*. 2004; Bonari *et al.* 2004; McGrath *et al.* 2008). PNMH problems, including depression, can have adverse outcomes for the woman, her baby and wider family (Henderson *et al.* 2003; Moehler *et al*. 2006; O'Hara 2009; Fisher *et al.* 2012; Bonari *et al.* 2014).

1.2.2 Anxiety

Perinatal depression is often co-morbid with anxiety disorders (O'Hara 2009). A variety of anxiety disorders are prevalent in the perinatal period which include generalised anxiety (GAD), obsessive–compulsive, panic, and social anxiety disorders (O'Hara *et al.* 2014). Symptoms include feelings of tension, worry, unease and insomnia (Osnes *et al*. 2019) resulting in impaired daytime functioning and

adversely impacting mood (Swanson *et al*. 2011). Anxieties are often related to the child's health/wellbeing but other common anxieties are related to fear of parenting criticism and lack of support (Brockington *et al*. 2017a). In many cases, the severity and effect of anxiety symptoms do not warrant an anxiety disorder diagnosis, nonetheless, they do cause mild-to-moderate levels of distress and impairment (O'Hara *et al.* 2014). However, research has shown that infants exposed to maternal anxiety whilst in-utero tend to have more sleeping and feeding problems, are highly reactive, develop later behavioural problems (Van den Bergh *et al*. 2005) and consistently linked with pre-term birth and low birth weight for gestational age (Glover and O'Connor 2002).

1.2.3 Postpartum Psychosis

Postpartum psychosis (PP) commonly occurs in the first few weeks postnatally (Langan Martin *et al*. 2016) and is a mental illness emergency necessitating urgent specialist treatment (Brockington 2017b; Perry *et al*. 2021). Whilst there is currently no universally recognised definition of PP, DSM-5 criteria state episodes of PP are usually classified as severe episodes of mood illness, denoted with a peripartum onset occurring in pregnancy or include a postpartum specifier within four weeks of delivery for severe episodes of mood/psychotic illness (APA 2013). PP is characterised by elated, dysphoric or labile mood, agitation, insomnia, disorganised behaviour and thought processes including delusions and hallucinations (O'Hara *et al*. 2014). These symptoms can be interspersed with brief, asymptomatic periods of lucidity (Di Florio *et al*. 2013). PP is estimated to effect 1-2 per 1000 women (Munk-Olsen *et al*. 2016). This estimate is based on data from the developed world (Vanderkruik *et al*. 2017) however, previous research suggests the incidence of PP is consistent across cultures (Kumar 1994). It has been suggested that PP is an

overt presentation of bipolar disorder that coincides with the considerable hormonal changes after childbirth (Sit *et al*. 2006; Perry *et al*. 2021).

1.2.4 Bipolar Disorder

Bipolar disorder is a severe mental disorder characterised by recurring periods of (hypo)manic and depressive episodes (Geoffroy *et al*. 2014). Estimated lifetime prevalence rates of bipolar disorder range from 2.8 to 6.5% (Bauer and Pfennig 2005). Women with bipolar disorder are at an increased risk of experiencing perinatal mental ill-health (Kendell *et al*. 1987; Austin and Priest 2005; Munk-Olsen *et al*. 2009; Perry *et al*. 2021). Over one third of women with bipolar disorder are at risk of experiencing a postpartum relapse and have at least a one in five risk of experiencing PP (Wesseloo 2016) making this group of women particularly vulnerable to PNMH episodes. According to Lindahl *et al*. (2005), perinatal suicides rates are higher among women with a previous history or existing mental health problems exacerbating the vulnerability of this group of women.

Given the prevalence of the common and/or impairing mental disorders mentioned, known risk factors such as history of mental illness, family history of mental illness, social and obstetric factors and potential adverse outcomes of PNMH, it is important therefore, that women at risk of and/or experiencing PNMH problems are identified and receive effective, timely treatment.

1.3 Potential impact of perinatal mental health problems

PNMH problems have wide ranging consequences. The potential impact of PNMH problems on the mother can include future mental health problems (Bonari *et al*.

2014), feeling stigmatised resulting in poor engagement with perinatal and preventative care (Fisher *et al*. 2012), a negative impact on breastfeeding duration (Henderson *et al.* 2003), detrimental effects on mother-infant bonding (Moehler *et al*. 2006; Brockington 1996), being more likely to engage in unhealthy behaviours such as smoking, alcohol and substance misuse and poor self-care and parenting practices (O'Hara 2009). PNMH problems are also associated with impacts on the wider family in terms of relationship issues between women and their partner/families (HEE 2016). If untreated, evidence indicates that maternal mental health conditions can impact on a child's cognitive and emotional development (Stein *et al*. 2014; The Wave Trust 2014), place children at an increased risk of developing mental health problems (Schore 2014), affect mother-infant attachment (Brockington 1996) and reduce compliance with child health-promotion and prevention programmes (Turner *et al*. 2003). However, adverse outcomes for mother and child are not inevitable; two key moderating factors associated with poor outcomes are the severity and persistence of mental health symptoms (Goodman 2019). According to Goodman (2019), appropriate interventions can prevent or reverse the negative trajectory of maternal depression for both mother and child. Thus, early identification and intervention in PNMH disorders improves outcomes for both mother and child (Austin and Priest 2005) and as such, its importance is reflected in current national health policy (NHS England 2016). Indeed, a cross party manifesto acknowledged the importance of early intervention and pledged that services must be in place in all areas to ensure that women who are at risk or suffering from mental health problems are given appropriate support at the earliest opportunity (The Wave Trust 2014). This includes specially trained parent and infant mental health MWs and HVs in order to

improve identification and support for families who need it most (The Wave Trust 2014).

The cost of PNMH disorders to the NHS and Social Services is estimated to be approximately £8.1 billion over the lifetime of each annual cohort of births. Much of this cost relates to the adverse impact that PNMH disorders have on the child (Public Health England 2020). According to Brockington *et al*. (2017a) identifying parents and infants at risk during the perinatal period provides opportunities for primary and secondary prevention of mental illness and its adverse consequences on the developing child resulting in long term health and social care cost savings. Thus, timely identification and treatment of PNMH disorders has both financial and health benefits.

Death by suicide remains the leading direct cause of maternal deaths in the UK (Knight *et al*. 2020). Research has shown that survivors of suicide loss are at a higher risk of developing major depression, PTSD, suicidal behaviours and forms of complicated grief that are more prolonged and intense when losing a loved one under traumatic circumstances (Young *et al*. 2012). According to Knight *et al.* (2020) the MBRRACE-UK maternal deaths report found that many mothers who had died should have received specialist care (for example, those with mental health disorders), but had not been referred. Consequently, not referring women for specialist PNMH care can have a devastating outcome for women and survivors of suicide loss.

1.4 Risk factors for perinatal mental health problems

Pregnancy and the postnatal period are a time of vulnerability for the onset or relapse of mental health disorders (Davey *et al*. 2011; Smith *et al*. 2011; Rezaee and Framarzi 2014; Biaggi *et al*. 2016;) with some women at an increased risk of experiencing PNMH problems. For example, many authors have shown that women with a history of mental illness (Kendell *et al*. 1987; Austin and Priest 2005; Munk-Olsen *et al*. 2009; Howard *et al*. 2014;) and a history of first degree relative with mental illness, especially bipolar disorder (Austin *et al*. 2008; Meltzer-Brody *et al*. 2014; NICE 2014; Bauer *et al*. 2018; Bauer *et al*. 2019; Perry *et al*. 2021) are at a greater risk of experiencing PNMH problems. Other risk factors associated with experiencing PNMH problems include, but are not limited to, social factors such as economic status, poor social/family support (Inandi *et al.* 2005; Benoit *et al*. 2007), housing concerns, life stresses, previous or current history of physical, sexual or emotional abuse (Austin and Priest 2005; Smith *et al*. 2011; Biaggi *et al*. 2016), and obstetric factors such as unplanned pregnancy (Inandi *et al*. 2005), primiparity (a woman pregnant for the first time) (Jones *et al*. 2014), mode of delivery and hyperemesis gravidarum (excessive nausea and vomiting) (Kendell *et al*. 1987).

In addition to those women with known risk factors associated with PNMH problems, pregnancy and motherhood can be challenging for many women thereby increasing their vulnerability to experiencing PNMH problems. Changes to a woman's body (Deklava *et al*. 2015), adjustment and transition to parenting a newborn (Parfitt and Ayres 2014) and the pressure to breast feed (Deklava *et al.* 2015; RCOG 2017) are just some of the challenges faced by women in the perinatal period that impact on their mental health. Furthermore, sleep deprivation and an inability to relax can be

triggers for depression in the perinatal period (Jarrett *et al.* 2017). Women from disadvantaged groups are also susceptible to PNMH problems. For example, a recent integrated review by Vahdaninia *et al.* (2020) found that Black, Asian and Minority Ethnic (BAME) populations, refugees and asylum seekers are at a higher risk of PNMH problems and have poor engagement with mental health services, in terms of initiation, retention and dropout from treatment. Women in same sex relationships (Ross *et al.* 2005) and bisexual women (Ross *et al.* 2012) are also reported to be predisposed to perinatal depression, mainly due to a lack of support and a discriminatory attitude from family members. Women with high levels of symptoms of a range of perinatal mental disorders such as depression and anxiety have a high prevalence of having experienced domestic violence (Howard *et al*. 2013). Furthermore, in an age where social media is a daily activity for a growing number of people, 'social media envy' is reported to aggravate depression and anxiety in individuals in the perinatal period (Karim *et al*. 2020).Thus, although for many women pregnancy and motherhood is a positive experience, for some women this significant life event can be overshadowed by mental health problems and present challenges to their mental well-being (Howard *et al.* 2014).

1.5 Role of midwives

Midwifery is a distinct profession governed by the Nursing Midwifery Council (NMC). A MW's scope of practice is recognised as an accountable professional working in partnership with women to provide support, care and advice during the perinatal period to conduct births and provide care for the newborn; responsibilities includes among others, the detection of complications in mother and child, accessing medical care or other appropriate assistance and carrying out emergency measures (ICM

2017). NMC Standards of Proficiency for MWs (2019) clearly set out MWs role in relation to women's PNMH across six domains which detail their expansive role in:

- Assessment, screening and care planning.
- Caring and supporting women and newborn infants requiring additional treatment/care from other services, e.g. medical, obstetric, mental health, social care and neonatal services.
- Demonstrating the ability to work in collaboration with interdisciplinary/ multiagency teams while providing midwifery care needed by women and newborn infants.
- Engaging in effective communication to have difficult conversations with pregnant women and new mothers including conversations about sensitive issues (NMC 2019).

Furthermore, the Maternal Mental Health Alliance (MMHA) (2014) highlight that MWs have a valuable role in supporting good PNMH which includes:

- Raising awareness about psychological health and wellbeing, signs of emerging PNMH problems and what to do if problems are detected.
- Tackling stigma and discrimination associated with poor mental health through being knowledgeable and confident in the routine care of womens' mental and physical health.
- Strengthening and promoting emotional wellbeing by providing sensitive and supportive antenatal and postnatal care, and reducing women's vulnerability to mental illness through emotional wellbeing care plans.

- Building trusting relationships that help women to disclose if they are unwell and increase the likelihood that MWs will identify any problems that arise.
- Identifying risk and current wellbeing through discussion and documentation of women's past and current mental health, being sensitive to any indicators of deteriorating mental health, and by using validated tools, such as the Whooley questions or Edinburgh Postnatal Depression Scale to strengthen their clinical assessment.
- Ensuring appropriate care by signposting or referring women for additional care if required, and supporting women to access this care.
- Educating family members of the negative effects that poor maternal mental health can have on infants, partners and other family members, and take action to reduce this. MWs can have a valuable impact by promoting emotional and practical support from partners and family members, and encouraging women to enhance their social networks through antenatal and postnatal activities (MMHA 2014).

1.6 Role of health visitors

HVs are registered nurses and/or MWs who have undergone specialist training in child health, health promotion, public health and education for the role of Specialist Community Public Health Nurse – Health Visitor (SCPHN-HV). According to HEE (2016), the role of HVs in improving women's PNMH and promoting optimum infant development includes:

- Promoting parents' sensitivity and responsiveness to their infants by understanding how infants communicate their feelings through their behaviours to help parents to improve the quality of interactions with their

babies and increase parents' understanding of infants social and emotional development. Consequently, children's emotional well-being and development will be enhanced as well as increasing overall parental satisfaction.

- Raising awareness of PNMH through antenatal contacts to ensure that pregnant women and their partners know how to maintain and enhance their psychological well-being, recognise signs of emerging mental health difficulties and what do to do if these occur.
- Tackling stigma and discrimination associated with poor mental health through being confident and knowledgeable in the routine care of mental and physical health in women and their families.
- Promoting emotional wellbeing by supporting women to maintain and enhance their emotional wellbeing and reduce their vulnerability to mental health problems by creating emotional wellbeing care plans, e.g. encouraging women to meet with other mothers and to establish social networks.
- Building a trusting relationship through continuity of care with the same HV whenever possible and offering therapeutic interventions or 'listening visits' when needed.
- Identifying risk and current wellbeing by discussing and documenting details of women's past and current mental health and being sensitive to any indicators that this may be deteriorating by using validated tools, such as the Whooley questions, Edinburgh Postnatal Depression Scale or Patient Health Questionnaire to strengthen their clinical assessment.
- HVs are also trained to acknowledge the impact that housing and financial worries have on parental mental health.

- Ensuring appropriate care by sign-posting and/or referring women for additional care or advice, if needed, and supporting women to access this when they have difficulties engaging with new services. In the event of additional services being unavailable or if there are long waits for treatment, HVs can provide support and emotional containment.
- Assessing risks to the infant and being sensitive and alert to the negative effects that poor parental mental health can have on infants, offering extra support where this is a concern and if needed, referring on for further assessment or intervention.
- Supporting partners and the parental relationship that may suffer as a result of postnatal depression and other mental health difficulties, and help foster emotional and practical support for mothers from their partners/other family members.
- Acknowledging the impact of maternal anxiety around parenting issues.
- Working collaboratively with GPs, MWs, adult mental health, Mother and Baby Units, social care, neonatal intensive care, paediatrics, children's centres and other specialist services such as PNMH CMHTs where they exist. The MW to HV hand-over and GP liaison provide opportunities to share information to enhance maternal mental health and alert others to problems that require additional intervention (HEE 2016).

There is considerable overlap and similarities between MWs' and HVs' responsibilities concerning women's PNMH as outlined by NMC (2019), MMHA (2014) and HEE (2016) and this highlights the significant role these HCPs play in assessing risk of PNMH problems, identifying and supporting women who

experience PNMH problems, and making referrals to secondary mental health services as appropriate. It is worthy of note that MWs and HVs also have other responsibilities within their job role, such as physical health checks, alongside mental health responsibilities. The numerous contacts during routine care within the perinatal period and overlap in roles to support women with PNMH problems provide opportunities for interdisciplinary partnership working between MWs and HVs to facilitate PNMH care of women.

1.7 Access to perinatal mental health services: Primary care and secondary care

The NHS is divided into different levels of care: primary, secondary and tertiary care but the latter is not discussed here. Primary care is often the first point of contact for most people in need of healthcare, can be accessed by self-referrals from individuals and include services such as GPs, MWs, HVs, dentists, opticians and pharmacists. Many conditions can be managed in primary care (Sampson *et al*. 2015) and Bauer *et al.* (2014) report that 90% of women with PNMH problems are managed in primary care. Typically, primary care management options available to MWs and HVs for women in need of PNMH care are non-directive counselling (listening visits) (Turner *et al.* 2010; Leonard *et al.* 2019), referrals to: GPs and Improving Access to Psychological Therapies (IAPT) (National Collaborating Centre for Mental Health 2018) services, giving general advice such as coping strategies and sign-posting to local support groups (DOH 2009; NICE 2014). Women requiring specialist PNMH care, for example, those with moderate to severe mental ill-health disorders that cannot be managed in primary care, necessitate referral to secondary care, usually in hospitals as inpatients or outpatients, and are referred by a primary care clinician (e.g. GP, HV, MW) (Sampson *et al*. 2015). MWs and HVs play a crucial role in

referring women for secondary mental health care, including specialist PNMH care where available. Throughout this thesis 'secondary care' and 'specialist care' are used interchangeably and refer to the specialised PNMH care women receive beyond primary care which is discussed in Chapter Two.

1.8 Midwives' and health visitors' perinatal care pathway

During the perinatal period women are offered regular contact with their MW and HV as part of routine perinatal care, with a wider multi-disciplinary team available for additional care needs. Women who require further support will be offered additional contacts/appointments as necessary. Figure 1.1 below shows the timeline for routine appointments that MWs and HVs offer to women during the perinatal period as discussed in section 1.1.

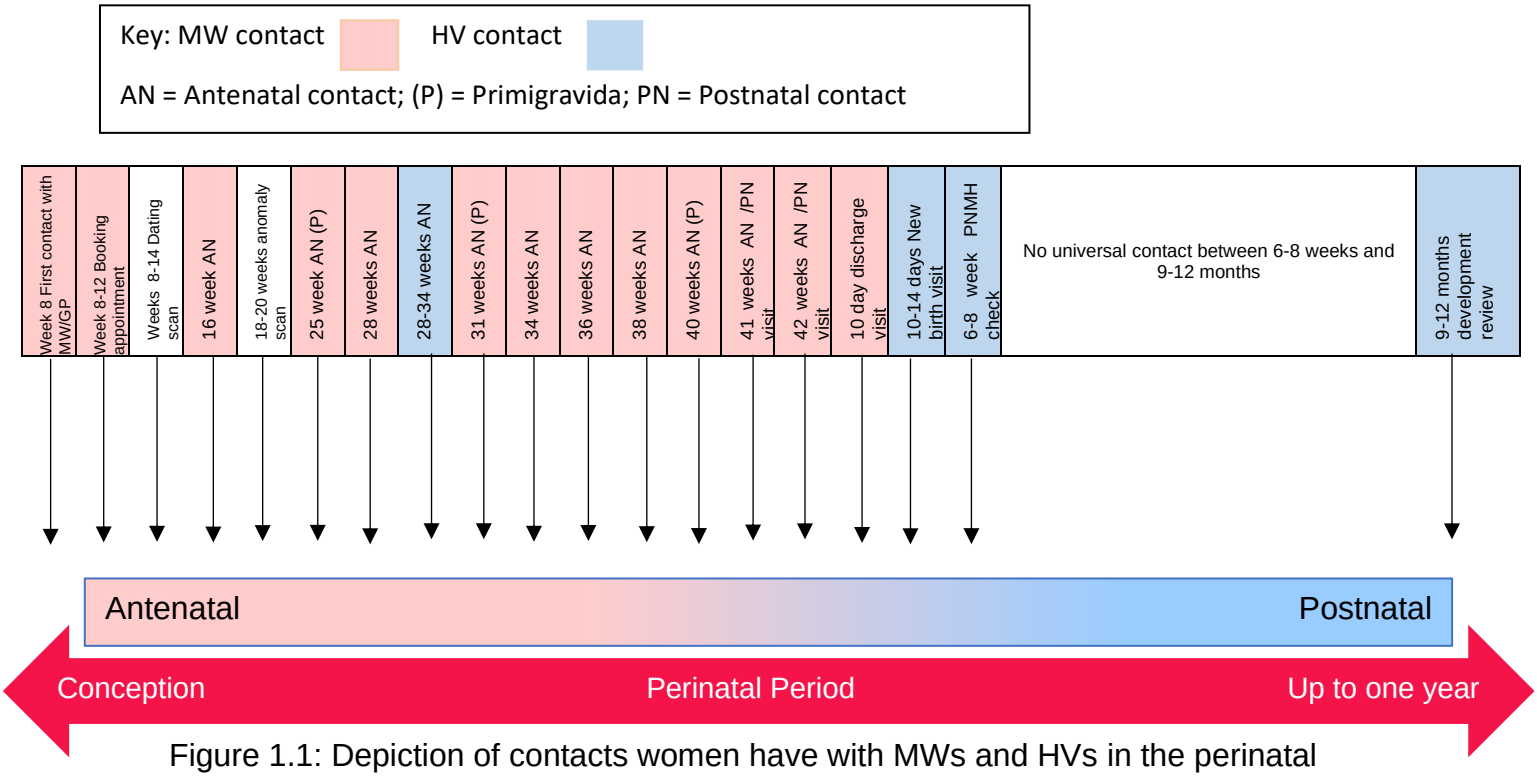


Figure 1.1: Depiction of contacts women have with MWs and HVs in the perinatal period adapted from NICE CG62 (2008) and Shribman and Billingham (2009).

1.9 Screening

Screening has been defined by the UK National Screening Committee as:

"the systematic application of a test or enquiry to identify individuals at sufficient risk of a specific disorder to warrant further investigation or direct preventive action, amongst persons who have not sought medical attention on account of symptoms of that disorder" (Department of Health 2000, p.6).

Since an estimated 50% of cases of PNMH disorders go undetected (Redshaw and Henderson 2016), it is important to routinely screen all women for PNMH disorders (Cox and Holden 2003; Henshaw and Eriksen 2015). Over the last 20 years a number of short, mental health screening tools have been designed which have been found to be both accurate at detecting risk of prevalence of mental health problems and practical in terms of being easy to administer (van Heyningen *et al*. 2018). MWs and HVs have reported not having time nor training to administer complicated diagnostic assessments (Ali *et al*. 2016) therefore, short screening tools that can be incorporated into primary care services such as maternity clinics and the community and that are efficient to use, are important attributes of a screening tool (Ali *et al*. 2016; Kroenke *et al*. 2003; Cox and Holden 2003). There is a lack of consensus and clear guidance on which screening tools to use in the perinatal period. However, there are a number of validated tools that are commonly used during this time. It is not the remit of this chapter nor thesis to provide a comprehensive review of all the available screening tools, instead a brief overview of tools recommended by NICE (2014) and those tools most frequently used by MWs and HVs of this study are provided.

1.9.1 Whooley questions

NICE (2014) recommends that HCPs routinely inquire about women's past and current mental health and suggest women are asked the following questions at their first contact with primary care and in the early postnatal period:

Whooley questions: *During the past month, have you often been bothered by feeling down, depressed, or hopeless?* (Yes = 1/No = 0)

During the past month, have you often been bothered by having little interest or pleasure in doing things? (Yes = 1/No = 0)

The Whooley questions (Whooley *et al*. 1997), sometimes referred to as the depression identification questions, screen for major depressive disorders in the general population and effectively rule out depression when a 'No' response (negative test) is given to both questions, and a 'Yes' response to one or both questions (positive test), identifies practically all woman who may require further assessment (cut off point ≥1) (Whooley 2016). If the Whooley questions elicit a positive response to either question then HCPs can follow this up with a third question: *"Is this something with which you would like help?"* (Arroll *et al*. 2003).

1.9.2 PHQ-2 and PHQ-9

The most commonly used screening tool in primary care is the Patient Health Questionnaire (PHQ) (Mitchell *et al*. 2016). Kroenke *et al*. (2003) produced a virtually identical tool to the Whooley questions, the 2-item Patient Health Questionnaire (PHQ-2), with a different time frame (last two weeks compared to during the past month), and a multiple choice response format (compared to the binary response Yes/No format).

PHQ-2: *Over the last two weeks, how often have you been bothered by feeling down, depressed, or hopeless?*

Over the last two weeks, how often have you been bothered by having little interest or pleasure in doing things?

The PHQ-2 uses a Likert scale score range: 0 = Not at all, 1 = Several days, 2 = More than half the days, 3 = Nearly every day. A cut off score of ≥ 2 or ≥ 3, indicates a risk for depressive disorder (Kroenke *et al.* 2003).

PHQ-9 (Kroenke *et al*. 2001) (See Appendix 1) is a 9-item self-report questionnaire designed to screen for depression and asks respondents how often they have been bothered by problems in the last two weeks. Items are rated using the same 4-point Likert-type scale as the PHQ-2 above. Total scores are rated as: 0-4 = no depression, 5-9 = mild depression, 10-14 = moderate depression, 15-19 = moderately severe depression or 20–27 = severe depression. A cut off score of 10 is suggested as indicating a possible diagnosis of depressive disorder (Kroenke *et al*. 2001).

1.9.3 GAD-2 and GAD-7

NICE (2014) also recommends primary care HCPs consider asking about anxiety using the 2-item Generalized Anxiety Disorder scale (GAD-2) (Spitzer *et al*. 2006):

GAD-2*: Over the last two weeks, how often have you been bothered by feeling nervous, anxious or on edge?*

Over the last two weeks, how often have you been bothered by not being able to stop or control worrying?

Similar to the PHQ-2, the GAD-2 comprises the first two questions of the GAD-7 (Spitzer *et al*. 2006). Score range: 0 = Not at all, 1 = Several days, 2 = More than half the days, 3 = Nearly every day. A score of ≥3 is considered a positive screen and NICE (2014) recommends that a further assessment using the GAD-7 or referring

the woman to her GP or, if a severe mental health problem is suspected, to a mental health professional. The GAD-2, together with the Whooley questions, are sometimes referred to by MWs and HVs in clinical practice as the universal PNMH questions.

The **GAD-7** (See Appendix 2) was developed as a brief screening tool for generalised anxiety disorder (GAD) consisting of seven items asking respondents about some of the main generalised anxiety disorder symptoms (for example, excessive worrying, trouble relaxing) experienced in the previous two weeks (Spitzer *et al*. 2006). A score of ≥10 on the GAD-7 represent a cut off point for identifying cases of GAD. Scores of 0-4 = minimal anxiety, 5-9 = mild anxiety, 10-14 = moderate anxiety and scores of 15-21 = severe levels of anxiety on the GAD-7 (Spitzer *et al*. 2006).

1.9.4 Edinburgh Postnatal Depression Scale

According to NICE (2014), if women respond positively to either of the Whooley questions above, they are at risk of developing a mental health problem, or there is clinical concern, for example, a history of mental illness, a history of previous PP or first degree relative with PP (NICE 2014), then HCPs should consider using the Edinburgh Postnatal Depression Scale (EPDS) (Cox *et al*. 1987) (See Appendix 3) or the 9-item PHQ as part of a thorough assessment. In the EPDS women are asked to read 10 statements and choose one of four possible responses related to their mood as they have experienced it in the previous seven days (Cox *et al*. 1987). Each EPDS item is scored 0-3; 0 = normal response score and 3 = the severe response score. Each item is then totalled to give an overall score. Women who

score 10, 11, and 12 should have a repeat EPDS 2-4 weeks after, and a total score of ≥12 indicates the woman should receive a further assessment (Cox *et al*. 1987) by an appropriate clinician, preferably a member of a PNMH team (Cox and Holden 2003).

Screening tools developed against a 'gold standard' diagnostic criteria for depression and anxiety such as DSM-5 (Diagnostic and Statistical Manual of Mental Disorders) criteria (American Psychiatric Association 2013) or ICD- 10 (International Statistical Classification of Diseases) (WHO 2019) have increased validity and credibility. The aforementioned tools were developed using 'gold standard' criteria. It is worthy of note that diagnosis for depression and anxiety based on somatic symptoms that meet DSM criteria such as fatigue, change in appetite, palpitations, lack of energy and poor self-esteem are symptoms associated with the normal physiological and psychological changes in pregnancy, the puerperium and postnatal period (Biaggi *et al*. 2016; Nath *et al*. 2018). Thus, the potential for false positives is possible with the use of screening tools when women respond positively to questions relating to such symptoms specifically referred to in some screening tools, for example, GAD-7. However, whilst some symptoms are associated with the normal physiological and psychological changes in pregnancy and postpartum, the specialist training of MWs and HVs (outlined in sections 1.5 and 1.6) facilitates the identification of women who are not experiencing the normal adjustments to pregnancy/motherhood.

1.10 Overview of NICE guidelines for clinical management of antenatal and postnatal mental health

NICE (2014) guidance apply to all HCPs (including MWs and HVs) who recognise, assess and refer women for mental health interventions in the perinatal period and offer guidance for primary and secondary care services to support effective identification and treatment of most mental health problems during this time.

Briefly, the key priorities for PNMH care according to NICE (2014) are: for HCPs to offer preconceptual advice/support for women with existing or previous mental health problems on how pregnancy and childbirth may affect mental health problems (including the risk of relapse) and how mental health problems and its treatment might affect the woman, the fetus/baby and parenting; and provide a care plan for women with PNMH problems. NICE (2014) also recommend that mental health professionals provide detailed advice regarding treatment decisions, and monitor women who are planning a pregnancy, pregnant or in the postnatal period; and HCPs working in primary care and those caring for women in mental health services to assess the level of need/support for women experiencing PNMH problems. Further key priorities, according to NICE (2014), suggest that HCPs monitor women's mental health by using validated self-report questionnaires, such as the EPDS, PHQ-9 or GAD-7; HCPs ensure that all women who have or are suspected of having a severe mental illness, or have a history of severe mental illness are referred to secondary mental health services (preferably a specialist PNMH service) for assessment and treatment and the referral communicated to the woman's GP; for primary HCPs (such as MWs and HVs) to be alert for possible symptoms of PP in the first two weeks after childbirth in women with past or current severe mental illness or women at risk of experiencing PNMH problems, and to ensure that women

with a sudden onset of PP are referred to secondary mental health services (preferably a specialist PNMH service) for immediate assessment (within four hours of referral) (NICE 2014). In short, HCPs have a responsibility to identify, assess, support and refer women with PNMH problems or those at risk of developing a PNMH problem, most notably women with existing/pre-existing mental illness and women with a family history of severe perinatal mental illness or a history of first degree relative with a mental illness. NICE (2014) also provides detailed guidance on the use of psychotropic medications and treatments for women with PNMH problems, not discussed here.

1.11 Brief outline of research question and design

PNMH problems are common and have wide ranging, adverse consequences for women, their wider family and cost implications to the state. Despite women being offered routine contact with HCPs during the perinatal period, particularly MWs and HVs, PNMH problems go undetected and untreated. Therefore, in an attempt to explain why women experiencing PNMH problems or women at risk of developing PNMH problems fail to receive timely referrals, this research set out to understand MWs' and HVs' decision-making in relation to referring women for secondary PNMH care to identify barriers and facilitators to effective and timely referrals. Importantly, since it is acknowledged that PNMH services across the UK (and internationally) are inconsistent in coverage and quality, this research aimed to explore the impact of local specialist PNMH service provision on MWs' and HVs' decision-making when referring women for secondary PNMH care.

The research employed a sequential, mixed methods research design comprising three phases which included qualitative, semi-structured interviews (Phases 1 and 2) and a quantitative questionnaire (Phase 3), details of which are covered in Chapters Three, Four, Five and Six. The research was conducted in two geographical areas selected because they each provided different levels of PNMH service provision; one area had specialist PNMH services and the other area did not. Specifics of the PNMH services provided by the two geographical areas are provided in detail in Chapter Four.

1.12 Thesis outline and structure

This thesis comprises seven chapters. **Chapter Two** provides a review of the literature relating to PNMH and explores a broad range of literature including: an overview of provision for PNMH services, PNMH screening practices, PNMH training/education and clinical decision-making in context to this study. This chapter concludes with identifying areas for further research and details the overall research question and aims of this thesis.

Chapter Three outlines the research methodology underpinning this research. Firstly, the epistemological assumptions and limitations are considered, followed by the rationale for the chosen methodological and philosophical decisions regarding this research.

Chapter Four presents the methods and findings from the first qualitative phase of this research with midwifery managers and health visiting clinical[2] leads in the two geographical areas chosen for the research. This phase was undertaken to understand current levels of PNMH service provision, local protocols for PNMH assessment and PNMH referral pathways amongst the participating research sites.

Chapter Five presents the methods and findings from the second qualitative phase with a purposive sample of MWs and HVs in the two geographical areas whereby semi-structured interviews explored MWs' and HVs' experiences and views of decision-making regarding referring women for PNMH care. The presentation of the findings is structured around the themes that emerged from the thematic analysis of the interview transcripts. Strengths and limitations of this phase are considered. The chapter concludes with a preliminary discussion of the findings.

Chapter Six presents the methods and results from the third and final phase of this research with a larger sample of MWs and HVs in the two geographical areas to examine and compare PNMH referral decisions using a bespoke questionnaire. A summary of the results of the statistical tests undertaken is provided followed by a preliminary discussion of these results. This chapter includes the strengths and limitations of the quantitative phase.

[2] These are essentially the same role but use different titles according to their respective profession, e.g. midwifery managers and health visiting clinical leads

The final chapter, **Chapter Seven** integrates the results from the first and second, qualitative phases and the third and final, quantitative phase and presents a discussion of the integrated findings. Overall strengths and limitations of this research are discussed. It includes a summary of the contributions to knowledge made. The chapter concludes with recommendations for practice and suggestions for future research.

CHAPTER TWO

A narrative review of the literature related to perinatal mental health referral decision-making among midwives and health visitors

2. 1 Introduction

This chapter provides a narrative review of the literature. For the purpose of conducting a comprehensive literature review, two distinct aspects of literature were explored. Firstly, a broad range of literature related to PNMH was identified. This included an overview of secondary PNMH service provision with a particular focus on UK provision, women's satisfaction and outcome data on PNMH provision, PNMH training/education and screening practices among MWs and HVs, and addressing barriers to accessing secondary PNMH care. Secondly, this review explored clinical decision-making among MWs and HVs in relation to referring women for PNMH care. Due to the paucity of research directly related to PNMH referral decision-making among MWs and HVs, clinical referral decision-making among MWs and HVs more broadly has been examined in order to draw parallels with PNMH referral decision-making specifically. Since this review explored a wide range of literature, a systematic review was not undertaken, however, a systematic approach to exploring and searching the literature was employed as outlined in section 2.2.

2.2 Search strategy

In order to identify literature pertaining to the two distinct aspects outlined above, a search of the literature was conducted using four health-related databases (See Table 2.1 for list of databases used and summary of literature search process employed). An internet search using Google Scholar and hand searching of journal reference lists from key articles already identified were also employed in the search process. Keywords such as: midwife/ives, health visitor/ing, perinatal mental health/care, service provision, protocols, clinical decision-making, decision making theory/theories, clinical judgement, referral processes and referrals were used anywhere within the article using AND/OR combinations. The * truncation symbol was used in order to include different forms of the same term, e.g., midwi* for midwife, midwifery or midwives, health visit* for health visitor for health visiting, refer* for referrals, referring, referral process. Database alerts were also created to identify newly published literature related to the key search terms above.

Table 2.1: Methods for Literature Search

Databases used	**CINAHL (Cumulative Index of Nursing and Allied Health Literature), MEDLINE, PubMed and PsychINFO and Google Scholar**
Key search terms used with AND/OR combinations	• Perinatal mental health/care, mental health/illness, service provision, psychiatric care/services, perinatal mental health screening/tools, perinatal mental health training/education, primary care, secondary care, Mother and Baby Unit, perinatal disorders, peri/postnatal depression, peri/postnatal anxiety, postpartum/puerperal psychosis, bipolar disorder, midwife, health visitor, referrals, referral processes • Clinical decision-making, decision-making theory/theories, clinical judgement, referral decisions
Review article abstracts	Article abstracts were reviewed and relevant articles were included
Review reference list of selected articles	Reference lists of selected articles were reviewed to identify further relevant literature
Database alerts	Database alerts were set up to identify newly published literature using the keywords listed above and identify work by key authors

2.3 Overview of secondary perinatal mental health service provision

2.3.1 In-patient perinatal mental health care

PNMH service provision is variable across the UK and varies considerably across countries. This review includes research relating to UK PNMH provision and also includes international literature relating to PNMH provision to allow differences and similarities to be made with the UK, particularly literature originating from countries that have similar PNMH services to the UK, e.g. Australia. Recently, Brockington *et al*. (2017a) explored worldwide distribution of specialist PNMH services from all nations with at least five million population and more than twice the mean world gross domestic product (GDP) per head, (assuming these countries would have some provision for mothers and infants, as some nations with a lower GDP, such as Brazil, India and Turkey, had some PNMH provision). They discovered that the UK had only half of the number of Mother and Baby Units (MBUs) in-patient beds required (this assessment was based on the requirement of five in-patient beds per million population (Brockington *et al*. 2017a). MBUs are specialist services that allow mothers with severe PNMH problems to be admitted jointly with their infant, while the mother is treated, to promote the relationship of the mother/infant dyad (Wai Wan *et al.* 2007). Brockington *et al*. (2017a) highlighted that international PNMH service provision is also under resourced as a similar picture of MBU availability was found in countries such as France, New Zealand and Switzerland whilst countries such as Denmark and Sweden did not have any specialist provision. Australia was identified as the nation with the most comprehensive spread of PNMH services although some of these services were private and therefore not accessible to all women (Brockington *et al*. 2017a).

Research by Castro *et al*. (2015) compared perinatal-psychiatric service delivery in Switzerland and the UK using a survey across two time points, 2000 and 2007, and by accessing published reports in the UK from 2000-2012; and found that although the number of MBUs has increased in both the UK and Switzerland, in-patient and primary care PNMH services were insufficient to meet the estimated demand of women requiring specialist PNMH care (Castro *et al*. 2015).

Fewer than half of mental health trusts/health boards in the UK provided specialist MBUs just over 10 years ago (Elkin *et al*. 2009). In 2016 the NHS published The Five Year Forward View for Mental Health (FYFMH) which set out clear objectives for expanding the provision for specialist PNMH care and improve mental health care in England and was a driver for change in PNMH service provision (NHS England 2016). UK data from the Maternal Mental Health Alliance (MMHA 2021) showed that currently there are only 22 MBUs across the UK providing a total of 169 in-patient beds (See Figure 2.1). Using the requirement for in-patient beds based on Brockington *et al*'s estimation (five beds per million population), with a UK population in excess of 66,700,000 (Office for National Statistics [ONS] 2019), the number of MBU beds needed in the UK is estimated at 333. Current UK MBU bed availability falls short of this number by 164 beds. Large areas of the UK have no specialised PNMH services (Castro *et al*. 2015) and where specialist services exist,

approximately as few as 5% of women having recently given birth gain access to these services (Brockington *et al*. 2017a).

Figure 2.1: Mother and Baby Units in the UK adapted from MMHA (2021)

Location has been found to be a barrier to accessing specialist PNMH care for some communities, particularly rural communities (Judd *et al*. 2011). Due to the variance in service provision, some women have to travel long distances to a MBU (Lever Taylor *et al*. 2019) or are treated in a general adult mental health ward without their babies (Castro *et al*. 2015). Connellan *et al*. (2017) reported that MBUs are favourable settings for interventions and programmes of care that lead to positive outcomes for women meeting the admission criteria. Since the evidence suggests that almost half of all women in the UK do not have access to specialist PNMH services (Bauer *et al*.

2014) this raises the question of what pathways of care are available to women living in areas that are deprived of specialist PNMH services.

2.3.2 Community-based perinatal mental health care

Encouragingly, the latest figures by the MMHA (2020) on UK coverage of PNMH CMHTs found that 80% of Clinical Commissioning Groups (CCGs) in England had specialised PNMH community teams that met Perinatal Quality Network Standards (Royal College of Psychiatrists [RCPsych] Centre for Quality Improvement 2020). However, Wales, Scotland and Northern Ireland had only 29%, 14% and 0% coverage respectively (MMHA 2020). Davies *et al*. (2018) conducted an online survey that aimed to identify what type of interventions were offered by Perinatal Community Mental Health Teams (PCMHTs) across the UK over a two month period. The survey was sent to 23 PCMHTs who were registered with the RCPsych Perinatal Centre for Continuous Quality Improvement (CCQI) as these teams were anticipated to be well established and meet commissioning guidelines for PNMH services (Davies *et al*. 2018) as set out by the Perinatal Quality Network Standards (RCPsych 2020). Of the 23 teams contacted, 17 (74%) responded. The psychological therapies offered by each of the PCMHTs ranged from one to eight with a mean of four different therapies being offered. The number of psychological interventions most frequently offered by the PCMHTs were Cognitive Behavioural Therapy (CBT) (59%), attachment and bonding interventions (59%), and mindfulness (47%), Eye Movement Desensitization Reprogramming (EMDR) (35%), Acceptance and Commitment Therapy (ACT) (24%) and Parent-Infant interventions, including Video Interactive Guidance (VIG) (18%) (Davies *et al*. 2018). These therapies were delivered in various settings by the PCMHTs: home visits (59%), GP surgeries (41%), out-patient settings (24%) and hospital settings (18%) (Davies *et al*. 2018). A

limitation of this study acknowledged by Davies *et al*. (2018) was that since the survey was designed to not over burden the busy respondents completing it, background information that may have clarified respondent answers such as the range of disorders treated, the staff included in the PCMHTs and local provision for psychological interventions within other local services were not collected. A further limitation of this study was that participation was restricted to current registrants of the RCPsych CCQI and many more CMHTs may have been working with this population of women and providing treatment therapies. Although the MMHA (2020) report that the majority of England has PNMH CMHT provision, similar to in-patient services, community provision is variable across the four UK nations.

2.4 Womens satisfaction and outcome data of specialist perinatal mental health services

The literature indicates that women with PNMH disorders who require in-patient admission prefer being treated in a MBU compared to a general psychiatric ward (Antonysamy *et al*. 2009; Meltzer-Brody *et al*. 2014; Higgins *et al*. 2016; Connellan *et al*. 2017). A patient satisfaction survey of women discharged from a MBU in the UK, found all 57 participants preferred being admitted to a MBU compared to a general psychiatric ward (Antonysamy *et al*. 2009). An important limitation of this research is that the participants of Antonysamy *et al*'s, (2009) study included in-patient women of a MBU only and did not provide comparisons of perinatal women from a general psychiatric ward.

An Australian study that aimed to analyse outcome data and service user feedback of an innovative 'Early Motherhood Service' providing specialist PNMH care to rural communities, found that 84% of the 107 women who completed feedback forms felt

very satisfied with the service (Judd *et al*. 2011). However, the 'Early Motherhood Service' comprised a dataset of 527 women referred to the service and it was not clear why so few women completed feedback forms. It may be that those women who did not complete feedback forms may not have had felt satisfied with the service. Feedback from forty women who participated in qualitative interviews about accessing a Perinatal Infant Mental Health (PIMH) service in Australia found the service had a positive impact on their well-being and recovery (Coates *et al*. 2017). However, in this research, Coates *et al*. (2017) approached 162 eligible women to take part and only 40 women agreed to be interviewed; thus, those women not willing to be interviewed may have had different views of the service. Furthermore, qualitative interviews for this study lasted between five and 25 minutes leading to reservations regarding the depth of data that can be explored during five minute interviews.

Although these studies have small sample sizes, they indicate a high level of satisfaction among women receiving specialist PNMH care (Antonysamy *et al*. 2009; Judd *et al*. 2011; Coates *et al*. 2017). Similar results were found in a large patient satisfaction survey conducted in North America where 73% (n=578) of the 800 women surveyed, stated they found the PNMH programme delivered at a mother-baby psychiatric day hospital, was helpful to them and over 87% (n=695) of women would recommend the service to others (Battle and Howard 2014). While these authors addressed the acceptability of the approach to care offered by the specialist PNMH services to women, most of the above studies (Antonysamy *et al*. 2009; Judd *et al*. 2011; Battle and Howard 2014) did not address effectiveness of the services in terms of outcomes.

Much of the research to date suggests that outcome data for women admitted to MBUs is encouraging in terms of recovery and symptom improvements. Meltzer-Brody *et al*. (2014) assessed the severity of perinatal psychiatric illness and other comorbid psychiatric symptoms in perinatal women admitted to a specialist perinatal psychiatric in-patient hospital in the USA within 24 hours of admission and within 24 hours of discharge. They found a significant reduction in symptoms of depression and anxiety and an overall improvement in functioning at discharge (Meltzer-Brody *et al*. 2014). There are, however, limitations to this study; it had a moderate sample size (n=91), data were collected from specialist psychiatric in-patients only so results may not be generalisable in different settings and no long term follow up data was provided to assess ongoing treatment response following discharge.

Using data obtained from clinical profiles of women admitted to an Australian MBU (n=191) at admission and discharge using a variety of self-report measures, Christl *et al*. (2015) showed significant decreases in EPDS scores from admission (mean score 19.28) to discharge (mean score 8.83). Overall, scores revealed that 73% of participants showed EPDS scores that indicated recovery, i.e. <13. Although these studies indicated promising short-term results, they did not provide long-term outcome data of women admitted to specialist PNMH services. However, more recently, Reilly *et al*. (2019) examined trajectories of clinical outcomes for women following admission to a private Australian MBU (n=75) using self-report measures at admission, discharge and three month follow-up. The authors found that scores for anxiety, depression and stress were reduced at discharge compared to admission scores, although a significant number of women showed increased symptoms for depression and stress at the three month follow-up. Neither of the above studies

included controlled comparisons with women receiving PNMH care in different settings, and both authors acknowledge this as a limitation and suggest future studies would benefit from using a controlled study design.

An evaluation of a community PNMH service in Australia found a significant reduction in depressive and anxiety symptoms in women receiving the service and increase in women's perceptions of coping with parenting (Harvey *et al*. 2018). The service was offered to women with mild to moderate PNMH disorders such as depression and anxiety disorders, and delivered in a variety of venues including GP practices, hospital out-patient departments, community health sites, kindergarten and home visits for housebound women following caesarean delivery (Harvey *et al*. 2018). The service consisted of 1 – 6 appointments providing specialist PNMH assessment and brief intervention and treatment services. Outcome data using a variety of self-reported measures (EPDS, Parent Coping Scale [PCS] and Health of the Nation Outcome Scale [HONOS]) was obtained on 104 women using the service between June 2015 and May 2017. Harvey *et al*. (2018) found statistically significant improvements in EPDS, PCS and HONOS scores from initial pre-intervention mean scores and final follow up mean scores. The authors acknowledge that using a randomised controlled design would have reduced bias. A further limitation of this study was that the time period between pre and post measure ranged from a few weeks to a few months. According to Coster (2013), selecting outcome measures to determine whether a particular instrument is appropriate to measure outcomes of a clinical intervention or program is only the first step. The second consideration is whether the selected measure is sensitive to the degree of change expected from the intervention (Coster 2013). It could be argued that women completing outcome

measures after a few months may have improved over time and not necessarily improved due to the intervention. Using a fixed timescale to measure follow up scores may have demonstrated effectiveness of the intervention. Harvey *et al*. (2018) acknowledged that a limitation of their study was it did not measure long term follow up (time period not defined) so it was unclear if the improvements were maintained.

Recent research by Geller *et al*. (2018), using outcome data from self-reported validated measures used to capture symptom and functional status at three time points from women attending a mother-baby PNMH day treatment programme, showed significant improvements in depressive symptoms, maternal functioning, birth trauma symptoms, emotional regulation, perceived stress and parenting stress. Parent and baby day units (PBDU) are specialised mental health day units offering high intensity, customised treatment to women with PNMH problems using group interventions and mother-infant dyad behavioural observations (Boath *et al*. 2004; Geller *et al*. 2018). This American study used data from seven self-reported measures on 47 women attending the day unit programme. The self-reported measures ranged from 10-item scales (EPDS) to 36-item scales (Difficulties in Emotional Regulation Scale [DERS]) and were recorded at enrolment on the programme, four weeks after enrolment and on discharge. Overall, mean symptom and functioning scores were improved over the course of participation through to discharge. Requesting outcome data at three time points using seven different measures appears a sizeable patient burden and it could be argued is a limitation of this study considering these women were in the perinatal period and thus responsible for caring for their infants. Another limitation is that of the 47 women

enrolled in the programme, only 20 women completed outcome data at discharge. The missing data from the remaining 27 women may have presented different data that may or may not have been favourable about the service as 19 of these women did not complete the programme.

In addition to the positive outcomes for women, some studies have shown positive outcomes for infants and children of mothers admitted to MBUs. Hill *et al*. (2019) conducted a small retrospective audit of clinical records of women with PP admitted to an Australian MBU over a five year period (n=25) to examine the health and wellbeing of co-admitted infants. Hill *et al*. (2019) found that on discharge, infants were found to be physically well, with normative growth and over a third were able to continue breastfeeding (36%, n=9). However, these results were based on clinical observations only and did not use standardised measures of infant growth and development which has the potential to introduce inaccuracies as a result of relying solely on clinical observations. Similarly, Wai Wan *et al*. (2007), conducted a feasibility study to compare the cognitive, behavioural, emotional and attachment outcomes of children whose mothers were admitted to a UK MBU (n=15) with those of offspring of well mothers not admitted and with standardised norms. Wai Wan *et al*. (2007) found 84% of children were still living at the same address as their mother 4-6 years after discharge from the MBU and showed no evidence of poorer emotional, social or cognitive development based on a variety of measures (i.e. observational, mother-reported and teacher-reported measures) than comparative standardised norms. This study had a small sample size and 13 of the 15 women were married which may not be reflective of a representative sample of women.

There appears to be a consensus in the literature that specialist PNMH services, be they in-patient or outpatient, are positively endorsed by women service users (Antonysamy *et al*. 2009; Judd *et al*. 2011; Millet *et al*. 2017) and effective in terms of positive outcomes for mothers and babies (Wai Wan *et al*. 2007; Meltzer-Brody *et al*. 2014; Christl *et al*. 2015; Hill *et al*. 2019) at least in the short-term (Reilly *et al*. 2019). Although much of the previous research had small sample sizes and did not use a controlled study design, findings suggest admission to MBUs appear to offer optimal recovery for women and minimise long-term adverse outcomes for infants, and interventions offered by PNMH CMHTs offer outcome improvements in the short term.

2.5 Healthcare professionals' perceptions of perinatal mental health service provision

2.5.1. Availability of perinatal mental health services

Studies have shown that MWs and HVs consider PNMH service provisions are inadequate to manage women's PNMH needs in the UK (Rothera and Oates 2008; Chew-Graham *et al*. 2009; McGookin *et al*. 2017; Edge 2010; Jomeen *et al*. 2013; Ashford *et al*. 2017; Bayrampour *et al*. 2018; Smith *et al*. 2019). Ashford *et al*. (2017) conducted semi-structured interviews to explore HVs' experiences of supporting women with perinatal anxiety and found that HVs in this study could refer to the following services: GP, IAPT, psychiatric services, PNMH services and children centres. However, the 13 participants were from seven NHS Trusts across the UK and thus, it was not clear how many of these services were available to each individual HV participant. Nonetheless, there was a consensus amongst the HVs that

there was a lack of PNMH services generally and that services were ‘patchy’, dependent on geographical area and ‘inadequate’ (Ashford *et al*. 2017, p.1262).

A key issue identified by Jomeen *et al*. (2013), who conducted two focus group discussions with HVs from two NHS Trusts in the North of England, was that HVs reported a lack of service provision once a PNMH issue had been identified. HVs found the lack of provision frustrating and anxiety provoking: *“…sometimes, you can go into a family, and you can think yeah this is definitely depression, … then it’s referring on … but then, if the referral process falls down, what do you do?”* (Jomeen *et al*. 2013, p.484). In contrast, availability and access to PNMH services gave HVs confidence to support their decision-making and created feelings of security in the knowledge they had services to refer to (Jomeen *et al*. 2013). It is noteworthy that in this study, each focus group consisted of four HVs, three of whom took part in both focus groups. One of the values of focus groups lies in the opportunity they provide to participants to be exposed to a range of viewpoints (Holloway and Galvin 2017) where members can react to what is being said (Polit and Beck 2012). It could be argued that since three of the four participants took part in both focus groups the range of views were limited. Typically, focus groups last around two hours (Polit and Beck 2012); the length of the focus groups was not stated by the authors and thus the depth of exploration was unclear. Nevertheless, Jomeen *et al*. (2013) highlighted the difference that the availability of service provision had on HVs confidence when making decisions in clinical practice.

Rothera and Oates (2011) invited 2872 HCPs (Obstetricians, MWs and HVs) from the East Midlands to complete a self-reported survey to examine their views relating to the identification, treatment and management of mental health disorders in childbearing women, and to identify areas where problems existed. A total of 768 HCPs responded (response rate 27%). Almost half of the HCPs (40.1%, n= 308) surveyed perceived their services for supporting women with mental health problems were inadequate. HCPs reported services were needed in terms of provision for women such as specialist perinatal psychiatric services (Rothera and Oates 2011). However, Rothera and Oates (2011) acknowledge the low response rate and single catchment area confined to the East Midlands as limitations as their findings may not be representative of practitioners' views on a national level.

More recently, Smith *et al*. (2019) conducted a systematic review of barriers to accessing mental healthcare for women with PNMH problems from women's and healthcare providers' perspectives in the UK. This review revealed multilevel barriers to accessing services such as inadequate resources, poor awareness of PNMH among HCPs and women, negative attitudes towards mental health among women and HCPs, fragmented services and lack of policies from HCPs perspectives. Increases in specialist PNMH services and specialist staff were suggested to be vital strategies in order to address these multilevel barriers (Smith *et al*. 2019).

There is evidence in the literature that PNMH service provision are fragmented. In an attempt to address fragmented care, research suggests the need for PNMH provision to be integrated with existing services (Green *et al*. 2008; Judd *et al*. 2011; Battle and Howard 2014; Millet *et al*. 2017). Structuring specialist PNMH services in

or near existing obstetric services, CMWs or GP services reduced barriers to accessing PNMH care (Battle and Howard 2014). In addition to reducing barriers to accessing specialist care, some authors suggest an advantage of integrated services, where a woman has her mental health assessed in an antenatal clinic, is that women are seen in a non-stigmatising environment (Green *et al*. 2008; Judd *et al*. 2011). The flexibility and integration of PNMH services was recognised by women and stakeholders alike, as recommendations were made for PNMH services to be co-located with maternity services and include outreach services in women's homes (Judd *et al*. 2011; Coates *et al*. 2017). Further advantages of integrated services are that women engage in PNMH care (Battle and Howard 2014), patient satisfaction is enhanced, there are increased perceptions of quality of care and they enable access to services (Baxter *et al*. 2018).

There is agreement in the literature that specialist PNMH services have also been found to be lacking for population specific groups in the UK and internationally, namely the BAME community and women of refugee status (Nithianandan *et al*. 2016; Edge 2010). Services were found to be lacking in areas such as: inadequate interpreting services, inequity of services and service provision for BAME women, HCPs skills and knowledge in communicating with BAME and refugee women, translated screening tools and interdisciplinary collaboration (Nithianandan *et al*. 2016; Edge 2010).

It appears from the literature that HCPs, most notably MWs and HVs, perceive PNMH services to be lacking in areas such as adequate provision, fragmented

services, deficiency of policy guidance in terms of PNMH referral pathways and provision for population specific groups such as BAME women.

2.5.2 MWs and HVs perceptions of perinatal mental health policies/guidelines

There is evidence that MWs and HVs perceive they lack policies and guidelines to manage women's PNMH needs. Rothera and Oates (2011) found that the staff they surveyed wanted access to specialist advice and referral protocols/guidelines (Rothera and Oates 2011). Many studies findings concur with Rothera and Oates and have found that PNMH services are not only needed in terms of specialist PNMH provision for women, but also for HCPs to access specialist advice and referral protocols/guidelines (Bayrampour *et al*. 2018; Carroll *et al*. 2018; Alexandrou *et al*. 2018) and importantly, in some cases the desire for improvements in their own policies and guidelines was over and above their request for improved services for women (Beauchamp 2014; Noonan *et al*. 2017b; Alexandrou *et al*. 2018; Carroll *et al*. 2018).

The desire for clear policies and guidelines reported by MWs and HVs regarding who/when/where/how to refer women for PNMH care and has been highlighted in studies since 2006 (Ross-Davie *et al*. 2006; Chew-Graham *et al*. 2008). Current NICE guidance suggests that clinical networks should be established for PNMH services to include clear referral pathways and management protocols for women with PNMH problems (NICE 2014). However, this does not appear to be the case from the findings of many studies in this review (Beauchamp 2014; Noonan *et al*. 2017b; Alexandrou *et al*. 2018; Bayrampour *et al*. 2018). Higgins *et al*. (2018) surveyed 809 MWs and nurses (including Public Health Nurses, hereafter referred to

as HVs, and Practice Nurses) in Ireland to explore barriers to addressing PNMH issues with women. They found that over two-thirds of the participants (65%, n= 426) reported a lack of clear PNMH policies/guidelines within their services was a barrier to addressing mental health with women. An earlier study by Higgins *et al*. (2017b) who surveyed 186 HVs to explore their knowledge of PNMH issues, perceived skill in providing PNMH care and current practices in PNMH care, found that although 52% of HVs (n= 96/186) reported access to PNMH services, only 42% (n= 79/186) reported access to PNMH policy/guidelines. A survey by Beauchamp (2014) conducted in the East of England to explore factors that may influence HVs (n= 46) use of the Whooley questions found that the lack of referral pathways was a barrier to using the Whooley questions for 48% of respondents (n=22). Similarly, an integrated review by Bayrampour *et al*. (2018) to determine MWs perceived barriers to screening, referral and management of PNMH issues found that inadequate referral pathways were reported in six of the 20 studies in the review. Thus, a lack of referral pathways may have significance for MWs and HVs as it is likely to impact on their clinical decision-making when deciding to refer women for PNMH care when they do not have referrals pathways to consult in clinical practice.

2.5.3 MWs and HVs perception of fragmented care

Numerous studies findings have shown that poor communication between HCPs were perceived to be associated with fragmented care (Nithianandan *et al*. 2016; Higgins *et al*. 2017a; Bye *et al*. 2018; Silverwood *et al*. 2019). Silverwood *et al*. (2019) conducted a qualitative study in the UK to explore HCPs (MWs, HVs and GPs) (n=23) experiences in identifying and managing perinatal anxiety, finding that most HCPs interviewed reported poor communication resulted in fragmented care: *“I think if we had a better way of communicating with our allied health professionals;*

with our MWs; with our GPs … then that would help" (Silverwood *et al*. 2019, p.772). The need for improved communication and integration between services and disciplines has been identified in previous research as a practice priority (Higgins *et al*. 2017a). Despite this, co-location of HCPs did not appear to improve communication between HCPs or improve inter-professional working (Silverwood *et al*. 2019). Health Visiting hubs, where HVs were centrally located, were felt to assist HVs in responding to women more efficiently but perceived by some HVs to compromise opportunities for inter-professional working (Silverwood *et al*. 2019). McCauley *et al*. (2011) suggested that where HCPs were not aware of the locally available services nor had an awareness of the roles of HCPs involved in caring for women with PNMH problems, caused fragmented care.

2.6 Barriers to referring women for secondary perinatal mental health care

2.6.1 Identification of womens' perinatal mental health needs

In order for MWs and HVs to refer women for secondary PNMH care, they must first be able to identify those women in need of referral. Extensive literature revealed that a variety of HCPs (including MWs, HVs, Practice Nurses and GPs) lacked a comprehensive knowledge of PNMH disorders (McCauley *et al*. 2011; Hauck *et al*. 2015; Higgins *et al*. 2017a; Higgins *et al*. 2018; Carroll *et al*. 2018; Noonan *et al*. 2019). Higgins *et al*. (2017a; 2017b; 2018) and Carroll *et al*. (2018) surveyed HCPs to identify knowledge, skills, competence and clinical practices related to PNMH identification, screening and referral. The authors highlighted that although HCPs (including Practice Nurses, MWs and HVs) appeared to have a good awareness of perinatal depression and anxiety in terms of identification, the HCPs appeared to lack knowledge (in terms of identification, risk factors and management strategies) across the broad range of PNMH illnesses, such as: bipolar disorder, obsessive

compulsive disorder, PP, eating disorders, schizophrenia and self-harm/suicide in the perinatal period. Noonan *et al*. (2019) supported these findings and found that of the 105 HVs surveyed, 77.2% (n= 81) had high levels of knowledge and confidence related to identification of stress, anxiety and depression (self-reported rating either very knowledgeable/confident or knowledgeable/confident). Similarly, MWs surveyed by Noonan *et al*. (2018) reported that 63.2% (n= 98 out of 157) perceived themselves to be knowledgeable on stress, anxiety and depression. McCauley *et al*. (2011) highlights that depression and anxiety were found to be the most commonly encountered disorders by MWs in their study, where less than a third of all MWs (n= 161) had encountered bipolar disorder, obsessive compulsive disorder, schizophrenia and mania. Lack of exposure to certain disorders may account for the knowledge deficit of such disorders. In an Australian study, Hauck *et al*. (2015) surveyed MWs using custom-designed questions and vignettes depicting childbearing women with the following disorders: an anxiety disorder, depression, a manic episode and schizophrenia, to ascertain current knowledge and perceived learning needs, and found the depression vignette was most often correctly recognised (93.9%, n= 223/238) whilst schizophrenia was least accurately identified (65.6%, n= 156) which supports the findings of Carroll *et al*. (2018). Thus, the more prevalent PNMH disorders such as depression and anxiety are more frequently identified by MWs and HVs compared to the less commonly encountered and occurring disorders such as bipolar disorder and schizophrenia.

To corroborate the notion of lack of knowledge amongst HCPs, the survey by Rothera and Oates (2011) found over half (65.4%, n=502) of participants would refer women with mild disorders to other services (not specifically outlined by the authors

but included referrals to services such as MBUs, Specialist PNMH CMHTs and general adult psychiatric services) as they were unable to identify the problem and/or provide the appropriate support. Furthermore, a lack of knowledge was apparent where 8% (n= 60, of which, 47 were MWs) of HCPs would refer a woman with a mild disorder to a MBU (Rothera and Oates 2011). However, Rothera and Oates (2011) noted there were differences between professional groups on their perceived need for additional support with managing women's PNMH needs. Significantly more HVs (31.9%, n=88) felt they required no additional support to manage mild disorders compared to MWs (8.3%, n=39) or obstetricians (12.5%, n=3) (Rothera and Oates 2011). This was thought to be due to the frequency in which HVs see women in the postpartum period and HVs being more accustomed to dealing with postnatal illnesses (Rothera and Oates 2011).

Thus, a wide body of literature suggests that MWs and HVs were familiar with and able to identify depression and anxiety disorders in the perinatal period but had limited knowledge of the wider range of mental health disorders/problems such as bipolar disorder, schizophrenia, eating disorders, suicide and self-harm (Jomeen *et al*. 2009; Hauck *et al*. 2015; Noonan *et al*. 2017a; Carroll *et al*. 2018). This presents a cause for concern; some mental health disorders and risk factors, such as a history of bipolar disorder/PP, place women in the perinatal period at high risk of becoming unwell/relapse (Kendell *et al*. 1987; Austin and Priest 2005; Munk-Olsen *et al*. 2009) and highlight the need for these women to receive timely referrals to PNMH services. Therefore, if MWs and HVs were unfamiliar with such disorders and/or the risk factors they may fail to make the appropriate and timely PNMH referrals for these women.

2.6.2 MWs and HVs training and education in perinatal mental health

Closely linked to the lack of knowledge of PNMH disorders was a shortfall in PNMH training which was highlighted in the literature where MWs and HVs required and desired further training. Some studies highlighted training needs specifically related to certain PNMH disorders. Qualitative interviews by Silverwood *et al*. (2019) with HCPs (GPs, MWs and HVs) on their views of the barriers and facilitators to identifying and managing perinatal anxiety found that very few participants had received training specific to perinatal anxiety. Most participants reported that their knowledge was acquired through clinical or personal experiences (Silverwood *et al*. 2019). A mixed methods study carried out by Bye *et al*. (2018) using a survey with women (n= 101) and focus groups with MWs and HVs (n= 33) in the South of England, to understand the barriers to disclosure and identification of eating disorders among women in the perinatal period, found all MWs and HVs reported receiving minimal, if any training on eating disorders. Their main sources of knowledge on eating disorders was the media (Bye *et al*. 2018).

Many authors have identified that the MWs and HVs training on PNMH focused on postnatal depression rather than the broad spectrum of PNMH disorders (Jomeen *et al*. 2013; Higgins *et al*. 2017a and 2018; Carroll *et al*. 2018). Unfortunately, this shortfall in PNMH education and knowledge among HCPs has been highlighted by research for many years (Ross-Davie *et al*. 2007). Ross-Davie *et al*. (2007) surveyed MWs pre and post a one day training session on PNMH and found significant shortfalls in knowledge and confidence particularly in areas such as prevalence of PNMH, risk factors for severe PNMH disorders and signs and symptoms of serious PNMH disorders. In addition, almost twenty years ago Matthey *et al*. (2003) pointed

out that the educational focus on postnatal depression took precedence in the presence of other disorders (i.e. anxiety disorders). Current research suggests that MWs still lack knowledge and confidence to provide PNMH care to women (Coates and Foureur 2019). However, since depression and anxiety are the most common health problems (NICE 2014), and HCPs have vast training demands outside of PNMH, then perhaps the time allocated to PNMH training should focus on the disorders that practitioners are most likely to encounter in clinical practice. It could be argued that this presents justification in favour of having a specialist PNMH practitioner in post; thus, if/when in doubt, MWs and HVs could liaise with specialist PNMH practitioners for advice and support where their own knowledge falls short. Nevertheless, given the associated risks and consequences of some of the rarer but severe PNMH illnesses, such as PP and bipolar disorder, arguably training and education is needed for MWs and HVs that incorporates these disorders.

The need for training in communication skills around enquiring about mental health has also been highlighted in the research (Higgins *et al*. 2018; Carroll *et al*. 2018). Over half of the participants (MWs, HVs and Practice Nurses) (68%, n=402) in Higgins *et al*'s (2018) study perceived they lacked knowledge to discuss mental health issues with women from a range of different cultural backgrounds. Culturally competent communication skills were highlighted as a training need so HCPs were sensitive to how a woman's social and cultural context may impact on her mental health (Nithianandan *et al*. 2016; Higgins *et al*. 2018). Evidence showed that some practitioners were reluctant and/or lacked confidence to broach sensitive subjects such as suicidal ideation (Hauck *et al*. 2015; Carroll *et al*. 2018; Higgins *et al*. 2018). Given that suicide is a leading cause of maternal death (Knight 2020) it could be

argued that it is unacceptable that some MWs, identified by Higgins *et al*. (2018), lacked the necessary skills to broach this subject. Indeed, Higgins *et al*. (2018) suggested that training strategies were needed to include role play and video work to enable HCPs to develop skills to open conversations on sensitive matters that could be incorporated in the first encounters practitioners have with women. MWs in particular appeared to lack confidence when broaching certain sensitive subjects with women and/or finding it difficult to broach mental health in general which supports findings from previous studies (Ross-Davie *et al*. 2007).

Considering that the onset of PP commonly occurs in the first 1 – 4 weeks postnatally (Kendell *et al*. 1987; Sit *et al*. 2006), MWs will have more frequent contact with women during this time than their HV counterparts (Refer to figure 1.1 in Chapter One). NICE (2008) guidance recommends MWs have three contacts with women during this time compared to just one mandated HV contact in the first four weeks postnatally (Shribman and Billingham 2009). Importantly, it is recognised that there is a high risk of suicide in women with PP affecting approximately 4% of women, with a 70-fold increased risk of suicide in the first year after childbirth (Pfuhlmann *et al*. 2002). Considering the prevalence and outcome data on PP, it may be reasonable to assume that MWs are more likely to encounter women experiencing PP in the immediate postnatal period compared to HVs and therefore, need to be aware of the risk factors, signs and symptoms associated with PP and the appropriate management strategy, i.e. referral to specialist PNMH services. Thus, training/education on PP is an area that requires addressing for HCPs and according to Higgins *et al*. (2018), especially for MWs.

In terms of barriers to identifying women for PNMH care, many authors reported a lack of training around the use of screening tools (Beauchamp 2014; McGlone *et al*. 2016; Higgins *et al*. 2017a and 2018; Carroll *et al*. 2018;) and on communicating the results of screening (Milgrom *et al*. 2011). UK-based qualitative interviews conducted by McGlone *et al*. (2016) (n=8) reported that only one MW had received training in relation to the Whooley questions. Likewise, Beauchamp (2014) surveyed 43 HVs to explore the factors that influence the implementation of the Whooley questions in screening for postnatal depression and discovered that only 12% (n=5) had received comprehensive training on using this screening tool. The need for training on using screening tools was identified as a priority, as a lack of training inhibited the use of tools (Beauchamp 2014). McGlone *et al*. (2016, p. 386) found that some MWs did not fully understand the purpose of asking the Whooley questions: *"…I do wonder sometimes what the relevance of some of the questions are…"*, which perhaps raises the issue of lack of PNMH knowledge and the quality of training received by MWs. However, having mental health education/training did not guarantee MWs were equipped with accurate knowledge of screening tools. Hauck *et al*. (2015) discovered that despite almost half of MWs having had recent PNMH education/training, 68% (n= 236) regarded the EPDS as a diagnostic tool rather than a screening tool. Training on communicating the results of screening tests were also needed. Milgrom *et al*. (2011) maintained that HCPs training should include how to communicate an accurate explanation of women's screening results. According to Milgrom *et al*. (2011) informing women they are 'depressed' on the basis of a positive screening result is potentially harmful and inaccurate, where a positive screen only indicates a higher chance of being found to be depressed by a

diagnostic-stage test. Instead, HCPs should provide plain, understandable advice relating to the women's screening results (Milgrom *et al*. 2011).

It appears from the literature that communication skills around PNMH requires addressing amongst MWs and HVs as failure to discuss mental health could potentially miss women who require referral for specialist PNMH care (Higgins *et al*. 2018; Carroll *et al*. 2018; Hauck *et al*. 2015).

2.6.3 Perinatal mental health screening practices among midwives and health visitors

Data obtained from quantitative and qualitative studies showed inconsistencies in MWs and HVs use of screening tools in terms of what tools were used, how they were used and the frequency of use (Jomeen *et al*. 2013; Beauchamp 2014; Bosanquet *et al*. 2015; Higgins *et al*. 2018). According to Jomeen *et al*. (2013), HVs who participated in the research focus group discussions in the North of England indicated that the Whooley questions and/or the EPDS were routinely used in practice. However, when using the Whooley questions, HVs reported using the tool in a non-standardised, flexible manner instead of applying the tool as intended (Jomeen *et al*. 2013), i.e. asking the standard Whooley questions verbatim (Whooley *et al*. 1997). Similarly, research conducted in the East of England by Beauchamp (2014) found that when asking the Whooley questions, almost half (46%) of the HVs asked the questions using their own words. By asking the questions in any other form than its original form affects the reliability of the psychometric properties (Beauchamp 2014).

Despite the Whooley questions having a 95% specificity rate for depression detection (Bosanquet *et al*. 2015), only 21% (n= 9) of HVs found the Whooley questions useful and only 24% (n= 10) had confidence they were effective in detecting postnatal depression (Beauchamp 2014) which may affect HCPs compliance with its use. In contrast to Beauchamp (2014), Jomeen *et al*. (2013) maintained that using screening tools in a flexible, non-formulaic manner with women potentially enables HVs to facilitate broader considerations of the co-morbidities of complex psychosocial and psychological factors. Qualitative interviews by Silverwood *et al*. (2019) identified further findings to those already mentioned; a perceived limitation of using screening tools was that HCPs felt women may deliberately provide a 'normal' response to avoid being identified as having perinatal anxiety.

Evidence in the literature revealed a lack of compliance with UK guidelines (Chew-Graham *et al*. 2008; McGlone *et al*. 2016; Ashford *et al*. 2017; Baker *et al*. 2020) where it advises that all women should receive a mental health assessment using the recommended screening tools (NICE 2014) (as discussed in the Chapter One). Many studies revealed that some professionals, including MWs and HVs, were not aware of current screening guidelines (Ashford *et al*. 2017), used conversational methods to assess womens mental health instead of using screening tools (Baker *et al*. 2020) and/or relied on intuition to alert them to any possible mental health problems (Chew-Graham *et al*. 2008). The lack of compliance for screening was also borne out in international studies in relation to their recommended guidelines for routine screening (McCauley *et al*. 2011; Alexandrou *et al*. 2018). Several studies have highlighted a link between lack of training on using tools and the subsequent

lack of use of screening tools in clinical practice (Beauchamp 2014; Rothera and Oates 2011; Higgins *et al*. 2018) which may account for the non-compliance of the use of screening tools. However, according to their respective standards of practice, both MWs and HVs are required to be proficient in detecting current or emerging health complications in women and make the necessary referrals needed (NMC 2019). Notwithstanding this, the use of screening tools appears to present an area of contention for MWs and HVs. According to NMC standards of practice (NMC 2018, p.4), practitioners must *"work within the limits of their competence"*. Therefore, in instances where MWs/HVs have not been properly trained in using screening tools, this indicates they are adhering to their professional standards of practice and working within the limits of their competence; on the other hand, not using them means they are not following current guidelines. Consideration needs to be given to the current PNMH training around use of screening tools to ensure that MWs and HVs can adhere to current guidelines whilst not compromising their professional standards of practice and are thus able to: *"demonstrate knowledge and understanding of pre-existing, current and emerging complications and additional care needs that affect the woman, including their potential impact on the woman's health and well-being; and the ability to recognise and provide any care, support or referral that may be required as a result of any such complications or needs"* (NMC 2019, p. 24).

A further consideration when using screening tools was the ethical implications around using tools without the support of specialist services, policies and the appropriate plan of care (Chew-Graham *et al*. 2008; Jomeen *et al*. 2013; Higgins *et al*. 2017b). Higgins *et al*. (2017b) highlighted that the process of screening is only of

value if followed by an appropriate plan of care. Deficits in PNMH services resulted in some HCPs viewing the identification of PNMH problems as a pointless exercise when they did not have the resources to refer women to (Chew-Graham *et al*. 2008). It would be interesting to explore the use of screening tools amongst practitioners working in areas that offer different levels of PNMH provision.

For many MWs and HVs, intuition often took precedence over the use of screening tools when assessing women's mental health. Although low confidence in the use of tools in detecting PNMH problems was exposed, it was not clear from the literature whether that was due to the lack of comprehensive training in using the tools or whether it was due to increased confidence in relying on intuition to make the correct clinical decisions/judgements. Nevertheless, intuition appeared to facilitate both professions when making decisions in clinical practice (Jefford *et al*. 2011; Noonan *et al*. 2017b). Since intuition is said to draw on previous experience and pattern recognition (Benner 1984), Jomeen *et al*. (2013) questioned how inexperienced HVs who have less amassed experience to fall back on, rely on intuition, which was not explored in their qualitative research. Since many studies have acknowledged the part that intuition plays in clinical decision-making, this is an area that requires further exploration in relation to identifying women with PNMH problems and making the necessary referrals to specialist PNMH services.

2.6.4 Lack of time to identify womens' perinatal mental health needs

Research suggests that both MWs and HVs reported lack of time as a barrier to identifying womens' PNMH problems (Higgins *et al*. 2018; Ashford *et al*. 2017). Heavy workloads prevented HCPs from having time to discuss mental health issues

with women (Higgins *et al*. 2018) and prevented HVs from supporting women experiencing mental health difficulties (Ashford *et al*. 2017). Changes in HVs working practices, where home visits had been discontinued, resulted in less opportunity for HVs to identify women with PNMH problems (Alexandrou *et al*. 2018). The large majority of MWs (78.8%, n= 335) surveyed by Higgins *et al*. (2018) considered lack of time allocated for each woman was a barrier to identifying PNMH problems. However, Higgins *et al*. (2018) postulated that practitioners may use lack of time with women as an excuse to avoid enquiring about their mental health as an 'opt-out clause' (p. 1880) that reinforced an embedded culture of avoidance and stigma around mental health. In addition, HVs reported that women with perinatal anxiety were high users of services, ergo took up HVs time, where they frequently accessed services such as child health clinics, duty telephone lines, GP appointments and Accident and Emergency services (Ashford *et al*. 2017) putting a strain on existing heavy workloads: *"So it comes across as anxiety by asking questions, you know, worrying about everything, contacting you all the time, wanting to see you all the time and calling you saying my daughter or my son is not doing this or that"* (Ashford *et al*. 2017, p. 1260). To mitigate the pressures of time when managing women with perinatal anxiety, Ashford *et al*. (2017) suggested that widespread screening and early identification of PNMH problems may mean women could be referred for appropriate treatment earlier resulting in reduced pressure on health visiting and other health services and crucially may improve the health and well-being of the mother (and, therefore, baby). McCauley *et al*. (2011, p.793) also acknowledged that MWs found caring for women with PNMH illness took 'more time' as these women were deemed 'more difficult' than other 'normal' women in their care.

2.6.5 Perceived stigma associated with perinatal mental health

Stigma associated with mental health was considered a barrier to HCPs when identifying and referring women for PNMH care (Jomeen *et al*. 2013; Carroll *et al*. 2018) both in terms of women's perceived stigma associated with PNMH problems and HCPs approach to PNMH. Some HVs in Jomeen *et al*'s (2013) study perceived women's fear of being labelled mentally ill and the reluctance of HCPs to broach certain sensitive subjects such as self-harm/suicide, sexual abuse/sexual violence and psychosis perpetuated the stigma associated with mental health (Carroll *et al*. 2018) and prevented HCPs from either broaching the subject and/or recording it in women's records (Noonan *et al*. 2017b; Higgins *et al*. 2018). Whilst Higgins *et al*. (2018) discovered that only a minority of participants (18%, including MWs and nurses surveyed) considered that documenting women's mental health could stigmatise them, this needs addressing since documentation is a valuable source of communication, and sometimes the only source, within multidisciplinary teams (Vermeir 2015). Moreover, MWs and HVs code of practice stipulates that they must identify risks or problems and record such information in accordance with their standards of practice (NMC 2018). Thus, if PNMH is not documented on a woman's record then this information has the potential to be missed by other members of the multidisciplinary team and ultimately delay/prevent necessary referrals. Stigma of mental health was illuminated by Noonan *et al*. (2019) who reported that almost half of HVs (49.5%) surveyed would not admit to colleagues if they had a mental illness suggesting a stigmatising attitude in relation to disclosure (amongst fellow professionals).

Although the majority of studies found MWs and HVs demonstrated a positive attitude regarding their respective roles in referring women with PNMH problems and managing women with PNMH needs (Rothera and Oates 2011; Jomeen *et al*. 2013; Hauck *et al*. 2015; Ashford *et al*. 2017; Coates and Foureur 2019), research by Hauck *et al*. (2015) questioned the authenticity of their attitudes. When explicitly asked about mental health the impact of social desirability bias should be acknowledged (Hauck *et al*. 2015). Hauck *et al*. (2015) highlighted that biases towards mental health are often unconscious and influence decisions and interactions associated with discrimination. Hauck *et al*. (2015) acknowledged that since their study received a 50% response rate (238/475), it may be that MWs with a negative attitude towards mental health declined to participate.

In an Australian study, McCauley *et al*. (2011) surveyed 161 MWs and uncovered poor attitudes amongst some MWs regarding caring for women with PNMH problems where the use of negative language and judgemental attitudes were evident. McCauley *et al*. (2011, p.794) argued that such attitudes may have been due to MWs feeling 'out of [their] depth' caring for women with PNMH problems coupled with the lack of training and experience in PNMH. Other studies made references to negative stereotypes, made by HVs and MWs, when describing women with postpartum depression: *"…she does not want to look after the baby, she has difficulties in taking care of it, and she is always in tears…"* (Alexandrou *et al*. 2018, p.997) and the use of negative language: *" …I was caring for a mother who had an acute psychosis … this particular experience was distressing to me due to the poor handling by other nursing staff … making comments like you poor thing having to look after that 'crazy woman'"* (McCauley *et al*. 2011, p.792).

Interestingly, in a Canada-based study, Kingston *et al*. (2015) surveyed pregnant women (n=460) using a 63-item closed questioned instrument on the barriers and facilitators to mental health screening, and reported that the majority of women (65%, n= 299) were reassured when PNMH was part of routine care and thus less stigmatising. Perhaps routinely enquiring about women's mental health would be seen as no different from enquiring about other aspects of her health and well-being which do not carry any associated stigma, for example, enquiring about infant feeding, milk supply, sleeping pattern, etc. However, in Kingston *et al*'s study, the lack of open ended questions in the survey did not allow women to generate potential barriers or facilitators other than those considered by the authors and thus, limited participants responses. In addition, the women in this study were predominately white, well-educated and married/co-habiting which limits the generalisability of the findings. Women from other backgrounds may have had different views regarding routine care and stigma. Arguably, if HCPs ensured that routine PNMH screening was applied to all women, then the stigma would be removed and importantly, women at risk of/or experiencing PNMH problems would be identified and referred as appropriate.

2.7 Perinatal mental health referrals: Clinical decision-making among midwives and health visitors

There is a paucity of research directly related to clinical decision-making among MWs and HVs about referring women for PNMH care; therefore, research was examined to explore decision-making in relation to making clinical referral decisions in general, and clinical decision-making among MWs and HVs to draw parallels with PNMH referral decisions.

2.7.1 Intuitive approach to decision-making

Decision-making is an essential and integral aspect of clinical practice that involves varied and complex processes (Orme and Maggs 1993; Porter *et al*. 2007). Traditional theories on decision-making as an intuitive process postulated by commentators such as Benner (1984) and Orme and Maggs (1993) still endure in recent and extant clinical practices (Almond 2001; Jefford *et al*. 2011; Barnfather 2013; Ménage 2016; Smith 2016; Hassani *et al*. 2016; Daemers *et al*. 2017).

Benner (1984) suggests that intuition is utilised in clinical decision-making in her seminal work 'From Novice to Expert'. In order to progress to an expert, nurses go through various stages of skill acquisition, which are demonstrated as blended stages on a continuum, namely: novice, advanced beginner, competent, proficient and expert (Benner 1984). According to Benner (1984) the expert nurse possesses a perceptual awareness, which is reinforced by familiarity, where they are able to interpret situations using a different set of constructs from the inexperienced nurse. This perceptual awareness or intuition is the select domain of an expert nurse/practitioner. Orme and Maggs (1993) confirm that before intuition can be of merit, pre-existing knowledge base of the appropriate and relevant interpretation of information must be obtained. Thus, intuitive decision-making is the exclusive realm of experienced nurses and relies on previous experience, familiarity and an established knowledge base (Benner 1984; Orme and Maggs 1993). Klein (2008) refers to this model of decision-making as the Recognition-Primed Decision (RPD) Model whereby people use their experience in the form of a range of patterns which encompasses a blend of intuition and analysis; the pattern matching is the intuitive element, and the mental simulation is the deliberate and analytical element.

The part intuition plays in decision-making is not without criticism, not least due to the difficulty in defining and quantifying intuitive decision-making (Smith 2007; Grant 1989). Muoni (2012), examined decision-making among MWs in high stress areas such as delivery suite, suggested that decision-making involves the handling of complex information with several competing goals and options. Muoni (2012) highlighted that environments such as delivery suite require MWs to make quick and accurate decisions regarding women's care, often under pressure from staff shortages, high patient turnover and long shifts which, arguably, are conditions not unique to the delivery suite environment. Such highly stressful situations may be encountered by MWs and HVs working in primary and secondary care settings whereby they too are required to manage complex information and competing goals. Muoni (2012) argues that in high stress environments, where MWs are required to make split second decisions, MWs rely on heuristics, the process of experienced-based techniques used in problem-solving or 'rules of thumb' (Cioffi 1998), to guide their decision-making and is supported by Wu *et al*. (2013).

Heuristics is further defined as cognitive short-cuts to simplify information and probability assessment that has the benefit of replacing lengthy, situational analysis (Muoni 2012; Cioffi and Markham 1997) and comparable to intuition as described by Benner (1984). However, Muoni (2012) points out that using heuristics can lead to errors in the absence of factual information where intuitive judgement is used prematurely. Whilst Muoni (2012) recognises the benefit of heuristics in that it simplifies the decision-making process, clinical decisions should always be evidenced-based and follow a systematic process. Thus, if intuition is used in decision-making in deciding if/when to refer women for PNMH care based on

Benner's theory, it relies on the previous experience of the practitioner and familiarity of doing so. Since mental health problems are common in the perinatal period, arguably HCPs are likely to have encountered past situations that require them to make referrals to secondary services and can draw on these experiences in future decision-making scenarios. However, given the rarity of some of the more severe PNMH disorders, HCPs may not have encountered such conditions in clinical practice and therefore, may not possess the necessary knowledge and experience, preventing them from relying on intuitive judgements to facilitate the decision-making process. In these instances, HCPs will require further techniques in their decision-making armoury to guide their clinical decision-making.

Intuition is an integral part of decision-making in health visiting practice (Barker 2001). Barker (2001) suggests that HVs base clinical decisions on a mix of knowledge, experience, observation and intuition whereby practice is guided by many and varied measurement tools which provide empirical evidence for measuring certain factors, e.g. tools for screening maternal mental health such as the EPDS, and child development and growth measures. Relying on measurement tools alone does not give insight into factors that are often multi-causal or explain whether the results are related to underlying psychological, social or cognitive factors (Barker 2001). Barker (2001) describes measurement tools as 'simple and secure instrumental assessments' and intuition as 'more sophisticated, sensitive and challenging' (p.293). Assessing a woman's mental health using validated tools relies on the woman's accurate and honest response to the screening questions. Debatably, in instances where the woman does not respond truthfully and the screening result does not accurately reflect the woman's risk of being diagnosed as

depressed, then MWs and HVs must employ other methods to assist with their assessment such as observation and intuition.

A UK-based qualitative interview study by Fiddick *et al*. (2020), to understand how CMHT practitioners made decisions about who to refer or not to secondary care psychological therapy services, acknowledged the part that intuition played in the decision-making process. However, although Fiddick *et al*. (2020) recognised that intuition was part of the decision-making theory process, the main findings from their research revealed that referral decisions were influenced by three main factors: self, service user qualities and organisational and wider social structures. In relation to self, referrals were based on practitioners attitudes and beliefs about psychological therapy. In relation to service user qualities, practitioners were more likely to refer service users who: requested referrals, were perceived to engage once a referral had been made and those at high risk of harm to themselves or others. Regarding organisational and wider social structures, referral decisions were based on external pressures (i.e. referrals were driven by requests from patients family or other professionals), an uncertainty about referral criteria and limited resources. Many of the participants discussed that limited resources made them prioritise some patients over others (Fiddick *et al*. 2020). There are limitations to this study: firstly, the authors originally intended to conduct focus groups but were unable to organise large groups, instead interviews were conducted with individuals and groups of two or three participants which may have influenced that breadth and depth of data generated as the recommended number of participants for focus groups, i.e. 6-12 (Polit and Beck 2012) was not achieved. Secondly, all participants were aware that the interviewer was a clinical psychologist which may have resulted in participants

voicing positive views of psychological therapies. Finally, these findings were based on interviews with 11 participants, with between nine months and seven years' experience; thus, it was a small sample size with participants that had minimal to moderate experience in their job role.

Daemers *et al*. (2017) conducted qualitative, semi-structured interviews with MWs to explore factors that influence clinical decision-making in MWs working in primary care in the Netherlands. Similar to previous research, Daemers *et al*. (2017) found that MWs in their study based clinical decisions on more than expertise and were influenced by the MWs' attitudes similar to the findings of Fiddick *et al*. (2020), and shared decision-making with women as well as the MWs' personal circumstances. They also discovered that clinical decisions were influenced by collaboration with other HCPs. For example, Daemers *et al*. (2017) found that although MWs and obstetricians wanted to provide the best care for women, the collaborative efforts to achieve this was challenged by the different philosophies of care and styles of practice. It is worthy of note that the MWs in Daemers study were based in primary care and it is likely that their attitudes would not reflect the medicalised view of the obstetricians and thus, tensions between these professionals would be pronounced. Interestingly, previous research has shown that collaboration with experienced colleagues influenced nurses decision-making in acute settings where information provided by experienced colleagues or their own experience were preferred over other sources of information such as protocols (Rycroft-Malone *et al*. 2009) and could potentially apply in primary care settings. This highlights the complexity of decision-making that encompasses varied and multi-faceted influences (Porter *et al*. 2007) that MWs and HVs face in every day clinical practice.

2.7.2 Hypothetico-deductive approach to decision-making

As an adjunct, a dominant and widely used approach to decision-making in healthcare is the hypothetico-deductive approach to clinical decision-making (Harbison 1991; Kovacs and Croskerry 1999; Jefford *et al*. 2011). Hypothetico-deductive approach involves various stages of decision-making. The first stage, hypothesis generation, involves the initial generation of hypotheses based on past experience and pattern recognition that relies on information regarding disease prevalence, heuristics and acuity of the patient's condition (Jefford *et al*. 2011; Kovacs and Croskerry 1999). The next stage is hypothesis evaluation. Here, a framework is used as a guide to gather more information about a patient that either confirms or eliminates the hypothesis generation or provisional diagnosis (Kovacs and Croskerry 1999; Jefford *et al*. 2011). The next stage, hypothesis refinement, which may occur alongside hypothesis evaluation, involves making further refinements to the previous hypothesis and prioritised by prevalence of condition that either confirms or rejects the hypotheses based on the patients presentation (Kovacs and Croskerry 1999). The final stage, hypothesis verification involves retrospectively considering the hypothesis before accepting it. However, hypothetico-deductive approach has been criticised for its confirmability bias. According to Donner-Banzhof (2018), confirmability bias occurs due to an inherent logic that associations will be found if they are being actively looked for. Also, hypothetico-deductive theory focuses on association over causality (Donner-Banzhof 2018). Thus, the medicalised hypothetico-deductive approach relies on a sound knowledge base in the first instance in order to generate initial diagnosis or 'hypothesis generation' and perhaps, would not be an appropriate approach to decision-making in its absence.

2.7.3 Clinical decision-making: Clinical guidelines/protocols

The use of clinical guidelines/protocols are widely employed in both midwifery and health visiting practice at local levels and recommended in current national guidelines (NICE 2014) as an aid to clinical decision-making. Clinical guidelines/protocols are purported to promote uniform standards of practice, clinical effectiveness and optimise patient care (Appleton 1997; Penney and Foy 2007). Appleton (1997) conducted a study across England to assess the extent to which clinical guidelines were useful for HVs to identify families requiring support and to examine guideline validity and reliability. Although clinical guidelines assisted HVs in identifying vulnerable families requiring extra support, Appleton (1997) argued that rigid adherence to guidelines could result in vulnerable families being missed. Furthermore, Appleton (1997) questioned whether clinical guidelines were applicable to areas of health visiting practice where skilled care focused on non-quantifiable processes. Appleton (1997, p.110) used the example of HVs assessing vulnerable families where, as part of that assessment, HVs relied on 'any other factor which makes HV instinctively uneasy'. According to Penney and Foy (2007) systematic reviews suggested that clinical guidelines produced modest to moderate improvements in care and advocated a pragmatic approach to the use of guidelines. In addition, research by Rycroft-Malone *et al*. (2009) that explored how protocol-based care affected clinical decision-making, discovered that nurses found protocols difficult to reference during time constrained situations and this may potentially be an issue for HCPs working in the community and busy hospital settings. Thus, due to the subjective nature of clinical guidelines, the unverified evidence of guideline usage and limitations in the practicalities of using guidelines/protocols, may suggest that clinical guidelines/protocols should be used concomitantly with other decision-making processes. Moreover, given the dearth of guidelines/protocols directly related

to the management and referral process for women with PNMH difficulties (Beauchamp, 2014; Alexandrou *et al*. 2018; Carroll *et al*. 2018; Noonan *et al*. 2017b; Higgins *et al*. 2018), it would seem that MWs and HVs are unable to exclusively rely on guidelines/protocols to facilitate decision-making in the absence of such and must therefore employ other decision-making processes, e.g. intuition and hypothetico-deduction.

In summary, based on the literature it appears there are many and varied decision-making processes that MWs and HVs utilise in clinical practice and no single process is sufficient or infallible. Rather, HCPs are likely to employ various decision-making processes when making decisions in clinical practice about deciding whether or not to refer women for PNMH care. Potential factors that appear to impact on clinical decision-making are the previous experience of HCPs, attitudes of HCPs, knowledge of clinical conditions, the influence/collaboration of service users and/or experienced colleagues, the availability of resources and use of guidelines/protocols. Due to the lack of research directly related to decision-making about referring women for secondary PNMH care, it remains unclear what processes MWs and HVs employ when deciding whether or not to refer women and what barriers and facilitators they encounter in the process.

2.8 Gaps and limitations in the literature

The emphasis of the research explored in this review concentrated on HCPs (majority of studies focused on MWs and HVs but included other HCPs such as GPs, obstetricians, practice nurses) knowledge and confidence related to PNMH (Higgins *et al*. 2017a and 2018; Carroll *et al*. 2018; Buist *et al*. 2006a). Limited research has

explored clinical decision-making directly related to referring women for specialist PNMH care, possibly missing valuable insight into the complex process of referring women with PNMH problems which warrants further exploration. Given that mental ill-health is the most common perinatal illness and some women are at extremely high risk of experiencing PNMH problems, the adverse impact that PNMH problems can have on women and the wider society and the fact that an estimated 50% of PNMH cases go undetected, sometimes with tragic consequences, it would appear prudent to understand the processes of MWs' and HVs' clinical decision-making regarding referring women for secondary PNMH care.

This review has highlighted a number of areas that would be beneficial to explore. A survey approach dominated the research methodology where a qualitative approach was underrepresented. The qualitative studies in this review also lacked a comprehensive account of MWs' and HVs' experiences and perceptions of managing women with PNMH problems as little evidence was provided in the form of participant voices through use of verbatim quotes and/or descriptive accounts. Thus, despite claims of data saturation from a number of authors it is difficult to establish if this had been achieved due to the limited data evidence.

Although some studies examined barriers and facilitators to MWs and HVs in providing PNMH care, in terms of their assessment/screening of women, none of the studies directly explored factors that impact on MWs' and HVs' decision-making in clinical practice about referring women for specialist PNMH care which would provide insight into the complexities involved in this process. The link between lack

of PNMH training/education in relation to compliance with screening tools has been highlighted. This has implications for practice; namely, if all women are not being screened for PNMH problems there is potential for at-risk women and/or women experiencing mental health problems to go undetected and not receive the necessary referral to specialist PNMH services. It would, therefore, be useful to explore MWs' and HVs' experiences and views on using screening tools in clinical practice and how these tools assist decision-making when deciding to refer women for secondary PNMH care.

Furthermore, although research has highlighted the disparity of PNMH services (across the UK and internationally), and provided evidence of the positive impact that specialist PNMH services have on women and their child (at least in the short term), the impact that service availability has on clinical decision-making has not been addressed in the literature. In other words, does the presence of specialist PNMH service provision have an impact on MWs and HVs knowledge, confidence and clinical practices, such as use of screening tools, when deciding to refer women with PNMH problems. To that end, the following research question and overarching aims and objectives were developed:

Research Question
What factors influence midwives' and health visitors' decision-making in relation to referring women for secondary perinatal mental health care?

Aims:

- To explore MWs' and HVs' decision-making in relation to referring women for secondary mental health care in the perinatal period to further understand barriers and facilitators to accurate and timely referrals.
- To explore any impact of having a local specialist PNMH service on MWs' and HVs' decision-making regarding referrals for PNMH care.

Objectives:

1. To identify two geographical areas that offer different levels of perinatal mental healthcare service provision: an area that has specialist in- and out-patient services and an area that has no specialist PNMH service provision.

2. To conduct semi-structured interviews with a manager/clinical lead of MWs/HVs services within each Trust in the geographical areas to establish provision of PNMH care in that Trust, including protocols for referrals to secondary mental health care.

3. To conduct semi-structured interviews with a sample of MWs and HVs practising in each of the two geographical areas to explore in-depth their approach to referring women for PNMH care, including decision making about referrals to secondary care to identify barriers and facilitators to the referral process.

4. Using data from the interviews, devise a questionnaire to examine barriers and facilitators to referral decision making.

5. To administer a questionnaire to all MWs and HVs in the two geographical areas in order to ascertain the opinions and experiences of a representative sample and to examine and compare responses between those working in the geographical areas with versus without secondary specialist PNMH services, and between MWs and

HVs, regarding approach to referring women to secondary care, including decision-making about whether or not to refer women for PNMH care.

The following chapter details the methodology used with philosophical underpinnings and rationales for using the chosen approaches.

CHAPTER THREE

Methodological approach adopted for this research

3.1 Introduction

This chapter provides an overview of the methodological approach adopted to address the aims of the research presented in this thesis; namely, to explore MWs' and HVs' decision-making in relation to referring women for secondary mental health care in the perinatal period to further understand barriers and facilitators to accurate and timely, and to explore any impact of having a local specialist PNMH service on MWs' and HVs' decision-making regarding referrals for PNMH care. The specific methods used for the qualitative and quantitative phases of this research are discussed in detail in Chapters Four and Five, and Six respectively.

3.2 Mixed Methods Research

Research can be conducted from various paradigms or world-views (Tashakkori and Teddlie 1998; Morgan 2007) which include understandings of the nature of reality (ontology) (Tashakkori and Teddlie 1998), the study of knowledge (epistemology) (Creswell and Plano Clarke 2017), the values that guide the research (axiology) (Bahm 1993) and the process of how that knowledge can be obtained (methodology) (Creswell and Plano Clarke 2017). Historically, there have been two main opposing perspectives: positivist/postpositive paradigm (quantitative perspective) and interpretivist/constructivist paradigm (qualitative perspective) (Feilzer 2010) with their respective advocates purporting the advantages of qualitative and quantitative research. During the last few decades Mixed Methods Research (MMR) has

emerged as a distinct research approach (Ghiara 2020). According to Feilzer (2010), MMR offers a third paradigm to the debates surrounding qualitative versus quantitative research, which have been referred to as the 'paradigm wars' (Tashakkori and Teddlie 1998). MMR is a purposeful mixing of methods in data collection, analysis and interpretation of the evidence where the data integration enables researchers to examine the research question from different viewpoints and through varied research lenses (Shorten and Smith 2017).

According to Pluye and Hong (2014), MMR is any methodological combination that satisfies all three of the following conditions: i) the combination of at least one qualitative and one quantitative element, ii) rigorous use of the methods and iii) an integration of data collection and/or analysis and/or results. Timans *et al*. (2019) expand on the conditions stated by Pluye and Hong (2014) and argue that MMR is a misnomer, as what is mixed are the paradigms not the methods. Sandelowski (2014) points out that a contested area concerning MMR is where researchers make erroneous claims to identifying their research as MMR, when instead, they are conducting multi-methods research, i.e. where either exclusively multiple qualitative approaches or exclusively multiple quantitative approaches are combined (Schoonenboom and Johnson 2017).

Some authors agree that MMR is not without epistemological challenges (Tashakkori and Teddlie 1998; Salehi and Golafshani 2010). According to Tashakkori and Teddlie (1998) the real challenge of MMR is in the attempt to reconcile the two approaches with supporters of qualitative and quantitative research who ardently

uphold their separate approaches. Indeed, Florczak (2014) believes that qualitative or quantitative purists cannot fully engage in MMR due to their diametrically opposed worldviews of research. For researchers not indoctrinated in a particular research paradigm or worldview and for those who believe that dogmatic paradigms impede research progress, MMR offers a resolution whereby all types of knowledge can be embraced in the goal of understanding (Florczak 2014). Mbuagbaw *et al*. (2013) offers a balance to the perspective of the 'paradigm wars' and suggests that even where sources of conflict exist within research, the skills of the researcher help to overcome research challenges, such as sharing of ideas and resources, collaboration and networking with colleagues/peers, opportunities to train and learn from fellow researchers and learning from research mistakes.

A further epistemic challenge of MMR is whether the assumptions of quantitative and qualitative paradigms are afforded the same value or attention in a study and whether the data derived from the two methodologies are commensurate (Salehi and Golafshani 2010). Furthermore, the findings from one method may contradict the findings from the other which may make the value or validity of one method questionable (Salehi and Golafshani 2010). Greene *et al.* (1989) refers to this as 'initiation' and rather than view this negatively, instead suggests that finding contradictions that require clarification in research allows researchers to initiate a new study or reframe the research question.

Despite the challenges of MMR, many researchers have embraced this method as a viable alternative to the single/mono method design (Salehi and Golafshani 2010;

Florczak, 2014). Johnson and Onwuegbuzie (2004) argue that MMR is complementary to traditional qualitative and quantitative research where the benefit of its methodological diversity, coupled with the shared principles of pragmatism, result in superior research. Hammerberg *et al.* (2016) suggest that the flexibility and multiplicity of MMR affords researchers the freedom to use qualitative and quantitative research to explore data that concerns experiences, meanings and perspectives, and factual or measurable data. MMR allows researchers to select methods best suited to the research question rather than with regard to any predetermined biases of superiority aligned with a particular research method (Johnson and Onwuegbuzie 2004). It allows empirical precision to be combined with descriptive precision (Onwuegbuzie and Leech 2007) or in other words, the combination of quantitative and qualitative research. By bridging the gap between qualitative and quantitative research (Onwuegbuzie and Leech 2007), MMR has the potential benefit of capitalising on the respective strengths combined (Östlund *et al*. 2011) and provides a comprehensive and more complete understanding of the problem (Vedel *et al*. 2019). However, Sandelowski (2014) challenges the assumption that only MMR can address diversity and complexity in research and suggests that single or mono methods studies require multi-faceted and sophisticated skills that are also capable of addressing complexity. Nevertheless, MMR is thought to account for the complexities in contemporary healthcare (Simons and Lathlean 2010) and addresses the challenges of implementing evidenced-based practice where a single methodological approach is often deemed insufficient (Palinkas *et al*. 2015).

There are several research designs that can be employed in MMR. These are described as: convergent, sequential exploratory and sequential explanatory (Creswell 2015; Vedel *et al*. 2019). In convergent MMR, qualitative and quantitative research methods are combined during the data collection and analysis stage and results from each method can be combined and compared (Vedel *et al*. 2019). Sequential exploratory design involves collecting data following an iterative process where the data collected in one study contributes to the data collected in subsequent studies (Driscoll *et al*. 2007). In a sequential explanatory design, qualitative methods are informed by the quantitative results (Vedel *et al*. 2019). Considerations for researchers when deciding which MMR design to employ other than the timing (or sequencing), include the priority (or weighting) of the qualitative and quantitative elements of the research design (Creswell and Plano-Clarke 2017). The priority options for MMR are: equivalent status where qualitative and quantitative approaches are used equally to understand the phenomenon under study (Tashakkori and Teddlie 1998); quantitative priority where the emphasis is placed on the quantitative approach, supplemented by the qualitative approach; and qualitative priority, with a focus on the qualitative methods which is supplemented by the quantitative approach (Creswell & Plano Clark 2017). According to Schoonenboom and Johnson (2017), by conducting an equal-status study (where the qualitative and quantitative components have equal weight and value), researchers can demonstrate that paradigms can be mixed and that the incompatibility thesis, i.e. the notion that qualitative and quantitative inquiry is informed by opposing ontological and epistemological approaches rendering it inappropriate to integrate these approaches within a single study (Hathcoat and Meixner 2015), does not always apply to research practice.

According to Greene *et al*. (1989), MMR fulfils five purposes:

1. Triangulation - where corroboration and correspondence of results are sought from different methods.

2. Complementarity - where elaboration, enhancement and clarification of the results from one method are sought which can then be combined with the results from the other method.

3. Development – where the results from one method are used to help develop or inform the other method.

4. Initiation – where new questions or contradictions are discovered from the results of one method which in turn generates a new study or a reforming of new questions.

5. Expansion - where the breadth and range of inquiry are extended by using different methods for different inquiry elements.

Bryman (2006) conducted a content analysis of peer reviewed journal articles that included mixed method or multi-method research in the title/abstract to explore their rationale for conducting MMR. Articles were selected from the Social Sciences Citation Index over a ten-year period. Across the 232 studies selected for the review, Bryman (2006) found 16 reasons for using MMR which, similar to Greene *et al*. (1989) most notably included the ability to explore unexpected results (where quantitative and qualitative research can be combined when one generates unpredictable results that can be understood by employing the other); to aid instrument development (utilised in contexts in which qualitative research is employed to develop questionnaires in order that improved wording or more

comprehensive closed answers can be generated); and enhance credibility of the research by employing both approaches to increase the integrity of the findings. Bryman (2006) concluded that there was significant benefit to researchers in examining the rationale for conducting MMR and the ways in which MMR is carried out in practice. However, despite methodological considerations for conducting MMR, Bryman (2006) highlights that research outcomes may not always be predictable.

Similar to Bryman (2006), Schoonenboom and Johnson (2017) recommend that researchers commence a study with a clear research question and consider the purpose for conducting MMR. Many authors agree that MMR requires added resources, time and expertise, therefore it is important for researchers to justify their rationale for using such an approach (McKim 2017; Cameron 2011; Creswell and Plano-Clark 2017). When considering the skillset of the researcher, Creswell and Plano-Clark (2017) recommend that researchers gain experience in both methods before embarking on a MMR study. Time needed to obtain ethical approvals, gain access to participants, complete data collection, analyse the data and integrate the findings are all aspects that require consideration (Creswell and Plano-Clark 2017). Although these issues are not unique to MMR and apply to both qualitative and quantitative research, conducting MMR means consideration for issues related to both methods need to be addressed. Given the additional requirements of MMR in terms of skill-set, resources and challenges, Cameron (2011) advocates researchers explicitly state their philosophical position and methodological justification for using MMR.

3.3 Methodological decisions for this PhD

A sequential, exploratory MMR design was employed to address the aims of this research. Phase 1 was conducted with managers and clinical leads to explore PNMH service provision and referral options and pathways available to MWs and HVs within the participating research sites. The findings from Phase 1 provided context to Phase 2 of the research which explored MWs' and HVs' experiences and decision-making about referring women for secondary PNMH care with a sample of MWs and HVs from across the participating sites; an iterative process of collecting and analysing qualitative interview data (in phases 1 and 2 discussed in detail in Chapters Four and Five respectively) informed the content of a bespoke questionnaire, containing mainly quantitative response options (in Phase 3 discussed in Chapter Six). It was important to conduct the interviews in the first instance since this research was an unexplored topic. Therefore, the design of the questionnaire was dependent on the content of the interviews conducted in Phases 1 and 2 of this research. The questionnaire was administered to all MWs and HVs in all participating sites to examine whether the findings from Phase 2 were representative of the wider population of MWs and HVs, and to statistically test for differences between the two geographical areas (one with NICE (2014) recommended PNMH service provision and one without PNMH services) and between professional groups.

Sequential, exploratory MMR was chosen because a paucity of research evidence was available relating to the aims of this research; therefore, a qualitative method was implemented to explore the experiences and opinions of MWs and HVs to garner rich and in-depth data via semi-structured interviews. This phase embraced

an interpretivist/constructivist paradigm that reflected the multiple realities of the participants. Qualitative research was appropriate as it involved exploring the experiences and opinions of MWs and HVs with first-hand experience of making decisions about referring women for PNMH care in order to seek in-depth explanations.

The subsequent quantitative phase was appropriate as it involved a deductive element, developed from the literature and the preceding qualitative interviews, where descriptive statistical data provided breadth to the data and focused on specific variables that could be explored empirically amongst a larger sample of MWs and HVs in order to statistically test for differences between the two geographical areas and professional groups. Hammerberg *et al*. (2016) state that quantitative research concerns 'factual data' to answer the research question, for example, to obtain probability data on opinions, views, or preferences and/or to define and isolate variables. In the current research the questionnaire allowed for data on opinions to be collected from a large sample of MWs and HVs. In addition, it was important to the researcher to provide recommendations for practice which potentially could improve PNMH care for women; the use of MMR as a methodology in healthcare research seeks to provide hard data for the decision-makers who determine health policy (Doyle *et al*. 2012) and thus, provides further rationale for the quantitative phase.

The timeline for the sequential exploratory data collection can be seen in Table 3.1 below.

Table 3.1: Timeline for sequential, exploratory data collection

Date range	Data Collection Phase
May 2018 – August 2018	Phase 1: **Qualitative** semi-structured interviews with Managers/Clinical Leads
May 2018 – October 2018	Phase 2: **Qualitative** semi-structured interviews with MWs/HVs
January 2020 – March 2020	Phase 3: **Quantitative** questionnaire with MWs/HVs

For this research, equal weighting of importance was given to the qualitative and quantitative studies. By using sequential MMR, the data from the qualitative research were used to develop the questionnaire via an iterative process involving development of themes from the qualitative interviews that informed content of the subsequent questionnaire. The combined findings of the qualitative and quantitative data were triangulated, i.e. corroboration and correspondence of results obtained from different methods, (Green *et al.*1989) and an overall interpretation of the findings was developed which is discussed in detail in Chapter Seven.

3.4 Philosophical position: Pragmatic approach

A pragmatic approach was deemed suitable for this research as, similar to MMR, pragmatic research does not require the researcher to be aligned to a particular philosophical orthodoxy, but rather embraces a flexible approach where the researcher has the freedom to use different approaches that possess key characteristics or conventions that reflect the research question (Savin-Baden and Howell-Major 2013). Since this research employs a sequential MMR design the pragmatic approach lends itself to the complementary, supportive and flexible nature of MMR (Plowright 2011). Thus, knowledge is constructed and based on the understanding of the world where mixing methods is a more holistic approach to

research (Johnson, Onwuegbuzie and Turner 2007) and where pragmatic researchers do not expect to find a single truth (Feilzer 2010).

Like MMR, pragmatic research affords the researcher the freedom to use the 'best suited' method, technique or procedure associated with quantitative or qualitative research to answer the research question (Feilzer 2010; Plowright 2011; Savin-Baden and Howell-Major 2013; Bowling 2014). However, Morgan (2014) argues that the emphasis on 'what works' is inadequate to clarify the value of pragmatism as this disregards the choices about the goals to be pursued and how to achieve those goals. Instead, Morgan (2014) believes that pragmatism places importance on joining beliefs and actions in a process of inquiry in the search for knowledge or, in other words, combining the beliefs and methods of quantitative and qualitative paradigms to answer the research question. Thus, comparable to MMR, the benefit of pragmatic research is it allows for inductive and deductive methods to be used at different stages of the research process (Johnson and Onwuegbuzie 2004). Morgan (2014) suggests the appeal of pragmatism for mixed methods researchers is in its practicality rather than its broader philosophical stance. Kaushik and Walsh (2019) concur with Morgan and believe pragmatism concerns problem-solving in the 'real world'. To that end, pragmatic research is deemed appropriate for this study as it is 'real world' research, carried out with MWs and HVs who have experience of making decisions about referring women for PNMH care; are subject to the inherent cultures, language and institutional influences of their respective professions and influenced by their collective and individual experiences. In pragmatic research the epistemological assumptions are applied as appropriate to the methodological

phases of the research (Johnson and Onwuegbuzie 2004) as in a ‘best suited’ approach (Savin-Baden and Howell-Major 2013; Bowling 2014).

Further benefits of being a pragmatic researcher are, according to Onwuegbuzie and Leech (2005), a positive attitude towards quantitative and qualitative methods that enables pragmatic researchers to use qualitative research to inform quantitative research and vice versa. As a result of choosing a pragmatic approach to the current research, this research will both explore (via qualitative semi-structured interviews) and statistically examine and compare (via a quantitative questionnaire) referral-making decisions among MWs and HVs working in geographical areas with different levels of PNMH service provision. In this way, quantitative data can compensate for the lack of generalisability of qualitative data (Onwuegbuzie and Leech 2005) and the combining of these approaches provides a more comprehensive understanding of the data. Considering the diversity and complexity of data generated from a MMR design and the multiplicity of paradigms that could be employed, pragmatism offers a broad and flexible paradigmatic lens through which to view the current research.

3.5 Chapter summary

This chapter has outlined the justification for the methodological decisions taken in this research, namely the use of MMR and a pragmatic approach. The following chapters (Four, Five and Six) provide a detailed account of the methods, results and discussion for the sequential exploratory MMR studies mentioned in this chapter.

CHAPTER FOUR

Phase 1: Midwifery and health visiting perinatal mental health referral pathways and service provision in the participating Trusts

4.1 Introduction

The aim of this phase was to understand the PNMH referral pathways and service provision that were available to the MWs and HVs working in two geographical areas providing different levels of PNMH services. Understanding PNMH referral pathways and the secondary PNMH service provision was important for the subsequent studies of the research which aimed to explore the application of these pathways and the impact available services has on clinical practice of the MWs and HVs (outlined in Chapters Five and Six). This chapter presents the methods, findings and discussion of the review of PNMH referral pathway documentation, review of Trusts' website information, and of five one-to-one, semi-structured interviews with midwifery managers and health-visiting clinical leads.

4.2 Methods

4.2.1 Recruitment and sample

Research participants were recruited from two geographical areas (Area 1, hereafter referred to as Blue Area and Area 2, hereafter referred to as Green Area), comprising four NHS Trusts, which were selected for the research based on the different levels of PNMH services offered in these areas:

Blue Area was selected based on its comprehensive provision of PNMH services. Blue Area provides healthcare for a population of approximately 2.9 million. It covers a large geographical area and contains an extensive socio-economic and culturally diverse population. It has a population density of 332 persons per square kilometre. The percentage of BAME population varies across the area and ranges from 2.5 – 13% of the population depending on location. Based on the Index of Multiple Deprivation measures (including 7 domains: Income, Employment, Health and Disability, Education, Skills and Training, Barriers to Housing and Services, Living Environment and Crime), Blue Area is ranked in the top 20% most deprived areas in England. The largest industry sector in this area is manufacturing and ceramics. Blue Area comprises three geographically contiguous NHS Trusts in England. NHS Trusts 1 and 2 employs MWs, and NHS Trust 3 HVs. This area provides PNMH care for women living in the locality of Trusts 1, 2 and 3, as recommended by NICE (2014) and offers the following provision: Specialist PNMH Community Mental Health Teams (CMHTs), In-patient Mother and Baby Unit (MBU), Out-patient Parent and Baby Day Unit (PBDU), specialist PNMH MWs and HVs and Consultant Perinatal Psychiatrists.

Green Area was selected for this research as it did not have any specialist PNMH services. Green Area serves the healthcare needs for approximately 230,000 people living in the locality. It is a predominately rural area with the fourth lowest population density in England (89 persons per square kilometre). The BAME community make up 1.8% of the population in this area. Based on the Index of Multiple Deprivation, Green Area is ranked in the top 25% most deprived areas in England. The largest industry sector in this area is agriculture, forestry and fishing. Green Area comprises

1 NHS Trust in England and employs both MWs and HVs. At the inception of this PhD (January 2017), Green Area did not provide any specialist PNMH services. However, from April 2019, after conducting the first two phases and prior to conducting the third and final phase of this research, Green Area provision included a PNMH CMHT. At the time of writing this thesis (July 2021), Green Area does not have any further specialist PNMH service provision.

Midwifery managers and health-visiting clinical leads were invited to take part in this research based on their job role within the four participating NHS Trusts. Managers/clinical leads were sent an email which included an invitation to take part (Appendix 4) and a Participant Information Sheet (PIS) (Appendix 5). Participants demonstrated their willingness to take part by return email. All five managers/clinical leads invited to take part in the interviews agreed to participate.

4.2.2 Data collection

Semi-structured interviews were conducted between May 2018 and August 2018. Managers/clinical leads were contacted to arrange a convenient time to conduct the interviews, with the option of either a face-to-face interview or telephone interview. All managers/clinical leads requested to be interviewed via telephone. Prior to the interviews, managers/clinical leads received a consent form via email (See Appendix 6); consent forms were signed and returned via email.

An interview guide was devised to address the aims of the research (Appendix 7). The interview guide questions broadly covered PNMH assessment, secondary

mental health service provision for women in the perinatal period and local referral pathways for MWs and HVs when deciding to refer women for PNMH care. The interview guide included questions relating to PNMH training for the MWs and HVs and suggested improvements in local PNMH service provision. This was in order to understand the current provision more fully within each Trust and the application of referral pathways for MWs and HVs in clinical practice, for example, whether MWs/HVs received comprehensive training on use of screening tools which could impact on the use of tools in clinical practice. The interview guide was reviewed by a team of expert academics and practitioners in perinatal psychiatry, psychology and midwifery, and feedback given on its appropriateness and relevance to the research and revised accordingly.

Telephone interviews were conducted by the researcher in a private office in order to ensure privacy. The duration of interviews can be seen in Table 4.1 below.

Table 4.1: Duration of Phase 1 interviews with managers/clinical leads

Manager/clinical lead of Area/Trust		Duration of interview in minutes
Blue Area	Trust 1	13 (MW manager)
	Trust 2	15 (MW manager)
	Trust 3	60 (HV clinical lead)
Green Area	Trust 4	16 (MW manager) 13 (HV clinical lead)

Key: Blue Area = (with PNMH service provision); Green Area = (without PNMH service provision)

Information regarding PNMH referral pathways was also obtained by requesting related documentation from the participants following the interviews and supplied by

three out of the four Trusts (Trusts 2, 3 and 4). In addition, each of the Trust websites was reviewed by the researcher to garner further information on PNMH services and referral pathways.

4.2.3 Data management

Interviews were audio-recorded using an encrypted digital dictaphone and transcribed non-verbatim. Recordings and transcripts were stored in a secure and locked storage cabinet in a restricted access office at the University of Worcester and on a password protected computer in accordance with GDPR guidelines and the University of Worcester's data management policy. Confidentiality was assured by anonymising data. Following non-verbatim transcription, digital audio recordings were deleted.

4.2.4 Data analysis

The pragmatic decision to use non-verbatim transcription was taken as this preserves selected qualitative data that achieve the research aims whilst ensuring participant confidentiality (Sandelowski 1994). The aim of this phase was to gather specific information about PNMH referral pathways (using a variety of sources including the semi-structured interviews as well as reviewing Trust referral pathways documentation and examining Trust websites) rather than explore participant experiences that aimed to garner rich, in-depth data. Thus, direct quotes were not used during this phase as specific information on referral pathways was required. Interview findings and information gleaned from referral documentation and Trust websites are presented in Table 4.2.

4.2.5 Ethical approvals

Ethical approval was granted by the University of Worcester (UW) Health and Science Research Ethics Committee (reference number SH17180018-R) (Appendix 8). NHS Permissions were granted by the HRA (reference number 235568) (Appendix 9) and by each Research and Development (R and D) Department of the four participating NHS Trusts in the form of a Letter of Access.

4.3 Findings

Findings from the interviews, review of PNMH referral pathway documentation and of Trust websites are summarised in Table 4.2 which presents details of the Area/NHS Trusts PNMH services provided, PNMH training provided to the MWs/HVs by the Trusts, details of PNMH referral pathways and suggested improvements needed in PNMH services as perceived by the participants.

Table 4.2: Summary of findings from semi-structured interviews with managers/clinical leads and review of referral pathway documentation# and of Trust websites in Blue Area and Green Area

Area	NHS Trust	Services/personnel managed by manager/clinical lead	PNMH services provided by Trust	PNMH Training provided by Trust	PNMH assessment and referral pathways	Suggested improvements needed in PNMH services
BLUE AREA	Trust 1 MWs	Matrons, consultant obstetric unit, MBC FMBU and CMWs; specialist midwives in: safeguarding, maternity related bereavement, PNMH; PNMH nurse; overall responsibility for guidelines, mandatory education and public health.	PNMH nurse Specialist PNMH MW Access to MBU Access to PBDU Consultant Perinatal Psychiatrist PNMH CMHT	Annual, one hour generic mental health training for MWs Permission for staff to attend external training but must cascade to other staff	MWs use Universal PNMH questions to assess womens' PNMH; referral options to specialist MW, GP and/or secondary care	Collaborative working between professionals / agencies / joined up services Improving MH provision in line with Better Births recommendations Record and collect KPI data on PNMH
	Trust 2 MWs	Matrons, consultant obstetric unit, MLU and CMWs; specialist midwives in: IBCLC, safeguarding, bereavement, Vulnerable women/improving women's health; overall responsibility for guidelines, mandatory education and public health.	Specialist MW for vulnerable women Access to MBU Access to PBDU Consultant Perinatal Psychiatrist PNMH CMHT	One hour generic mental health training every two years to include DOLs and MCA training Permission for staff to attend external training External training in mental health approved for specialist MW	MWs use Universal PNMH questions to assess womens' PNMH; referrals options to specialist MW, GP and/or secondary care	More consultant psychiatrists in PNMH More specialist MW hours (currently X1 full-time specialist MW in post) Joined up working between professionals/agencies Easier access to CAMHS PNMH to form part of KPIs
	Trust 3 HVs	Clinical lead for 0-19 years services Lead on policy, SOPs, practice development, mandatory training. Manages incident reports, participates in RCA investigations	Specialist PNMH HV Access to MBU Access to PBDU Consultant Perinatal Psychiatrist PNMH CMHT	CNNs and community staff nurses – half day PNMH training when new to post HVs undertake PNMH assessment training when new to post/area Online annual training package for PNMH 3 HVs trained in iHV PN/Infant MH training and are MH champions	HVs assess women's PNMH using universal PNMH questions - positive response and/or verbal response not congruent with woman's behaviour /appearance prompt HV to complete GAD7 and PHQ9. Women at risk* of / experiencing PNMH issues referral options to GP and/or secondary care; women with mild symptoms referred to GP, IAPTs or third sector organisations	Improved collaboration between CAMHS/PNMH services/Maternity services PBDU outreach for women with travel difficulties/unable to attend PBDU Improve care for BAME women with better assessment, literature and interpreting services

Table 4.2 continued: Summary of findings from semi-structured interviews with managers/clinical leads and review of referral pathway documentation# and of Trust websites in Blue Area and Green Area

Area	NHS Trust	Services/personnel managed by manager/clinical lead	PNMH services provided by Trust	PNMH Training provided by Trust	PNMH assessment and referral pathways	Suggested improvements needed in PNMH services
GREEN AREA	Trust 4 MWs	Operational and strategic management of maternity services including hospital and CMWs	No dedicated PNMH services at time of interviews** In 2018 bid placed to commissioners for PNMH service	Basic annual e-learning training Currently introducing Solihull Approach[3] training Some MWs selected for traumatic birth resolution training	MWs assess women's PNMH using Universal PNMH questions. Referral options available: GP, mental health crisis team, A and E dept and 999 in an emergency	Dedicated PNMH services for women Specialist PNMH MW Improved training in PNMH – during training and post qualifying PNMH to form part of KPIs
	Trust 4 HVs	Clinical lead for 0-25 years services	No dedicated PNMH services at time of interviews** 6 HV-led listening visits In 2018 bid placed to commissioners for PNMH service	All HVs trained in Solihull Approach Trust supports HVs in accessing external PNMH and infant MH training	HVs assess women's PNMH using Universal PNMH questions; Referral options available: GP, mental health crisis team, A and E dept and 999 in an emergency	Dedicated PNMH services for women Specialist support commissioned for families in PNMH care in form of MBU, birth trauma, family therapy Specialist PNMH community roles, e.g. Specialist PNMH HV And specialist in infant MH

Key: Blue Area = with PNMH services; Green Area = without PNMH services; #= for Trusts 2, 3 and 4; A and E dept= Accident and Emergency Department; CMHT= Community Mental Health Team; CNNs= Community Nursery Nurses; DOLS= Deprivation of Liberty Safeguards; FMBU= Freestanding Midwifery Birth Unit; IBCLC= International Board Certified Lactation Consultant; iHV= Institute of Health Visiting; KPIs= Key Performance Indicators; MBC= Midwife Birth Centre; MBU= Mother and Baby Unit; MCA=Mental Capacity Act; MH= Mental Health; MLU= Midwifery Led Unit; PBDU= Parent and Baby Day Unit; RCA= Root Cause Analysis; SOPs= Standard Operating Procedures; IATPs= Improving Access to Psychological Therapies; * women at risk= previous history of mental health disorders, first degree family history of mental health disorder; ** Trust provided PNMH CMHT in April 2019

[3] The Solihull Approach (Douglas 2017) is an evidence-based programme, included in the *Healthy Child Programme* (Shribman and Billingham 2009) that aims to increase emotional health and well-being of parents and infants through their reciprocal relationship. https://solihullapproachparenting.com/quick-guide-to-the-solihull-approach/

Table 4.3: PNMH service provision for Blue Area and Green Area

Area	Blue Area			Green Area
	Trust 1	Trust 2	Trust 3	Trust 4
PNMH Services provided	• In-patient Mother and Baby Unit • Parent and Baby Day Unit • PNMH Community Mental Health Team • Specialist PNMH MW • Specialist PNMH HV • Consultant Perinatal Psychiatrist			• No dedicated PNMH services*

Key: Blue Area = area with PNMH services; Green Area = area without PNMH services; *at the time of the interviews; From April 2019 this area has a PNMH CMHT

4.4 Blue Area: Perinatal mental health service provision

As shown in Table 4.3 above, Blue Area which comprised 3 NHS Trusts, had PNMH services as recommended by NICE (2014), namely, specialist PNMH in-patient provision in the form of a MBU; specialist out-patient services in the form of a PBDU and PNMH CMHT. Each Trust had a specialist PNMH MW or HV in post as well as a Consultant Perinatal Psychiatrist. However, despite the comprehensive service provision, all participants from Blue Area highlighted there was a lack of 'collaborative' and 'joined-up' working between maternity/health visiting services and secondary PNMH services. The participants highlighted a need for improved communication and liaison between agencies that reflected a coordinated approach to care between the various HCPs/agencies; and 'easier access' to services such as CAMHS both in terms of referrals for pregnant under 18 year old's and referrals for children. Exact details of what was deemed 'easier access' was not discussed. Furthermore, the manager from Trust 2 identified that at the time of the interview the current specialist PNMH MW provision was 'not enough' and expressed a desire for increased specialist PNMH MW hours, although this increase was not quantified.

As shown in Table 4.2, the clinical lead for Trust 3 reported that improved PNMH care was needed for Black, Asian and Minority Ethnic (BAME) women in the form of appropriate literature and interpreting services. Furthermore, the clinical lead suggested that outreach work was needed from the PBDU for women unable to travel to the unit.

4.4.1 Blue Area: Referral pathways

Trusts 1, 2 and 3 had PNMH referral pathways in place (See Table 4.2). Managers from Trusts 1 and 2 gave a standard response when asked about the guidelines MWs used to assess women's PNMH and reported that MWs followed local Trust guidelines but did not elaborate further on what these were.

Each specialist PNMH service in Blue Area had their own referral criteria. The PBDU and MBU provided care for women in the locality of Blue Area. Specific referral criteria was obtained from the PBDU (Outlined in Table 4.4) and the MBU (See Table 4.5) in the form of related documentation and reviewing website information.

Table 4.4: Referral criteria for Parent and Baby Day Unit for Trusts 1, 2 and 3

Preconception referral criteria	Preconception counselling available for women with existing severe and enduring mental health difficulties and for women with previous postpartum psychosis
Antenatal referral criteria	Pregnant women (confirmed following ultrasound scan) experiencing a moderate to severe depression
	Family history of bipolar disorder
	History of schizophrenia
	Previous postpartum psychosis
	Previous depression resulting in hospital admission
	Pathological anxiety related to childbirth
Postnatal referral criteria	Referrals accepted for women with babies under 12 months of age (where referrals are made at 10/11 months, treatment options will be limited to assessment/signposting if appropriate)
	Severe depression following childbirth
	Postpartum psychosis or manic episode
	Anxiety related to childbirth/infant
	Attachment disorder
	Existing severe mental health difficulties where professionals seek specialist advice or co-work
	Child Protection issues but only where the mother has significant mental health problems
Exclusion criteria	Mild to moderate depression
	Following miscarriage, stillbirth or termination of pregnancy
	Substance abuse/addiction where there are no mental health problems
	Social issues where there are no mental health problems
	Child Protection issues where there are no mental health problems
	Mental health problems related to specific factors which require specialist intervention but are unrelated to pregnancy/childbirth

Referrals to the MBU were accepted directly from MWs and HVs (as well as other HCPs such as GPs, Crisis Team, CMHTs and Obstetricians). Review of the MBU referral criteria obtained from the MBU website are outlined in Table 4.5. The MBU referral criteria appear to overlap with referral criteria for the PBDU (See Table 4.4) and the PNMH CMHT (See Table 4.6). Examination of the related documentation and websites for these services do not provide explicit guidance for HCPs on whether one service should be chosen over another.

Table 4.5: Referral criteria for Mother and Baby Unit for Trusts 1, 2 and 3

Referral criteria for MBU	Referrals accepted from 28 weeks gestation and for mothers with babies up to 12 months of age
	Postpartum psychosis / previous postpartum psychosis
	Bipolar affective disorder
	Schizoaffective disorder and other psychoses and serious / complex conditions
	Mothers with the above conditions under the age of 18 will be managed in collaboration with CAMHS and Social Services.
	Pregnant women over 28 weeks gestation who are experiencing a moderate to severe depression.
	Previous depression resulting in hospital admission
	Current moderate to severe depression.
	Minimum age of mother: 16 years old.
Referrals not accepted	Community crisis referrals are not accepted by the MBU. Referrals received by local CMHT as urgent/crisis must assess women first then discuss with MBU prior to processing a referral.

Trust 1

No referral documentation was forthcoming from Trust 1. Review of the website offered generic information on PNMH only (in terms of defining PNMH and a list of charitable/third sector organisations available to support women with PNMH difficulties).

Trust 2

Review of the PNMH referral pathway documentation for Trust 2 revealed that in this Trust, at the initial booking appointment MWs were required to assess women's mental health using the Whooley questions and the GAD-2 (i.e. the Universal PNMH questions) and also enquire about the following: present/previous mental health treatment/in-patient care; history of severe postpartum mental illness in a first degree relative and family history of mental health problems; alcohol and drug misuse; social networks / living conditions / social isolation / housing / employment / immigration status and make enquiries regarding domestic abuse.

Trust 2 referral pathway documentation also stipulated that MWs ask the Universal PNMH questions between 24-34 weeks of pregnancy. Following the initial assessment at the booking appointment, and/or if women respond 'Yes' to the Universal questions, the MWs should:

- Assess if social reasons / relationship / history of domestic abuse is pregnancy related
- Consider referral to PBDU (referral criteria apply – See Table 4.4)
- Consider referral to PNMH CMHT (referral criteria apply – See Table 4.6)
- Offer an Early Help Assessment[4]
- Consider referral to Specialist MW clinic (referral criteria apply – See Table 4.7)
- Liaise with HV
- Signpost to GP or self-refer to IAPTs if mild to moderate depression
- Inform specialist MW if referred to PNMH CMHT

Referral pathway documentation for the PNMH CMHT (detailed in Table 4.6 below) did not offer further details on referral criteria, for example, it did not stipulate that referrals must satisfy certain criteria or if one or more criteria must be met.

[4] An Early Help Assessment is an initial assessment and planning tool that facilitates and coordinates multi-agency support to help identify the needs of children and adults in the family (HM Government 2015).

Table 4.6: Perinatal Mental Health Community Mental Health Team referral criteria for Trusts 2 and 3

	Referral Criteria
Antenatal	Pregnant women (confirmed following first ultrasound scan) experiencing moderate to severe depression
	Family history of bipolar disorder
	Previous puerperal psychosis
	Moderate/severe anxiety related to childbirth
	Current moderate to severe depression
	Women with existing severe and enduring mental health difficulties where professionals need to co-work or seek specific advice
	Previous depression resulting in hospital admission
	Minimum age of mother: 16 years old
Postnatal	Referrals received up to infant of 1 year of age
	Severe depression following childbirth
	Puerperal Psychosis or manic episode
	Anxiety related to childbirth/infant
	Attachment disorder
	Minimum age of mother: 16 years old

Table 4.7: Referral criteria for specialist MW clinic for Trust 2

Specialist MW Clinic Criteria	Appointments offered after 20 weeks gestation
	Women with a learning disability where there is suspected mental illness
	Substance misuse
	Women suffering with mild to moderate severity anxiety and depression that is being treated by the GP and does not meet PNMH CMHT criteria
	Previous traumatic birth experience affecting mental wellbeing in pregnancy

Unlike the PNMH CMHT and PBDU who accepted referrals following confirmation of pregnancy by ultrasound scan, the Specialist MW clinic accepted referrals after 20 weeks gestation. There was no minimum age limit on referrals to this clinic. MWs were required to assess women using the Whooley questions and the GAD-2 and

record the results in women's electronic and pregnancy handheld records prior to referral to the specialist MW clinic.

Review of referral pathways documentation for the PNMH CMHT and PBDU revealed considerable overlap in referral criteria between the two services, and offered HCPs no instructions on which service to decide to refer to. However, the PNMH CMHT and PBDU advised referees that they may contact them to discuss appropriateness of potential referrals. Referrals made to the PBDU require MWs and HVs to complete PHQ-9 and GAD-7 scores as part of the referral.

Trust 2 documentation states that for ongoing concerns in the antenatal period, MWs should ask the Whooley questions and the GAD-2. These questions are asked again at least once in the postnatal period (although the exact timing was not specified in the guideline documentation) but prior to transfer of care to the HV. MWs can liaise directly with the PNMH CMHT, HV, GP and specialist PNMH MW to discuss ongoing concerns and possible referrals. If 'Red Flags' are present then the documentation stipulates that MWs refer women for an emergency GP appointment or refer to mental health team out of hours service. Red Flags referred to:

- Recent significant change in mental state or emergence of new symptoms
- New thoughts or acts of violent self-harm
- New and persistent expressions of incompetency as a mother or estrangement from the infant

If a mental health emergency or crisis occurs whilst a woman is an in-patient within the maternity department then the Liaison Mental Health Team were available 24 hours a day, 7 days a week. Trust documentation did not stipulate what was considered an emergency or crisis.

Trust 3

The clinical lead from Trust 3 gave a detailed account of the assessment guidelines for HVs. They explained that during a woman's first contact with the HV, similar to the MWs assessment above, HVs are required to ask about: past or present mental illness; severe mental illnesses such as schizophrenia, schizoaffective disorder, bipolar disorder, psychosis and severe depression; anxiety disorders such as tokophobia, OCD, PTSD, panic disorder, and GAD; eating disorders such as anorexia nervosa, bulimia nervosa; drug and alcohol use disorders; past or present treatment for mental illness by a GP, primary care mental health service, secondary care mental health service, or specialist PNMH service and history of severe PNMH illness in first degree relatives: mother, sister or daughter.

The clinical lead confirmed that during this first contact, HVs are required to ask women the Universal PNMH questions. In the case of a positive response to either questions, HVs are required to offer women a targeted mental health assessment involving a structured clinical interview using the PHQ-9 and the GAD-7. The clinical lead pointed out that scores from self-reported tools must always be used in combination with clinical judgement as there will be women whose clinical presentation will not be congruent with their numerical score. Review of the Trust referral pathway documentation showed that subsequent care planning is based on

overall scores of the self-reported tools in combination with the number of symptoms reported, the severity of symptoms reported and the degree of symptom related impairment, duration of symptoms and precipitating factors and psychosocial stressors. According to the Trusts' PNMH referral pathway documentation, the collated information will enable practitioners to determine whether women's mental health problems are mild, moderate or severe (See Table 4.8 for PHQ-9 and GAD-7 score rating as stated in referral pathway documentation). The outcome of the clinical interview and any subsequent care planning should be discussed (with consent) with the GP.

Table 4.8: Level of depressive illness/anxiety according to PHQ-9 and GAD-7 scores in Trust 3

Overall Score	**PHQ-9**
0-4	Indicative of a minimal level of depression
5-9	Indicative of a mild depressive illness
10-14	Indicative of a moderate depressive illness
15-19	Indicative of a moderately severe depressive illness
20-27	Indicative of a severe depressive illness
Overall Score	**GAD-7**
0-4	Indicative of a minimal level of anxiety
5-9	Indicative of a mild level of anxiety
10-14	Indicative of a moderate level of anxiety
15-21	Indicative of a severe level of anxiety

Trust 3 referral pathway documentation sets out guidance for HVs where mental health problems are suspected, and where mental health symptoms are suspected to be mild, moderate or severe. HVs complete a medical history and health needs assessment during the antenatal contact and subsequent referrals are made according to referral criteria, i.e. asymptomatic women with a history of mental health problems, for example previous PP or bipolar disorder, or women with a first degree

family history of mental health disorders and/or women experiencing current mental health problems. Referral options include referral to a woman's GP or to a mental health professional, although the specifics of the mental health professional are not explicitly stated.

Where mental health problems are suspected to be mild, the plan of care involves referrals to primary care (GP and IAPTs), self-help strategies on diet, exercise and sleep, and signposting to voluntary sector or community organisations. HVs should adopt a 'watchful waiting' approach and arrange to reassess women within two weeks.

Where moderate mental health problems are suspected, the referral documentation states that HVs should consider referral to: the GP for further assessment, referral or treatment; referral to a specialist secondary PNMH outpatient/day service for further assessment and treatment (See referral criteria in Table 4.4). HVs should continue to offer health related advice on diet, exercise and sleep and signpost women to community support groups and activities that promote parent-baby relationships.

Trust 3 pathway documentation states that where mental health problems are suspected to be severe, an urgent response is required where practitioners must decide on the appropriate action to take. The options include: referral to the GP for an urgent assessment, referral to the appropriate access Team (this is a single point of contact for adult mental health services within the Trust), liaise with specialist PNMH HV, duty professional for the specialist PBDU or nurse in charge of the MBU

so advice can be obtained. Where there is immediate risk to the mother, baby or others, HVs must ring the Emergency Services.

4.4.3 Blue Area: Perinatal mental health training

Training in PNMH across the three Trusts in Blue Area is outlined in Table 4.2. In Trust 1 PNMH training available to the MWs consisted of one-hour, annual training either online or face-to-face. The manager from Trust 1 reported that MWs were funded to attend external PNMH training on the agreement that the training was cascaded to other MWs within the Trust. However, this was not discussed in specific terms such as 'Train the Trainer' concept[5] but alluded to in a more informal way. Trust 2 MWs received one-hour training in mental health every two years which included Deprivation of Liberty Safeguards (DOLS) and Mental Capacity Act (MCA) training which was not specific to PNMH. Trust 3 provided the most comprehensive training package, which was delivered by the specialist PNMH HV, where HVs were required to undertake PNMH assessment training when new to post. This training consisted of use of tools (Universal PNMH Questions, GAD-7 and PHQ-9) and communication skills around broaching mental health and asking difficult questions. Following this training, HVs receive annual updates on PNMH. In this Trust, three HVs were mental health champions and had undertaken training in postnatal and infant mental health and were sources for advice/support for other HVs in the Trust.

4.5 Green Area: Perinatal mental health service provision

Green Area comprised one NHS Trust. This Trust employed both MWs and HVs and did not have any designated PNMH services at the time of the interviews. Both participants from this Trust voiced a desire to have dedicated PNMH services. The

[5] Train-the-Trainer is a framework for training staff to enable them to train other people in their organisations.

midwifery manager expressed a need for a dedicated PNMH service to include a specialist PNMH MW. Improved PNMH training, both during midwifery training and post qualifying was also highlighted by this manager, however, specific details about improved PNMH training were not provided by them. The clinical lead for HVs also expressed a desire for a specialist PNMH service, specifically including care for women needing PNMH care in the form of a MBU, birth trauma therapy, family therapy, specialist PNMH HV and a specialist HV for infant mental health. In the absence of dedicated PNMH services, women requiring secondary PNMH care in Green Area were managed by adult mental health services.

4.5.1 Green Area: Referral pathways

Trust 4

Referral pathways to secondary PNMH services did not exist within this Trust at the time of the interviews due to the absence of specialist PNMH services. Nevertheless, PNMH care pathways did exist where MWs and HVs were responsible for identifying and monitoring women's mental health using local Trust guidelines which reflected current NICE (2014) guidelines, i.e. MWs and HVs asked the Universal PNMH questions during planned and emergency contacts as stated in NICE (2014) guidelines. Findings of Universal questions were recorded in the electronic patient records. Once the Universal scores were recorded, the guidelines did not instruct HCPs further. According to Trust documentation, MWs and HVs could not refer women directly to adult mental health services; instead, referrals were made via GPs. In-patient provision was available at a local, adult general mental health hospital where there was no provision for mothers to remain with their baby. Mothers needing in-patient care who wished to remain with their baby were accommodated in

a MBU in another location. Out-patient provision was provided by Community Psychiatric Nurses (CPN).

In order to provide an up to date portrayal of PNMH referral pathways within this Trust (due to the addition of a PNMH CMHT in April 2019) and to give context to Phase 3 of this research (discussed in Chapter Six), current PNMH referral pathway documentation has been examined as have Trust website information. Review of PNMH referral pathway documentation and the Trust website revealed that in Trust 4 MWs and HVs (and other HCPs including GPs and obstetricians) can refer women to the PNMH CMHT using the criteria as detailed in Table 4.9.

Table 4.9: Referral criteria for PNMH CMHT in Trust 4

Referral criteria to PNMH CMHT	Severe mental illness during pregnancy or within one year of childbirth (Women aged 16-18 years old – open to any secondary mental health services – who are planning a pregnancy or currently pregnant must meet one of the criteria below)
	Past history of severe mental illness
	Past history of perinatal mental illness
	Family history, in a first degree relative, of bipolar disorder
	Women requiring assessment for tokophobia
	Minimum referral age: 16 years of age

Similar to the referral criteria from the PNMH CMHT in Blue Area, a minimum age criteria was set at 16 years for the PNMH CMHT in Green Area. Other similarities existed between this service and Blue Area specialist PNMH services where referral criteria was based on past history and/or family history of mental illness and included women requiring assessment for tokophobia.

Trust 4 documentation states that when a woman becomes acutely mentally ill a referral to the mental health crisis team can be made, but are accepted for maternity in-patient women only. In the following out-patient emergency situations, MWs and HVs should refer women to their GP for an urgent assessment, signpost women to the local Accident and Emergency (A and E) Department or if the emergency is immediate, dial 999:

- A recent significant change in presentation and acting out of character
- A rapidly changing fluctuating mental state
- New thoughts or acts of violent self-harm
- New and persistent expressions of incompetency as a mother or estrangement from the infant
- Evidence of psychosis
- Suicidal ideation – particularly of violent nature

4.5.2 Green Area: Perinatal mental health training

In Trust 4, MWs had e-learning training in PNMH. The manager did not elaborate on the content of this training other than to describe it as ‘basic’. At the time of the interviews MWs within the Trust were also being trained in the Solihull Approach (Douglas 2017). Additionally, an (undisclosed) number of MWs had been selected to attend training on traumatic birth resolution. The clinical lead for HVs in Trust 4 confirmed that all HVs had been trained in the Solihull Approach (Douglas 2017). HVs in this Trust were also supported in accessing external PNMH training and/or infant mental health training, either by full/part funding and/or given study leave to attend the training.

4.6 Discussion

This phase sought to understand PNMH referral pathways and service provision available to MWs and HVs in two geographical areas to understand what the referral criteria and care options were for deciding upon and making PNMH referrals for women. The information from the interviews, review of referral pathway documentation and Trust websites highlighted details of PNMH referral pathways and service provision across the two geographical areas which provides context in advance of the interviews and questionnaires conducted for the subsequent phases of this research.

Across the two geographical areas, all Trust PNMH pathway documentation (where documentation was available) accurately reflected current NICE (2014) guidelines where MWs and HVs were required to assess women's mental health using the Universal PNMH questions. There was also congruence across Trusts on referral criterion to secondary services and this met with NICE (2014) guidelines (as outlined in the introductory chapter). In Trusts 3 and 4, it was apparent from the referral documentation that referral to a woman's GP was central to the overall plan of care for women needing PNMH care, prior to/in addition to referrals made to specialist PNMH referrals (where available). This was particularly important for Green Area as, at the time of the interviews, there were no dedicated PNMH services in this area. Therefore, Green Area MWs and HVs had limited options of referring women to their GP, the local A and E or 999 in an emergency. Maternity in-patient women requiring PNMH care could be referred to the mental health crisis team.

Although in the main, referral criteria for specialist PNMH services were consistent across the Trusts, a notable difference was that Trust 2 referral criteria for the specialist MW clinic was restricted to women over 20-weeks' gestation. The manager did not explain why this criterion was in place. A possible reason why this criteria was implemented for this service may be in order to limit the numbers to cope with the demand in referrals. A UK study carried out by Darwin *et al*. (2015) on women's experiences of antenatal mental health referrals at one large, inner city hospital found that local mental health specialist midwifery services received numerous referrals, and consequently implemented more stringent eligibility criteria than recommended by NICE guidelines in order to manage their capacity. However, a possible implication of not referring women before 20 weeks gestation, could leave women with pre-existing mental ill-health vulnerable and not under the care of specialist services such as specialist PNMH MW services. Importantly, the evidence suggests that women with a history of mental health problems are at high risk of becoming unwell in the perinatal period (Wesseloo *et al*. 2016). Thus, women who require timely referrals to PNMH care due to previous or pre-existing mental ill-health, such as women with bipolar disorder or those who have experienced PP, are potentially bereft of appropriate plans of care, support, treatment or prevention in the interim from specialist midwifery services.

Examination of the available referral pathway documentation uncovered a further difference: only Trust 3 explicitly set out referral criteria based on the scores of the PHQ-9 and GAD-7. In this Trust, practitioners were provided with clear guidance on what the respective PHQ-9 and GAD-7 scores indicated in relation to women's severity of mental health problems. Trust 2 did not refer to these scores in their

documentation nor instruct practitioners to complete the PHQ-9 and GAD-7 if they received a positive response to the Universal PNMH questions. Trust 4 stated that scores from the Universal PNMH questions should be recorded on the electronic patient records but did not elaborate on how practitioners should proceed on the basis of the scores.

Participants from Blue Area described a lack of 'joined up'/'collaborative' working between midwifery and health visiting services and secondary PNMH care where the managers/clinical lead recognised a need for improved communication between HCPs to prevent fragmented care for women. This finding is supported by a UK-based qualitative study of PNMH patients and healthcare professionals, that found there was a need for improved liaison and communication between services at all levels of healthcare to increase and support joint working (Rothera and Oates 2008). Poor communication and a lack of collaborative care between HCPs has been suggested to contribute to increased mortality rates (Posthumus *et al*. 2013; Knight *et al.* 2020) highlighting the importance of a collaborative approach to working.

The HVs clinical lead from Blue Area was dissatisfied that PNMH services did not accommodate the BAME community in that area. They suggested that the literature available to BAME women was limited and interpreting services were inadequate. This supports the findings of a systematic review by Watson *et al*. (2019) that explored PNMH services in Europe and found a lack of culturally appropriate services where women experienced poor understanding due to language problems if

information was not provided in their first language and interpreting services were not available.

A similar finding amongst the midwifery managers in both areas was that PNMH data were not recorded as part of local Key Performance Indicators (KPIs). However, the midwifery managers asserted that PNMH information should form part of KPIs as it would enable maternity services to provide evidence to commissioners highlighting gaps for such services, including areas where NICE guidance is not being met, monitor practitioners' compliance with NICE guidance and could be added to the KPI data presently collected by MWs. KPIs are data routinely collected by NHS England and the Department of Health as a consistent way of measuring the performance of NHS screening programmes, according to specific public health priorities, to ensure screening data targets are being met and to take action if they are not being met (Latinovic 2015). Although PNMH data are not included in national KPIs, local health services namely, Clinical Commissioning Groups (CCGs) are also responsible for setting KPIs at a local level (Ham *et al.* 2015). The clinical leads for health visiting across the two areas stated that PNMH data formed part of local KPIs where data was recorded for the 6-8 week contact when HVs screened women using the Universal PNMH questions.

Interview data revealed that training provision for PNMH across the two areas largely consisted of one hour generic mental health training, either annually or two yearly training. Only Trust 3 (Blue Area HVs) provided training specifically focused on PNMH which was delivered by the specialist PNMH HV. The manager from Trust 4

(Green Area) recognised that the e-learning available to MWs was ‘basic’ and expressed a desire for improved PNMH training during midwifery training and post qualifying but did not specify details.

4.7 Strengths and limitations

This phase has a number of strengths and limitations. The recruitment methodology for this phase received a 100% response rate as all managers/clinical leads invited to participate agreed to take part (n=5). Due to the busy schedules of the managers/clinical leads all interviews were conducted via telephone. Although telephone interviews have been criticised for missing visual cues in conversations, there is limited evidence regarding their shortcomings when compared to face-to-face interviews (Novick 2008). In this research, the benefit of telephone interviews afforded the participants the flexibility to take part in the research at their convenience and to fit in with their busy schedules and may be a possible reason why all managers/clinical leads agreed to be interviewed.

Despite the researcher’s best efforts to obtain PNMH referral pathway documentation from all Trusts (via verbal and formal requests in writing) following the semi-structured interviews, only three out of the four Trusts provided formal documentation. Thus, data relating to Trust 1 was limited to the knowledge and recall of the manager only and did not include information from Trust referral pathways documentation. It is possible that participants may not have been able to recall in detail the content of their respective referral pathways documentation during the interviews. On reflection, when inviting the managers/clinical leads to take part in the research, it would have been prudent of the researcher to request that participants

have a copy of their respective referral pathways in readiness for the interview. Not requesting this information in the initial invite is considered a limitation. Obtaining robust evidence of formal documentation for all Trusts would have provided completeness of data for this phase of the research.

Since the researcher was acutely aware of the participants' busy schedules and was mindful of keeping the interviews short and concise some questions remained unanswered. For example, obtaining clarification from the midwifery manager what was considered improved PNMH training or how many more specialist MW hours were needed in Trust 2. However, these interviews did not set out to engage in detailed questioning used in exploratory interviews. Nevertheless, responses to some unexplored questions may have provided useful data which may have assisted analysis of the results in subsequent phases of the research.

4.8 Conclusion

This phase of the research confirmed the availability of PNMH services in Blue and Green Areas and highlighted the disparity in services across the two geographical areas. Unsurprisingly, participants from Green Area expressed a desire for dedicated PNMH services. However, even with Blue Area having NICE recommended PNMH services, the managers and clinical leads perceived there were areas that required improvement, such as interdisciplinary collaboration and communication, and additional specialist PNMH MW hours. Despite the disparity in PNMH services across the two areas, Trusts' referral pathways documentation (where available) reflected NICE (2014) guidance and stipulated that: MWs and HVs screen women for PNMH difficulties using the Universal PNMH questions and EPDS and enquire

about history/family history of mental illness as part of a clinical assessment. Referral pathway documentation revealed that only Trust 3 set out clear guidance for HVs, according to PHQ-9 and GAD-7 scores, on what these scores indicated in terms of PNMH severity. The documentation from Trusts 2 and 4 did not include details of what actions to take regarding the PHQ/GAD scores other than to record the scores on patient records.

Review of the referral pathway documentation showed considerable overlap relating to referral criteria to the various specialist PNMH services i.e. PNMH CMHT, MBU and PBDU. Review of the referral pathways documentation exposed a lack of detailed instructions/guidance for MWs and HVs on which specialist PNMH service, where available, they should refer women to based on clinical judgement, medical history and/or screening results. Thus, overall review of the available referral pathways documentation exposed ambiguities and gaps for the HCPs using the pathways in clinical practice.

Information from the interviews showed that PNMH training provided by Trusts 1, 2 and 4 was limited in terms of scope and length; only Trust 3 appeared to provide training that was specific to PNMH. The information gathered in this study helps to give context to the next phase of the mixed methods research as detailed in Chapters Five and Six.

CHAPTER FIVE

Phase 2: Qualitative semi-structured interviews with midwives and health visitors to understand perinatal mental health referral decision-making

5.1 Introduction

This chapter presents the methods, findings and discussion of 24 qualitative, semi-structured interviews conducted to understand PNMH referral decisions among MWs and HVs. The interviews were part of a Mixed Methods Research (MMR) study as discussed in Chapter Three. There is a dearth of literature exploring professional decision-making amongst MWs and HVs in relation to referring women for secondary PNMH care. Previous research has largely focused on MWs' and HVs' knowledge of PNMH and confidence in managing women's PNMH. This phase aimed to explore the perceived barriers and facilitators to PNMH referral decision-making among MWs and HVs and to explore any impact of having a local specialist PNMH service on MWs' and HVs' decision-making regarding referrals for PNMH care.

5.2 Sample

A purposive sample of MWs and HVs was selected for participation based on two elements: their respective job roles and location, i.e.as they were employed by the four participating NHS Trusts, located across two geographical areas, that each provided different levels of PNMH service provision (Details of the service provision provided in Chapter Four, section 4.2.1). Purposive sampling is an approach to recruitment in the form of non-probability sampling which does not strive for

complete representation of the target population and where participants are selected that are deemed the most benefit to the study (Polit and Beck 2012).

5.3 Recruitment process

All MWs/HVs from those purposively sampled were invited to take part via hardcopy invitation packs and identical email packs containing an invitation to take part (Appendix 10) and a Participant Information Sheet (PIS) (Appendix 11). The invitation packs were delivered/sent to the MWs/HVs via a gatekeeper who was asked to forward the invitation packs via the internal post and intranet accordingly. The gatekeepers were the personal assistant to the manager/clinical lead of the MWs/HVs. In one Trust only, the gatekeeper was the designated research midwife. Potential participants showed their willingness to participate by either posting the paper reply slip to the researcher (at their own cost as no pre-paid addressed envelopes were included in the invitation packs) or via email as instructed on the invitation letter. Additional measures to promote the research included displaying posters in staff areas requesting participation from MWs/HVs (Appendix 12) and sending a reminder invitation email via the gatekeepers to all MWs/HVs working in the participating Trusts, two weeks following the initial invite (Appendix 13). Each MW/HV employed by the participating Trusts was invited to take part. Twenty-four participants were recruited for the research (MW = 16; HV = 8) over a six-month period from May 2018 to October 2018. Demographic profile of the participants can be seen in Table 5.1. The number of MWs/HVs employed by the participating Trusts can be seen in Table 5.2. A breakdown of participants by geographical area, can be seen in Table 5.3.

Table 5.1: Demographic profile of Phase 2 interview participants

			Number
Profession	Midwife	HMW 12**	16
		CMW 4**	
	Health Visitor		8
Years qualified*	0 - 5		3
	6 - 10		5
	11 - 20		4
	21 + years		12
Qualification as a Registered Mental Health Nurse	Yes		2
	No		22

*Years qualified are not necessarily synonymous with time spent in current post
** HMW = Hospital-based MW; CMW = Community MW.

Table 5.2: Number of MWs/HVs employed by participating Trusts

Geographical Area	Number of MWs	Number of HVs	Total Number of MWs/ HVs in geographical area
Blue Area comprising 3 NHS Trusts	Trust 1 = 300	Trust 3 = 166	766
	Trust 2 = 300		
Green Area comprising 1 NHS Trust	Trust 4 = 90	Trust 4 = 40	130
Total number	690	206	896

Key: Blue – geographical Blue Area with specialist secondary PNMH service provision; Green - geographical Green Area without specialist secondary PNMH service provision. These figures represent numbers employed and not whole time equivalent and include managers and specialist MWs/HVs.

Table 5.3: Distribution of MWs/HVs who participated in interviews by geographical area/ Trust.

Geographical area / NHS Trust		Number of MWs Interviewed	Numbers of HVs interviewed	Total number interviewed by area
Blue Area	Trust 1	6 (HMW= 5; CMW =1) (2%)*	N/A	15 (2%)*
	Trust 2	5 (HMW=5) (1.7%)*	N/A	
	Trust 3	N/A	4 (2.4%)*	
Green Area	Trust 4	5 (HMW=2; CMW=3) (5.5%)*	4 (10%)*	9 (6.9%)*
Total number		16 (2.3%)* (HMW=12; CMW=4)	8 (3.9%)*	24 (2.7%)*

Key: Blue Area = with specialist secondary PNMH service provision; Green Area = without specialist secondary PNMH service provision. HMW = hospital-based MW; CMW = community MW; ( ) * = % of MWs/HVs employed who participated in the research.

5.4 Data collection method

Semi-structured interviews were used to understand PNMH referral decisions among MWs and HVs. Interested participants were contacted to arrange a convenient time to conduct an in-depth, semi-structured interview, for either face-to-face interview or telephone interview (See Table 5.4 for location of interview). Recruitment was boosted as whilst the researcher attended the research sites to conduct scheduled interviews, additional MWs/HVs who had not responded to the email/letter to participate, volunteered to be interviewed.

An interview guide (Appendix 14) was devised to address the aims of the research and explore areas that previous research had not set out to explore. The interview guide posed questions about professional decision-making around PNMH care and explored any impact of having a local specialist PNMH service on MWs' and HVs'

approach to PNMH referral decision-making. It covered three broad areas: assessment, training and referrals. The interview guide was reviewed by a team of expert academics and practitioners in perinatal psychiatry, psychology and midwifery and feedback given on its appropriateness and relevance to the research. Furthermore, the researcher's academic supervisors provided ongoing constructive feedback on the interview guide suitability and appropriateness.

Table 5.4: Location of interviews with MWs and HVs

Geographical Area/Trust		Number of Face-to-face Interviews and %	Number of Telephone Interviews and %
Blue Area	Trust 1	6 (100%)	0
	Trust 2	4 (80%)	1 (20%)
	Trust 3	1 (25%)	3 (75%)
Green Area	Trust 4	7 (78%)	2 (22%)
Total number of interviews and %		18 (75%)	6 (25%)

Key: Blue Area = with specialist secondary PNMH service provision; Green Area = without specialist secondary PNMH service provision

A small pilot study was carried out to examine the clarity of the interview guide using a convenience sample of MWs/HVs known to the researcher. Pilot participants were not employed by participating Trusts. Pilot participants were asked to give feedback on the clarity, structure and relevance of the interview questions, and whether there were any further questions they felt should be included.

Although an interview guide was used, interviews were participant-led and adapted according to the response from the participant which allowed additional questions to be added to obtain greater depth from the interviewee. The interview guide underwent one revision (Appendix 15) to ensure the questions remained congruent with the aims of the research, focused on emerging areas of interest to explore in more depth and reduced the duration of the interviews as the participants were time restricted due to workload. Face-to-face interviews were conducted in a private room on Trust premises. The researcher conducted telephone interviews in a private office to ensure privacy. The duration of interviews ranged from 14 minutes to 1 hour and 21 minutes, with a mean duration of 36 minutes. Table 5.5 shows duration of interviews based on location. Interviews were audio-recorded using an encrypted digital dictaphone and transcribed verbatim by the researcher. In addition to audio-recordings, key words and phrases were noted during the interviews to aid the thematic analysis process when analysing the data (Tessier 2012) and provided a backup in the event of audio recording failure of which there were none.

Table 5.5: Duration of Phase 2 interviews by location

Location of interview	Mean length of Interview	Range of interview length
Face-to-face	34 minutes	14 – 81 minutes
Telephone	45 minutes	30 – 80 minutes

5.5 Ethical approvals and processes

Ethics approval to conduct this research was granted by the University of Worcester (UW) Health and Science Research Ethics Committee (reference number SH17180018-R) (Appendix 8). Permission to conduct the research in the NHS was

granted by the HRA (reference number 235568) (Appendix 9) and by each Research and Development (R and D) Department of the four participating NHS Trusts in the form of a Letter of Access.

Participants were asked to sign a Consent Form (Appendix 16) prior to the interview taking place. For face to face interviews, consent forms were signed at the time of the interview. In the case of telephone interviews, participants were emailed a copy of the consent form and either signed it in person and returned it via post to the researcher or more commonly, signed the consent form and emailed it back to the researcher. Informed consent was obtained by informing participants about the nature of the research and any aspect of the research that influenced their willingness to take part, such as what was required of them when taking part and the time it was likely to take. As per the PIS, participants were informed that their participation was voluntary and they were free to withdraw, without reason and could request their data be withdrawn up to two weeks after data collection. No participant chose to withdraw from the study.

Confidentiality was assured by anonymising data obtained from the interviews. Names and identifiable details were removed from transcripts. Recordings and transcripts were stored in a secure and locked storage cabinet in a restricted access office at UW and on a password protected computer. Audio recordings were deleted following transcription as stipulated in the PIS.

During the data collection period personal safety measures were employed. The researcher travelled to the various research sites and adhered to a lone researcher process whereby a text message was sent to a designated person to indicate arrival on site and a further text message sent once the researcher had safely returned home/to university.

5.6 Methodological decisions for using Thematic Analysis

Thematic analysis (TA) was chosen as the method to analyse the data as it is a widely used approach in health focused research that provides a robust, systematic framework for analysing qualitative data (Braun and Clarke 2014). TA is consistent with the epistemological position of MMR and the principles of pragmatism (Braun and Clarke 2006). Braun and Clarke (2006) suggest the advantage of using TA lies in its flexibility; TA can be applied across different epistemological approaches instead of being aligned to a particular epistemological position.

TA is an approach to analyse and describe patterns, or themes, within the data (Braun and Clarke 2006). Braun and Clarke (2006) offer clear guidance for conducting TA in a deliberate and rigorous manner. Roberts *et al*. (2019) highlight that a lack of a detailed account of TA makes it challenging to assess the quality of analysis and demonstrate research credibility. Conducting TA in a rigorous and methodical manner not only yields useful results but demonstrates trustworthiness of the research through interpretation and representation of textual data (Nowell *et al*. 2017). Braun and Clarke (2006) allude to the fact that the flexibility of TA is not synonymous with superficiality. They point out that a pitfall of TA is failing to analyse the data at all where researchers produce a collection of interview extracts with no

analytic narrative or simply paraphrasing extracts (Braun and Clarke 2006). Instead, they suggest that extracts from TA data should illustrate or support the analytical content of the data.

A detailed analysis of the data allows the researcher to look beyond description of the data and attempt to explore underlying meaning beyond the spoken words. Researchers can provide evidence of high quality research by seeking opportunities to document and justify research decisions (Polit and Beck 2012). According to Polit and Beck (2012), this can be achieved by transparently documenting research decisions by seeking opportunities to have decisions reviewed by others and describing how themes were developed. TA was chosen for this phase as it embraces a flexible approach where the themes are not necessarily the most prevalent details that occur within the data but those that capture something important in relation to the research question (Braun and Clarke 2006) and maximise the portrayal of participant voices.

5.6.1 Data analysis: Thematic Analysis

Braun and Clarke's (2006) seven-step process is not linear, but creative and complex in nature and aids the TA process. It is described in detail in their seminal paper of 2006 (Braun and Clarke 2006) and later expanded on (Braun and Clarke 2013; 2019); the seven steps are as follows:

1. Transcription
2. Reading and familiarising self with the data
3. Coding
4. Generating initial themes

5. Reviewing themes
6. Defining and naming themes
7. Writing the report

The process of developing themes began by immersion in the data through listening to the audio recordings, reading and re-reading the transcripts before any coding of the data began (Braun and Clarke 2006). Interviews were transcribed verbatim. By personally transcribing the data, the researcher was further immersed in the data (Braun and Clarke 2013). Although Halcomb and Davidson (2006) question the necessity of verbatim transcription, i.e. the process of word-for-word reproduction of verbal data, interviews were transcribed verbatim to ensure transparency of the data and to portray as accurate an account of participant voices as possible. However, the inclusion of a detailed account of participant non-verbal behaviour was not recorded as not all interviews were face-to-face and as reflected in the chosen methodological approach. This initial phase of TA represents the beginning of analysis, where the researcher can familiarise themselves with the data (Braun and Clarke 2006; Maguire and Delahunt 2017).

The organic process of generating the codes was achieved by examining the transcripts line by line and highlighting repeated words and concepts within the text to pick out semantic and latent codes relating to the aims of the research. In other words, highlighting explicit words spoken by the participant (sematic codes) and those words or phrases that the researcher interpreted as relevant to the research aims (latent codes) (An example of TA of an interview transcript is provided in Appendix 17). Comments were noted in the transcript margins on the researcher's

initial thoughts and ideas. The codes represented participant focus on an issue and were not necessarily an indication of participant agreement but reflected the different views of participants that were relevant to the issue in question. This was an iterative process where the researcher went back and forth from the original data and the initial codes. Through this process, using the aims of the research as a guide, codes that were identified from the data were grouped together, refined and identified as sub-themes. The sub-themes were revised and following interpretation, were grouped together to become the emerging themes. As part of the TA process, emerging themes were subsequently reviewed and refined with a member of the researcher's supervisory team until agreement was reached, and finally given 'names' and labelled as themes.

The interviews produced a considerable amount of data. Although it is acknowledged that manual methods of organising qualitative data have a long-respected history, they are becoming increasingly outdated because of more sophisticated Computer Assisted Qualitative Data Analysis Software (CAQDAS). The researcher attended training on using a CAQDAS programme (NVivo) that managed qualitative data and despite this, decided to manually organise the data. The decision to manually organise the data enabled immersion in the data through the process of transcription (Polit and Beck 2012) and TA (Braun and Clarke 2006). In addition, following a discussion with the researcher's supervisor, an experienced qualitative researcher, who favoured the manual method for organising data, it was acknowledged that CAQDAS programmes for organising qualitative data could turn a cognitive process into a mechanical and technical activity (Polit and Hungler 1999) and thus, forged the decision to manually organise the data. The verbatim quotes that formed the

subthemes and themes were manually collated and presented in a Microsoft Word table (Appendix 18).

5.7 Data saturation

There is contention in the literature on the concept of data saturation. Proponents of data saturation differ on the view of what data saturation is and how claims of data saturation are made. According to Guest, Bunce and Johnson (2006), in qualitative interviews, data saturation occurs where no new themes emerge from the analysis of the data. They suggest that, in purposive samples, data saturation can be achieved by twelve interviews (Guest, Bunce and Johnson 2006). Other authors suggest that data saturation is reached when there is enough data to replicate a study (O'Reilly and Parker 2012; Walker 2012). O'Reilly and Parker (2012) acknowledge that oftentimes, saturation is a requirement of academic journals to demonstrate quality of the research. According to O'Reilly and Parker (2012), importance should be given to the transparency to which data saturation claims are made and not determined solely on the basis of the number of participants. Hagaman and Wutich (2017) challenge Guest, Bunce and Johnson's (2006) perspective on data saturation and suggest that when conducting qualitative research across multisite locations (as in the case of this research), sample sizes ranging from 20 – 40 are required to reach data saturation for meta themes (themes within a theme or in other words a sub-theme). However, in homogenous samples, 16 or fewer are needed to reach data saturation (Hagaman and Wutich 2017). Recruitment in this phase extended beyond twelve interviews (n = 24 interviews) to explore the experiences/opinions of the different professional groups across the geographical areas. Following analysis of the data, three participants who had volunteered to be re-contacted if needed, were re-interviewed to explore the identified themes in more detail and deepen the

richness of the data. It was felt that saturation had been reached as the themes were fully explored and participants at the latter stages of this phase raised no new themes during the interviews.

5.8 Reflexivity

It is acknowledged that qualitative research is prone to subjectivity due to the interpretations of the participants' behaviour, and data collection is influenced by the values, beliefs, interests and experiences of the researcher (Jootun *et al*. 2009) therefore, a reflexive approach to the research was employed. Reflexivity, the process of critical self-reflection and the analysing and interpretation of data (Topping 2010; Polit and Beck 2012) was used throughout this research; from the pilot stage, when conducting the semi-structured interviews, to analysing the data. Polit and Beck (2012) suggest the use of a reflective journal or diary throughout the research journey as a useful tool to aid the reflexive process which was used during this research. Central to the reflexive process was being self-aware and introspective which enhances the quality of the research (Polit and Beck 2012). In addition, Roddy and Dewar (2016) provide a framework for reflexive questioning which they describe as the 7 Cs, namely, connecting emotionally, considering others perspectives, (being) curious, collaborating, compromising, (being) courageous and celebrating. When conducting the interviews, the researcher was mindful of the 7 Cs in an attempt to enhance reflexivity.

The researcher holds current registration as a MW and HV with the Nursing Midwifery Council (NMC) and was deemed an 'insider researcher' (Burns *et al*. 2010). As such, it is acknowledged that the researcher had the potential to influence

the research in terms of how the research was conducted, the analysis and reporting of the data (Holloway and Galvin 2017; Hesse-Biber and Leavy 2011). The benefits of being an insider-researcher are said to include ease of access to study sites, the ability to build an early rapport with participants, a shared and better understanding of the language and culture of the participants and being more readily accepted by participants (Burns *et al*. 2010). Wilkinson and Kitzinger (2013) point out that insider researchers are neither unitary or fixed and often can be partial and change across the course of a research project. To that end, the researcher belonged to both professional groups (an insider) but had never practiced in the research sites (an outsider) and was thus able to wear 'two hats' during the research, both as an insider and outsider.

Criticisms have been made regarding insider-researcher in qualitative research where there is a danger that the researcher could make assumptions about an observation without seeking clarification for rationale underpinning certain behaviours (Bonner and Tolhurst 2002). Furthermore, Bonner and Tolhurst (2002) caution researchers of becoming 'enmeshed' and developing too much rapport with participants and thus risk losing perspective on the research focus. During interviews the researcher was mindful to create, not distance from participants, but a boundary where the role of researcher and the purpose of the research remained utmost in her mind. Being aware of past experiences, working practice and professional cultures, personal perspectives, feelings and actions regarding the research were reflexively considered by the researcher during the research process.

Supervision is also said to enhance the reflexive process whereby it is used to engage with researcher subjectivity and to address the 'emotional work' of research (Elliot, Ryan and Holloway 2011). Academic supervision provided opportunities for the researcher to discuss 'forms of noticing oneself and staying engaged emotionally as well as creating a reflective distance' (Elliot, Ryan and Holloway 2011, p. 442). Lengthy and in-depth discussions took place during supervision whereby the academic stance of reflexivity was addressed and more importantly for the researcher, the supervisory team shared the benefit of their experiences and perspectives of conducting research which fostered a breadth of perspective that the researcher may not have otherwise considered.

5.9 Trustworthiness

When addressing issues of rigour or quality in qualitative research, Holloway and Galvin (2017) favour the term 'trustworthiness' and 'authenticity' over the positivist terms of 'reliability and rigour' (Polit and Back 2012). Holloway and Galvin (2017), describe trustworthiness in qualitative research as methodological soundness and adequacy. The first step to enhance the trustworthiness of this research was conducting a small pilot study involving a few members of the study population, using a convenience sample, to ensure clarity and appropriateness of the questions. The pilot study assisted the researcher in gaining experience in conducting interviews and generated practical information on using the audio-recording equipment to ensure there was no equipment failure.

Polit and Hungler (1999) suggest that researcher credibility is important in establishing confidence in qualitative data since the researcher *is* the data collecting

instrument as well as the creator of the analytical process, therefore their training, qualifications and experiences are important in establishing confidence in the data. To that end, the researcher holds professional qualifications as both a MW and HV and has previous qualitative research experience whilst completing a master's degree, thus enhancing confidence in the data.

Guba (1981) *in* Shenton (2004, p.63) proposes that four criteria should be considered by qualitative researchers in pursuit of trustworthiness, namely, credibility, transferability, dependability and confirmability. Credibility is described as confidence in the truth of the data and interpretation of the data (Polit and Beck 2012). Qualitative researchers should ensure the credibility and dependability of the research by transparently describing the steps taken in the research process to show the development and reporting of the findings, which can be achieved through an audit trail (Korstjens and Moser 2018).

Rodgers and Cowles (1993) describe four types of documentation used to develop an audit trail: contextual, methodological, analytical and personal response documentation. Contextual documentation comprise fieldnotes taken during observational and interview data (Rodgers and Cowles 1993). Interviews were audio-recorded, key words were noted during interviews and events documented, such as interruptions during interviews. Methodological documentation, according to Rodgers and Cowles (1993), concerns decisions made regarding the strategies used to conduct the research which are provided in this thesis. Analytical and personal response documentation concerns the researcher's thought processes and

reflections on the collection and analysis of the data and is evidenced through reflective journal accounts (Rodgers and Cowles 1993), which is not only said to enhance the trustworthiness of qualitative research but also aids the TA process (Nowell *et al.* 2017). Reflexivity acts as a guard against personal bias in making judgements in research (Polit and Beck 2012). In an attempt to remain self-aware and reflect on ways in which personal bias may have affected data collection and analysis, the researcher kept a reflexive journal throughout the research process to document the research journey and record any decisions made. Furthermore, during the analysis of the data, the iterative TA process included regular consultation with the researcher's supervisory team to discuss interpretation of the findings and emergent themes. Since two of the supervisory team were not HCPs they were able to provide interpretation of the findings which may not have been considered by the researcher.

Holloway and Galvin (2017) expands upon the notion of credibility and suggest that credibility or internal validity is whether the findings of the study accurately reflect the aims of the research and the social reality of those taking part. This can be established by taking the findings back to the participants through member checking (Holloway and Galvin 2017). A version of member checking or rather, participant verification occurred after each interview *in situ* (Polit and Beck 2012) where the researcher summarised her interpretation of the main points of the interview with participants and asked for participant clarification. Bloor *et al*. (2001) suggest that participant verification is achieved when verbatim transcripts are sent to participants for verification. Verbatim interview transcripts were not sent to participants since the

contact details of all participants were not known to the researcher due to the nature of the recruitment process in some cases.

Transferability is described by Polit and Hungler (1999, p.717) as "*the extent to which the findings of the data can be transferred to other settings or groups".* However, Holloway and Galvin (2017) question the concept of transferability in qualitative research as they suggest that many qualitative researchers do not aim to achieve transferability or generalisability as they focus on specific instances not necessarily representative of other populations. The focus of the qualitative phase was to gain a rich understanding of the human experience (Polit and Beck 2012) and not strive for generalisability. Within the qualitative phase, verbatim quotations and thick description was used to demonstrate the researcher's interpretations of the findings. Carminati (2018) suggests that where qualitative research seeks to bridge a gap in the literature then the concept of generalisability is worthy of address. To that end, the findings of this research informed the next quantitative phase in the form of a bespoke questionnaire where generalisability could be addressed.

According to Shenton (2004) dependability is addressed by reporting the detailed processes within the study thereby enabling future researchers to repeat the study if not necessarily obtain the same results. Providing detailed information on the methods used and the analytical decisions made, also provides an assessment of if proper research practices have been followed (Shenton 2004). This has been achieved by providing a thorough account of the methods used, details of the data collection and audit trail, and a reflective appraisal of the research.

Confirmability refers to objectivity where it is established that the data, findings and interpretations are those reflected by the participants and not the researcher's bias, motivation or interest (Polit and Beck 2012). Strommel and Wills (2004) suggests that confirmability should determine whether two or more researchers can corroborate on the decisions made during the research on the data collection and interpretation of the data. This research has demonstrated confirmability in several ways: by giving a detailed account of the methods used and the reasons for making analytical decisions, triangulation of the research via the mixed methods design, maintaining a reflective journal, being reflexive throughout the research and finally through detailed discussions with the researcher's supervisory team to consider interpretation of findings.

5.10 Findings

Three themes were identified from the interviews (Table 5.6), namely:

- Identifying Need
- Education, Skills and Experience
- Referral Pathway

Table 5.6: Themes and sub-themes generated from Thematic Analysis of interview data

Identifying Need • Continuity of carer • Disclosure • Time
Education, Skills and Experience • Targeting Resources • Intuition and confidence
Referral Pathway • Use of Screening Tools • Knowledge of Referral Pathway

Themes were not explicitly described by participants but assigned by the researcher to capture pertinent issues within the data. Each theme incorporated two or more sub-themes. The themes and sub-themes related to the barriers and facilitators expressed by the participants in relation to decision-making regarding referring women for PNMH care. To maintain confidentiality and anonymity, participants were assigned a unique identifier before analysing the data, for example, MW1, HV1, etc. Participant quotations are presented using colour codes: blue for Blue Area (area that provides specialist PNMH services as outlined in Chapter Four, section 4.1; n = 15) and green for Green Area (area that does not provide specialist PNMH services, outlined in Chapter Four, section 4.1; n = 9), to differentiate between the areas of service provision.

5.10.1 Theme 1: Identifying need

One of the themes generated from the data through the TA process was identifying need relating to PNMH and the subsequent referrals. When deciding whether to refer women for secondary mental health care, MWs/HVs must first identify those women who need PNMH care, which is a key part of their job role (NMC 2014; NMC 2015).

5.10.2. Continuity of carer

Several influences related to identifying PNMH needs were discussed by the MWs/HVs, one of which was continuity of carer. According to Sandall (2018, p.3), in maternity services continuity of carer refers to continuity of the *person* looking after women during their maternity journey, before, during and after birth. MW13 appeared to agree with this definition in the quotation below and describes what they perceive to be the benefit of continuity of carer:

"I think, continuity if it works and they roll it out as they say, that would be amazing to have a midwife antenatally, intrapartum and postnatally. So, if there's any birth

trauma or mental health issues from that then that midwife's going to know and will be able to follow it through, and not have to ask those difficult questions coz she'll have witnessed it…" (MW13)

MW13 demonstrates that continuity of carer is viewed favourably ("that would be amazing"); however, the quotation suggests that it was not happening in practice at the time of the interview. In contrast, one of the MWs practising in the area with PNMH services believed that the MWs were providing continuity of carer in the antenatal and postnatal period (MW4). Other MWs in this area did not agree (MW10) and described a lack of continuity of carer they encountered in practice:

"We are very, very good ... at continuity of carer antenally and postnatally. So, although we haven't cracked the intrapartum bit, our continuity of care is very, very, good. And so, it does mean that women are under a very small team of midwives, so they tend to get to know their team of midwives..." (MW4)

"We used to have a model where you would generally book your women that were going to be on your GP service care.... A lot has been taken away, so that there might be a midwife who is just a booking midwife for example. She books women from all sorts of areas during her day. So, she doesn't necessarily have that link with women, and I think that some of that [continuity of carer] *has been lost."* (MW10)

From the quotes above, it appears that not all MWs in Blue Area perceived they provided continuity of carer. However, both groups of participants appeared to view continuity of carer positively and perceived it to be important when identifying PNMH problems. For example, when asked: "What do you think would help you in your assessment of a woman's perinatal mental health?" MW6 responded:

"I think first of all you've got to gain a better, you know, build a relationship with the woman. I think continuity helps as well and good communication …" (MW6)

MW6 appears to suggest that the relationship between professionals and women facilitates the assessment of PNMH problems and to that end, continuity of carer

facilitates the building of relationship between them. Other participants, including some HVs, concurred that continuity of carer and relationships are important to facilitate women's disclosure of PNMH problems:

"I think what we're trying to do within midwifery anyway is trying to provide continuity of carer." (MW12)

"I'm all about the relationship. All about it… How on earth can you expect someone to come to you [and say] *'I feel rubbish... or this is happening to me' without building up that relationship I will never know. So that is the big thing for me and it's very difficult for health visitors to pick these initial concerns up erm ...without that."* (HV6)

"If I had to give you one word, to sum it up in one word, it is about relationships. It's about the relationship with me and the mum, it's the relationship between the mums and babies, the relationship between me and GP, me and the midwife. Relationships is what is needed and what make everything work and that is a thing that gets in the way of everything. You know when there isn't relationships. When I don't know who the GP is and I don't know the midwife, or the midwife doesn't know that mum. You know that's where everything falls down" (HV1)

Continuity of carer was perceived to be important for relationship building and for the opportunity it gave professionals to monitor a woman's mood and detect deterioration in mood over time as demonstrated by MW12:

"...you've seen that woman for seven, eight months antenatally, and then a couple of weeks postnatally, so you can see how their mood is and how they deteriorate, how they feel emotionally or whether they feel like they are getting support…" (MW12)

In this instance, observing a deterioration in a woman's mood supports the MWs' assessment of the woman that ultimately may require further action, for example, in the form of a referral. MW13 agrees that continuity of carer provides the opportunity to observe changes in women's behaviour:

"Continuity of midwife. So, building up that relationship for a woman wishing to disclose [PNMH problems] *or/and a midwife being able to observe any changes in that woman's behaviour. If she's not seeing her every antenatal appointment or*

through to postnatally, if it's a different midwife, they're not going to notice those subtle changes potentially." (MW13)

While none of the HVs used the term 'continuity of carer', they alluded to it during the interviews; both in a positive way where continuity of carer was evident and negatively where there was a perceived lack of continuity of carer, similar to the sentiments expressed by the MWs. In health-visiting, continuity of carer is defined as seeing the same HV at all or most contacts (Health Education England 2016). HV3 discusses the lack of continuity where community nursery nurses (CNNs) were carrying out contacts that were previously carried out by HVs to demonstrate the changes in health-visiting services and the potential impact that the lack of continuity of carer may have on identifying PNMH problems:

"At the moment with these key contacts that we're allowed to do ... a lot of the time it's the nursery nurses that do the nine-month and two-year check. We're moving from this service and it's so upsetting. We can do home visits but only if there's a need. But I think the people that have the need are not going to come to clinic. We're not going to pick up all these cues at home or be able to open a conversation." (HV3)

HV3 clearly views a lack of continuity negatively ("it's so upsetting") and alludes to the fact that where CNNs instead of HVs conduct the nine-twelve month and two-year health and development review, it is perceived to be a missed opportunity for HVs to identify any PNMH problems. HVs had hitherto conducted these 'key' contacts and thus had the opportunity to assess women's mental health. The allocation of these 'key' or mandated contacts to CNNs appear to occur across both geographical areas:

"...the 12-month check, that was the health visitor and I believe the nursery nurses are going to be allowed to do that now and the 2 years [check]*, the nursery nurses do that."* (HV7)

It appears from the interview data that the consensus amongst MWs (with the notable exception of MW4) and HVs is that their experiences of continuity of carer was negatively affected by some of the changes in how midwifery and health-visiting services were delivered. For example, antenatal booking clinics instead of individual MWs booking women in their care; and CNNs conducting contacts previously carried out by HVs. HV7, practising in an area with PNMH services, highlighted the changes in health-visiting practice were not confined to one area of the country and may be indicative of changes in practice throughout health-visiting services generally.

Participants from both areas highlighted that services were subject to recent changes. For MWs/HVs, the changes in services were largely discussed in terms of where the contacts took place and how this impacted on continuity of carer. For example, home visits replaced by contacts in a clinic environment meant, as one MW stated, "now you don't even do a booking at home, they're never seen in their home" (MW12); another HV commented "you know our six-week contact is a clinic contact?" (HV5). Some HVs discussed that seeing women in the home environment provided the opportunity to assess women's parenting and/or was a conducive environment for assessing women's mental health or for women to disclose PNMH problems:

"I'd have to see, is this baby safe? Or is she [the mother] *feeling a bit low? And that she can't cope. It's all very individual isn't it? In the back of your mind you've always got to have 'is that baby safe in this home with this mother'. And … either I'd sit down with the mum, you know …and just explore it a bit further"* (HV8)

"… so if I go into a house erm, so I'm looking for … probably the attachment with the baby, seeing how she is with the baby, how she's handling the baby, how she's looking at the baby, what she's doing, how she's caring for the baby's needs. How she talks about the baby, what her worries are, her anxieties" (HV7)

"We were seeing them [women] *at home, yes. And of course they're more relaxed. I just think it makes it easier … the immediate impression of her in her home, in her space, and her presentation and the way she is with the child, what she tells me, what other people in the family may tell me if she's there in front of them."* (HV2)

"[without home visits] *we're not going to pick up all these cues at home or be able to open a conversation. And you know I'm not going to witness a very untidy granddad in the corner of the room and what effect he is having on the family, or the bins overflowing or if the house is pristine. So you know, it's* [mental health assessment] *just going to be very much a tick box exercise"* (HV3)

The data suggests that there appeared to be little difference between the two areas, and between professional groups in relation to continuity of carer in terms of what participants perceived as the barriers that a lack of continuity of carer presented and the perceived facilitators of continuity of carer and how this impacted on identifying women in need of PNMH care. HV6 compared practice prior to the recent changes to how she practiced at the time of the interview, demonstrates the impact the changes have had on continuity of carer and the subsequent perceived impact on relationship building:

"I know people don't like change and we don't like the fact that we're not visiting, but you can see the difference in your practice… four years ago when I qualified, it was a completely different role to what I am doing now… you were able to contain people, whereby now you're not able to. With the more significant mental health issues, I think it's got to help to see somebody that you know, somebody you can build a relationship up with. Erm, because those women who have issues with anxiety or depression, they've got to feel that they can trust you in order to be honest and tell you exactly how they feel." (HV6)

HV6 acknowledged the recent changes in delivery of health-visiting services and appeared to prefer her practice prior to the changes as she alluded to being able to "contain" women with PNMH problems. She perceived that the benefit of continuity of carer and relationship between professional and woman will aid disclosure of

PNMH problems. Similarly, another HV acknowledged the lack of continuity negatively:

"[lack of] *Continuity and relationships is one of the biggest bug-bears that I hear talked about with my colleagues."* (HV5)

The comment from HV5 is suggestive of a collective negative view amongst her colleagues regarding a lack of continuity of carer. MW14 discussed the planned changes in maternity services in line with the recommendations of Better Births (NHS England 2016a),[6] and envisioned these changes would have a negative impact on continuity of carer. MW14, based in a rural GP surgery where two MWs held the caseload for two GP practices, explained that she had been able to provide continuity of carer under the previous service model:

"Between me and the other midwife I'd see pretty much 95% of my women every appointment apart from when I was on annual leave. And if I didn't [see the women] *my colleague did and vice versa. I'd see ladies from the booking to delivery and postnatal."* (MW14)

However, she voiced her concerns about the changes to services:

"…but by changing into big teams … I don't think the continuity is going to be as good." (MW14)

MW10 acknowledged that changes in maternity services were happening in the area with specialist PNMH services:

"...obviously there's loads of changes going on with maternity services isn't there…" (MW10)

[6] Better Births is an initiative for maternity services in England to provide safer, more personalised, family friendly care where every woman should have access to information to enable her to make decisions about her care; to provide continuity of carer; and to support staff to enable them to deliver women-centred care, working in high performing teams and well-led organisations to break down organisational and professional boundaries. https://www.england.nhs.uk/publication/better-births-improving-outcomes-of-maternity-services-in-england-a-five-year-forward-view-for-maternity-care/

A further change in services mentioned by the HVs across both areas (with and without specialist PNMH services) that affected continuity of carer, was that the majority of HVs reported having fewer contacts with women in their care than they had had prior to the recent service changes. The majority of HVs viewed this negatively as they felt that fewer contacts with women meant less opportunity to build a relationship with women and thus for women to be 'open and honest' about their mental health as discussed by HV7:

"I suppose now we don't really build up that rapport with the woman coz we don't see them so often, so it's difficult to get a true picture of what's going on and maybe for her to be open and honest with us because we haven't got the rapport that we used to." (HV7)

HV2 concurs:

"And what I feel we're lacking is that we don't have those contacts anymore to really get to know them [the women] *so that they feel they can tell us* [about their PNMH problems]*."* (HV2)

The above quotations appear to suggest two consequences of not visiting women as frequently; firstly, the lack of contacts restricts the capacity to build a relationship between the women and HVs and thus affect women's potential for disclosure of PNMH problems. Secondly, fewer visits are likely to result in fewer opportunities to assess women's mental health needs. However, one HV felt the changes in health visiting services had some positive consequences, as she felt health visiting services needed 'tightening up', where women were encouraged to take responsibility for their own health and access help themselves instead of waiting for visits from the HV as described in the following quotation:

"I think health visiting needed tightening up a bit … you know a lot of it is now putting the responsibility on the parent… it's been over twelve months [since the service changes] *I can see how that works... The model is very much based on women, you know, taking responsibility for their own health and the health of their family, not relying solely on the health visitor to do everything, you know, take responsibility. You know, come and see us if you have a problem … you've got our clinics, come and see us… erm … asking for help is a sign of strength. You know it's that sort of responsibility … not sort of sitting around waiting for someone to come and knock on your door..."* (HV8)

The opinion that health-visiting services needed 'tightening up' was not shared by other HVs in the interviews. In contrast, other HVs expressed the view that fewer visiting/contacts was detrimental to continuity of carer and ultimately to the relationship between HVs and women.

From the interview data, an apparent difference between the participants was that, unlike HVs, MWs did not mention having fewer overall contacts with women. For MWs, continuity of carer and therefore the opportunity to identify mental health problems was affected by how the services were delivered, not by having fewer contacts with women in their care. For example, prior to the service changes, community MWs (CMWs) would conduct pregnancy booking appointments for women on their caseload. After the service changes, one MW was responsible for conducting pregnancy booking clinics instead of individual MWs seeing women on their caseload. This change in service delivery appeared to have reduced the potential for continuity of carer and consequently on MWs opportunity to assess women's mental health. The data also indicated that for HVs in both geographical areas, continuity of carer was affected by CNNs conducting some of the HV mandated contacts instead of HVs, home visits replaced by clinic contacts and less visiting overall.

5.10.3. Disclosure

For many participants across both professional groups and geographical areas, identifying women's mental health problems were dependent on whether women disclosed a history of and/or current PNMH problems when asked about their mental health. Closely linked to disclosure was the relationship between professionals and women; as previously discussed, many participants perceived relationships developed through regular contact with women by the same MW/HV, i.e. continuity of carer. However, one HV from the area without PNMH services challenged the belief that a trusted relationship between professional and woman resulted in disclosure of PNMH problems. She stated that in her experience women would disclose mental health problems only if they wished to do so, regardless of the relationship between the woman and professional:

"I'm a firm believer that clients tell you what they want you to hear, no matter how open [you are]*, how 'You can tell me anything' you are, you are going to get those who feel that they can't say that* [disclose PNMH problems] to you." (HV4)

Other participants acknowledged that disclosure was dependent on women's willingness to share that information:

"There are ones that will [disclose PNMH problems]. *But there are just as many out there who never will* [disclose]*…."* (HV2)

"It's difficult sometimes to say how many [women with PNMH problems] *I see because sometimes women don't tell you..."* (MW6)

"So, it all depends whether the lady is willing to tell you the information isn't it?" (MW5)

However, most MWs/HVs perceived disclosure was facilitated by the relationship between professionals and women, as illustrated in the quotations below:

"I think women are now able to disclose and discuss openly with someone they perhaps trust a little bit more..." (MW11)

"...the opportunity to build relationships with women, to feel comfortable [for her] *to share that kind of information."* (HV3)

There was an acknowledgement amongst most of the participants from both geographical areas that the perceived stigma associated with mental health amongst women was a barrier to disclosure:

"I think there is still a stigma attached to it [mental health problems]*."* (MW10)

"I believe there's a huge stigma with mental health. Huge, huge, huge stigma…" (HV4)

"...People thinking mental health is still something to be ashamed of. I'd say that's the biggest barrier." (HV8)

Similarly, MW14 suggested that the perceived stigma of mental ill-health amongst women was also pervasive amongst some healthcare professionals:

"So how can we expect women to you know, disclose it [PNMH problems]*, if you can't even talk about it and get supported by your own that you work with? And it's supposed to be a caring profession …if we can't recognise, sympathise within ourselves and our colleagues, how can we* [sympathise] *with the women?"* (MW14)

MW14 alluded to a lack of sympathy towards colleagues with mental health problems. She explained that where colleagues had taken sick leave due to stress the response from colleagues had been unsympathetic as she relayed a conversation about a colleague who had taken sick leave:

"'Oh, Lisa's off sick.'
'*What's she off sick with?'*
'Stress.'
'What do you mean stress? Why's she stressed?'

It's that attitude you know? But if you said she's broken her leg, they'd be like 'Oh my God'." (MW14)

The above extract suggests there is a perception that physical problems would elicit a concerned response, whereas a mental health problem is almost dismissed by some professionals. MW14 alluded to the fact that if professionals cannot demonstrate sympathy towards their colleagues with mental health problems, this attitude may pervade towards women too. If that were the case, the lack of a sympathetic attitude amongst professionals may discourage women from disclosing mental health problems or perhaps (hypothetically), MWs from deciding to refer women for specialist services.

To address the perceived stigma associated with mental health problems, some participants reported that disclosure was facilitated by normalising mental health problems. In attempting to normalise mental health problems and consequently encourage disclosure, participants operated in one of two ways. The first was by sharing their own experiences of mental health issues:

"You know, even the midwives are quite happy to share their own experiences. Many of them have had babies and suffered with their mental health so that makes it more normal and allows them [the women] *to talk about it."* (MW3)

"Having a baby in those first six weeks with sleep deprivation and everything like that. I know I wouldn't do it again. I've got one child and I thought I was going mad! And sometimes actually just saying to families and saying to mothers, actually you're okay to say I'm not enjoying this, … and often that takes the anxiety [away] *to have the health visitor go 'It is hard work and it's okay to not feel great'."* (HV4)

"I'll challenge her [the woman] *and say well you know it isn't always easy to live with* [PNMH problems] *because I know, 'coz I've had anxiety and I've driven my family nuts* [laughs] *I do bring myself into it in that respect."* (MW9)

The second was by MWs and HVs from both areas routinely asking about women's mental health and talking about how mental health problems were common during the perinatal period, thereby providing an opening for women to disclose and normalising it through discussions about mental health.

"And sometimes it's about normalizing how she feels as well. Especially for the mild ones. And sometimes I say… there's absolutely nothing wrong in feeling like this, it's ok to feel this way, and what you actually need is to speak to somebody." (HV6)

"Everybody has some degree of mental health/emotional impact on becoming a parent so I would say to all the families that we see and all the mothers and sometimes the fathers as well ... actually getting them to understand their emotional health as well." (HV4)

In Blue and Green Areas, MWs had electronic records that prompted them to routinely ask the Universal PNMH questions at designated times, which acted as a reminder for the MWs to enquire about a woman's mental health:

"The computer system we use has a series of questions that we ask anyway when prompted. So, in the last four weeks have you felt little interest in doing things, anxious, on edge or depressed or tearful. We have those standard questions but then obviously it's down to the individual midwife to deviate away from that and get a conversation going that's a bit more meaningful." (MW13)

"*We use a system* [electronic records], *which gives you prompts so you're asking the lady about how they're feeling, are they feeling depressed or feeling low or need help with their mood. So, we're having those conversations with their daily checks so that starts conversations* [about mental health] ..." (MW3)

Some participants felt that as a direct consequence of routinely asking about mental health, disclosure was encouraged as illustrated by the following:

"...so now because we talk about it more and it's much more of a national agenda, I would say that most women [are] *reporting some element of either historic mental health conditions or current or altered state of mood in pregnancy… because we're asking the question, women are giving us the answers."* (MW11)

"I know I feel that it is increasing [PNMH problems]. *And whether it is actually increasing or whether women are just more comfortable in talking about it I couldn't tell you."* (MW15)

MW3 from Blue Area mentioned disclosure in positive terms where she perceived women were 'getting better' at disclosing mental health issues because women were asked about their mental health:

"I think it's [disclosure] *getting better and I think we all talk to them* [the women] *about mental health …"* (MW3)

Similarly, some MWs from both areas alluded to a lack of parity of esteem where there was a lack of emphasis on mental health as the focus was on physiological aspects of pregnancy and the puerperium. A lack of emphasis on mental health might be a barrier to disclosure for women if MWs concentrated on the physiological aspects during pregnancy and the puerperium and failed to seek to identify mental health issues:

"There's not enough emphasis on mental health. We're always going on about diet and exercise and whatever, but we're never saying you know, well actually if you're feeling like this there might be something emotionally that we might need to talk about it and see what we can do to help you." (MW16)

"We talk about the normal physiological changes in pregnancy, you talk about the sickness, the backache and constipation, those sort of things… And that's the trouble isn't it? People could go to the end of their pregnancy 'Oh nobody asked me [about my mental health]*'."* (MW14)

In addition to discussing strategies that encouraged disclosure, some participants also discussed a barrier to disclosure in terms of the associated fear that they perceived women to believe whereby women were seen as a 'failure' (HV13) or it was a sign of 'weakness' (MW4) if they disclosed PNMH problems. However, a notable similarity between participants from areas both with and without PNMH

services was the perception that women feared that disclosing PNMH problems would result in removal of their child:

"The big fear for women is, will they take my baby off me? … sometimes they think that goes hand in hand and the thing we do is contact social services… [if a woman discloses PNMH problems]." (MW10)

"People don't want to admit to their friends and family and also some appear less likely to admit [PNMH problems] *to professionals as well. Erm… fear of you know, what the referral pathway is, you know, the classic 'Oh are my children going to be taken off me?'"* (MW13)

"A lot of women recently, in the last few weeks have sort of admitted to me that they think, I've been scared to ask for help coz you'll get social services involved or you'd think I couldn't cope." (HV8)

"I think mothers still feel we're going to take their baby away, it's that old fashioned view … that they're not good enough mothers and the children will be removed. And we've got the power to do that." (HV7)

The fear of child removal was discussed by participants from both geographical areas and there was a strong indication from the MWs/HVs that the fear felt by women was perceived by the MWs and HVs to be real, as conveyed by HV5:

"Well I think that the other thing that contributes to that [the stigma] *is that they are in the perinatal period and there's that perception that women don't want to be viewed negatively. I can I tell you this without a shadow of a doubt, women will still say things to me like, 'You're not going to take my baby away are you?' So, a significant proportion of women, still have that fear that their child will be removed. But for all the work that we've done to have those discussions about parity of esteem, all that kind of stuff, there is still that belief that health visitors and the health-visiting service are associated with that* [removal of children]*."* (HV5)

The interview data appeared to suggest that when identifying women's PNMH needs, disclosure was facilitated by the relationship between women and professionals (aided or thwarted by continuity of carer). Perceived stigma associated

with PNMH issues was deemed to be a barrier to disclosure by the participants as was women's perceived fear of child removal if they disclosed PNMH problems.

5.10.4 Time

Amongst both professional groups across both geographical areas, 'time' was the most frequently discussed issue that affected participants when identifying women in need of PNMH care and any subsequent management of PNMH problems. Most participants stated time or rather the lack of time, was a barrier to identifying women with a history of and/or current PNMH problems. Participants cited issues such as workload, staffing levels and organisational changes in services that governed the amount of time they had to effectively assess women for PNMH problems:

"Time is the biggest killer for us really. We're limited … we haven't got sufficient staff to cope … so I can't honestly say, I know hand on heart these women get enough time." (MW3)

"Lack of time is the biggest thing [barrier to assessing PNMH]*."* (HV1)

"How busy the ward area is, that's a major, major thing. And I do sometimes feel that you probably can't spend as much time with these ladies as what you'd ideally like. Just because there isn't … enough staff anyway." (MW8)

As the above quotation illustrates (MW8), postnatal wards were reported to be busy and understaffed, suggesting the MWs did not have the time to talk to women about their mental health. One MW in Green Area concurred and talked about MWs not having the time to carry out a 'proper assessment' of mental health that she felt would prevent women from deteriorating:

"I think it's allowing midwives and other professionals to have more time to be with the woman, with the family, to do home visits, to be able to follow up and carry through erm, proper assessment and interviews. I think that would actually stop women from deteriorating. If they felt that they had that support at the ground level." (MW12)

In the above quotation, MW12 did not expand on what she deemed a 'proper assessment' of a woman's mental health but it appeared to suggest that MWs needed time to carry out the assessment in the first instance.

However, the MWs in Blue Area appeared to have the notable benefit of having a specialist PNMH MW to whom they could refer women for a mental health assessment. MW3 implied that if the ward was busy, she could ask the specialist MW to assess women thereby taking some of the workload pressure off the MWs and ensuring women received a mental health assessment:

"We're quite lucky when they're inpatients because we've got a supportive midwife in post and … obviously if we're concerned on the ward we get [specialist MW] *to come and see them before they get discharged. So, it's quite good and better for us. And as you know working on a busy postnatal ward with 16, 17 discharges every day, our time is quite limited with the ladies..."* (MW3)

"If we were concerned about a lady postnatally, [specialist MW] *normally does just antenatal, but she would see a lady if we are concerned…"* (MW5)

The option of referring women to the specialist MW appeared to offer another layer of assessment for the women, whereby even if the MWs were busy, women would still get a mental health assessment from the specialist midwife. During the interviews, those MWs referring women to the specialist MW used phrases such as "if we've got concerns" or "if I'm worried" as a reason to refer women to the specialist MW. They did not describe following a referral pathway or carrying out an assessment themselves as part of the process to refer to the specialist MW. However, this back-up option of assessment from a specialist MW was something that MWs in Green Area (without specialist PNMH services) did not have at their disposal. This has potential implications for women in Green Area; if the MWs do not

have the capacity to complete a mental health assessment, then potentially this assessment could be missed altogether as they do not have a back-up option, i.e. specialist MW to whom they could refer. The lack of specialist PNMH MW was addressed by a MW in Green Area:

"…obviously by next year we're supposed to have an identified, whether it be a public health midwife or perinatal mental health midwife, erm so I think that is coming in the next six months. That's been identified as a risk within our unit [the lack of specialist MW]*, that we haven't got currently."* (MW12)

Similarly, HV2 discussed the promise of a specialist PNMH HV and her desire to have one in her area:

"We desperately need that [a specialist PNMH HV]. *Yes. We desperately need someone …. and there were murmurings about it* [getting a specialist HV] *ever since I've been here but nothing's ever come to fruition. They were looking at funding for it at one point. I think it would … it would just make life so much easier. Yes, we definitely need someone like that."* (HV2)

HVs also discussed the reality of heavy workloads that added time pressures to assessing women's PNMH. HV7 gives an example of a busy clinic in her area, where 30 women could attend a clinic that lasted 90 minutes. According to this example, women would get on average, a 3-minute consultation with a HV:

"Well the busy one [clinic] *is 30* [women] *and that's in quite an affluent area and they all want to discuss something or other. Generally, between 25 and 30* [women] *is an average clinic. And that's in an hour and a half."* (HV7)

The above quotation illustrates the realities of a busy clinic for HVs, but this was just one example of how HVs experienced time constraints. Some participants also discussed time in terms of capacity and workload in general. As a result of the service changes, HVs reported managing demanding caseloads and highlighted the lack of capacity to carry out some mandated contacts such as the antenatal contact:

"We just don't have the capacity really [to do an antenatal contact]. *I sometimes think we should have, but we don't ...in our office, we do prioritise primips* [primigravida's] *and child protection, then multips* [multigravidas] *might get a telephone call if we've got lots of capacity."* (HV3)

The above quotation not only acknowledges the lack of capacity to conduct antenatal contacts but also has wider implications for HVs in identifying women that need PNMH care where no antenatal contact means a missed opportunity to identify current or past mental health problems and make the appropriate referrals. This is particularly pertinent for women with existing mental illness who require timely, preventative referrals to specialist PNMH services (NICE 2014). However, the quote by HV3 states that primigravid women and women with children with child protection issues are given priority for antenatal visits. This appears to suggest that women with a history of and/or current mental health problems are not prioritised and thus fail to benefit from a routine antenatal appointment where any potential mental health problems could be appropriately addressed, e.g. referrals to PNMH services where necessary.

The issue of a lack of parity of esteem was relevant to the subtheme of 'time'. It appeared from the data that MWs in particular had many physiological assessments/examinations to complete during their contact with women. MWs suggested that they had limited time with women to address any mental health issues due to the need to complete physiological assessments (such as recording blood pressure, abdominal palpation, auscultating the fetal heart etc.) and/or tasks (testing urine, checking scan results, etc.). This was evident from the MWs in both geographical areas. The interview data suggested that physical tasks take priority during contacts between MWs and women:

"So definitely, like being able to get all the postnatal checks done and all the antenatal care side of things done, make sure all the scans and everything like that. Yeah it does, it probably ends up taking away from the other parts of the job. And I think the turnover is so quick as well. Yeah. See, you kind of can't sit and do that [assess mental health]*, which is a shame."* (MW8)

"*Yeah, without a doubt* [PNMH gets missed]. *Coz you've got … let's just say, a 28 weeker comes in. You have to start measuring her tummy, make sure they've got a growth chart printed off, 28 week bloods, you're talking to her about whooping cough, flu vaccine, are they well in themselves, you know the health check, DV* [Domestic Violence] *you know, you're asking about all those things. And going through those things, sometimes I think it's just easy to ask those things and just actually not listen to what they are saying. Because you're too caught up because you know that after 30 minutes when that lady's gone, you've got another one coming in."* (MW13)

"So, you're doing blood pressure, wee, telling them about whooping cough and everything else that goes with it. Talking about breastfeeding and talking about everything else in your few minutes. And most ladies that come into clinic are consultant care, so they've got problems … so I think in clinic there's not enough time [to discuss mental health]*."* (MW14)

"You can't assess someone's mental health in that time… Oh, bloods, weights, heights, histories, everything, previous children, any problems, any concerns, yeah it's just incredible ...screening..." (MW12)

The above comments appear to illustrate that some MWs had a task-orientated approach during contacts with women that focused on the physical aspects within their job role allowing little or no time to address mental health issues and suggesting a lack of parity of esteem. Overall, a large majority of participants in both areas perceived time to be a barrier to assessing women's PNMH.

5.11 Theme 2: Education, skills and training

The theme of Education, skills and training related to the barriers and facilitators when identifying women with PNMH problems and referring them for PNMH care and encompassed the skills involved in professional decision-making within MWs'/HVs' roles.

5.11.1 Targeting resources

Both geographical areas had undergone recent changes in service delivery as highlighted in the previous theme: Identifying Need. The sub-theme of targeting resources is closely linked to the sub-theme of time. Both sub-themes relate to workload and capacity in the changing environments of midwifery and health-visiting services. The sub-theme of 'targeting resources' captures, not only the time constraints on professionals and changes in midwifery and health visiting services, but also how these participants utilised their professional knowledge, judgment and skills to target the limited resources to women whom they perceived as needing PNMH care:

"...our services are very stretched. We've got a lot less health visitors. We can't provide the service that we could historically … we try to target the ones that are most vulnerable." (HV1)

"…a woman I saw not so long ago, I had a referral from the midwife to say that she'd actually been sectioned earlier in the year, so I did manage to do a targeted antenatal which is unusual." (HV7)

"…we're all so over worked and stressed aren't we." (MW12)

The interview data implies that despite the recommended contacts for women in the perinatal period, MWs and HVs from both areas perceived that their services are 'very stretched' (HV1) in terms of staff shortages and appear dissatisfied with the service they currently provide. Some health visitors in Blue Area felt similar frustrations despite the fact that this area has the recommended PNMH services as outlined by NICE (2014):

"Well I think the most important thing is the decline in the service as erm, the health-visiting service and the service provided to women with poor perinatal mental health. We used to provide a very good service with the listening visits. The tools we used worked well and since we've stopped using the EPDS and using the universal

[questions] *we don't capture as many women… you know, a lot of women we're missing … which will then have a knock-on effect with children's health as well."* (HV7)

HV7's comment appears to indicate that for HVs to identify and/or make decisions about referring women with PNMH problems, importance is placed on how the health-visiting services are delivered. The changes in service delivery were perceived to limit the support that HVs provided for women. HV7's comment is revealing as it suggests she preferred using a different screening tool to the one she was currently using as she felt it 'captured' more women with PNMH problems, and preferred conducting listening visits[7], neither of which she reported constituted the current recommended practice in her area. She also acknowledged the potential impact on children of failing to identify women with PNMH difficulties. The data also suggest that participants perceived that giving women extra contacts was important when responding to PNMH assessments, but this was reliant on resources as indicated by MW10:

"If I'd identified somebody who perhaps at that time had answered [positive] *to the marker questions but said 'I don't really want all of the extra services and I feel like I just need to work through things', I would just offer additional antenatal appointments, contact the health visitor about getting early access to the health visitor. But again, you know, that's all resources…"* (MW10)

MW10 appears to suggest that additional visits (from herself and other professionals such as the HV) would be useful for some women with PNMH problems (and not necessarily referral to specialist services) but the ability to conduct extra visits was dependent on 'resources'. Although she does not explicitly explain what the

[7] Listening visits are described by NICE (2014) as a preventative, psychosocial intervention based on non-directive counselling. Listening visits commonly consist of hour-long weekly visits for up to eight weeks (Turner *et al.,* 2010).

resources are, from the data it could be assumed increased staffing levels may enable increased capacity to visit women and/or spend more time with women, thus allowing the opportunity to assess women's mental health.

5.11.2 Intuition and confidence

When considering women's PNMH, intuition played an important part in participants' decision-making in the assessment and referral processes. Although many participants used the recommended screening tools e.g. universal PNMH questions (NICE 2014) to guide their decision-making, the tools were only one component when deciding whether to refer women for PNMH care. Many of the more experienced professionals i.e. those professionals who had spent several years in practice, discussed using their intuition to facilitate their decision-making when deciding to refer women with PNMH problems. Using their intuition gave them confidence when making clinical decisions. This was borne out by HV2 who discussed using her intuition to influence her decision-making regarding her approach to a woman's care, when the assessment (using the recommended tool) was incongruent with the woman's presentation:

"In fact, I had one lady just recently, who gave birth to a Down's baby. She didn't know she was having a Down's baby, she'd split up with her partner during the pregnancy and came across as really coping but she was always wide eyed and I thought you know, you're not coping, you're not coping! And one day I went there and she just cried the whole visit…. But she'd answered 'No' to the Whooley questions initially." (HV2)

HV2 demonstrates the value of following her intuition to guide her decision-making. Had she relied on what the woman had told her when asking the universal PNMH questions, she would have deemed the woman appropriate for core service (i.e. the mandated contacts only). However, she used her intuition and continued to visit this woman, using the excuse that she needed to monitor the baby's weight as a means

of gaining access to the woman. During the interview, HV2 went on to explain that once the woman had exposed her true feelings, she referred the woman to a charity that supports parents of children with Down Syndrome; the woman was seen by the GP and prescribed antidepressants; referred to a CPN and commenced a baby massage course to help her with attachment difficulties she was experiencing with her baby. This example illustrates the multifactorial processes involved in professional decision-making where assessment alone (despite using the recommended tools) is only one element of that process, another being professionals utilising their intuition.

Many of the participants discussed using their intuition based on previous experiences and knowledge when assessing women's needs for PNMH care. The participants were an experienced group of professionals (ranging from one year post qualification to 33 years with a mean length of qualification of 19 years) and the data suggests that individual practitioners were able to draw on their experiences when managing women with PNMH problems and that this appeared to give them confidence:

"Yeah I do [feel confident]. *I do, but I think that's because I've been nursing a long time. And erm, I worked at* [MBU] *Unit and so had a lot of support there. And I get a lot of support from the specialist perinatal mental health - health visitor. I talk to her now and again... Erm I do feel confident really..."* (HV7)

HV7, working in an area with specialist PNMH services, appears to gain confidence from liaising with her specialist PNMH HV with which HV6 agrees:

"I will have a lot of conversations with mums [in the hub][8] *in tears because of this, that and the other. And a lot of it is sleep deprivation or struggling to deal with other*

[8] The Hub is a community based telephone advice service managed by HVs offering advice and support to parents with children 0-5 years. Many Trusts throughout England have HV Hubs.

children, that kind of thing. And all of it is significant to that mum so it is really useful to have in that situation, some guidance really from [specialist PNMH HV]." (HV6)

HV3 below presents a moral dilemma of intuitive decision-making as she describes "opening Pandora's Box and leaving her in a miserable mess" which highlights the balance between identifying a PNMH problem and knowing the correct way to manage it without available specialist PNMH services, thereby making it worse for the woman:

"I've often got a sense that something isn't right but it's knowing the right way to open it up a little bit without opening Pandora's Box and leaving her in a miserable mess…" (HV3)

Many of the participants discussed the formal processes they use when making clinical decisions to refer women, for example, based on the woman's presentation/symptoms, history and family history, as well as relying on their observational skills:

"Erm, her previous experience, how she was with her other children, has she had any previous mental health problems, any depression. Sometimes we do get information from the midwife…" (HV7)

"At the first contact with maternity services we ask them [the women] *the NICE guidance on mental health questions … and then sometimes that does trigger, you know, past history or current concerns… women who have got a history of psychosis or had admission recently"* (MW10)

"…any suicide attempts, erm bipolar, schizophrenia, erm previous admission to [MBU]…*what I'm presented with, what's this woman telling me, the issues for her would affect my referral on* [to secondary PNMH care]*"* (MW11)

"Erm, the history, ongoing antenatal history, their behaviours, how they handle their babies, how they interact with their babies, how they interact with us [the MWs], *how they're interacting with their partner, if they're withdrawn…"* (MW 3)

"…their history, so medical history, anxiety problems, erm sometimes they come to you [have] *no eye contact, body language erm their general mood … kind of alarm bells start ringing… family history especially at booking* [appointment] *… so you can see if there's anything you know, relevant in there"* (MW 14)

"…looking at how she is, seeing her with her baby … just trying to pick up on the vibe of what's happening, about her history, her background…" (HV3)

"From booking, erm if there's already notes on her, erm on her records, if there's history [of mental health problems], *if she discloses it…as a midwife it's part of the whole picture when you book a woman… so you are looking for a background in mental health as well as their general health…"* (MW 15)

"…you're looking back at any history [of mental health problems] *because we all know that if you had problems in the past then you're more likely to have problems in the future…"* (HV2)

These quotes illustrate the composite factors that MWs and HVs rely on in their decision-making processes when deciding to refer women for PNMH care; in the examples above, both professional groups consider women's history of mental ill-health used in conjunction with women's presentation and/or their intuition.

Unsurprisingly, both professional groups said that a woman's presentation would influence their assessment and decision to refer women for PNMH care. However, intuition was often described in less tangible terms whereby participants 'had a feeling' that something was wrong but had no concrete evidence to support this feeling.

"Sometimes you just think in your stomach that something is not quite right." (MW3)

"… it's difficult to quantify but you get a feeling that something's not quite right." (MW1)

"…I think I rely on my common sense … it's your gut feeling at the end of the day that prompts you into doing whatever you do [referring]*"*. (HV6)

"So, you know, it helps you know, just talking, and your gut feeling and how you notice things like, I can remember as a student health visitor, and being in clinic and seeing a family and thinking, that family makes me feel really uncomfortable. Or seeing a mom and a baby's interaction and thinking that makes me feel stressed, what is going on there?" (HV1)

Intuition and history taking would appear to be important factors for MWs/HVs to consider for women who present as well but are at a high risk of becoming unwell due to their own and/or family history of mental ill-health.

The interviews indicate that intuition (gained through experience and knowledge) gave practitioners confidence when making clinical decisions, albeit in an indefinable way. Nonetheless, participants often acted upon their intuition to guide their practice and make the appropriate referrals, as illustrated by the example from HV2 (who continued to visit a mother with a child with Down Syndrome) despite the mother giving a negative response to the Whooley questions.

As part of the interview guide, participants were asked what factors they perceived as a barrier to them when assessing women's PNMH needs. Overall, the majority of participants from both geographical areas stated that they lacked the appropriate training in relation to PNMH and would like further education/training despite receiving regular mandatory updates on PNMH. The minimal training appeared to have an impact on a practitioner's confidence when dealing with women with PNMH problems:

"Erm I think confidence is a difficult one to assess because we've identified the lack of training, you always feel you could and should be doing more. But you don't know what the 'more' is or what it looks like." (MW11)

The interview data suggest there was very little difference in the desire for more training/education between the MWs in either area. The comments below also allude to the perceived deficiencies in the PNMH training received by the MWs:

"We don't get much training on perinatal mental health. I think training would help you recognize it and to see what is available to you service wise and you know what you do with that information because half of the time it's all very good saying I'm a bit worried about it and you don't really know what you've got to do with it." (MW7)

"But it is down to education. And there's not really any education [on PNMH] *out there is there?"* (MW14)

"I think managing people with PNMH is more useful [training needs]. *At the moment all we have is signpost knowledge, but we probably don't have enough understanding of long-term implications unless you've been through it yourself… I think what we really need is a focused study day around perinatal mental health … but without the resources it's very difficult isn't it?"* (MW3)

HV2 below acknowledged the importance of PNMH training and suggested HVs complete a module dedicated to mental health either during training or post qualification:

"We do get a perinatal mental health and maternal mental health erm, sort of in-house training which is quite good as a one-off thing… and I think the mental health thing is so massive… I do think that, erm I know this sounds ridiculous, but sort of like a module for health visitors completely based on mental health that would be sort of something that you would have to do once you qualified or be part of your training." (HV2)

The data suggest that some MWs, whilst they had access to mandatory updates/training on PNMH, were dissatisfied with the training they received and how it was delivered:

"It would be good if there was some sort of compulsory study day or interaction I think, to make mental health education within the profession more tangible and meaningful. I don't think it's good enough using e-learning personally." (MW13)

MW16 alludes to a lack of awareness amongst student MWs about PNMH, which may suggest a lack of training:

"I don't think it's [PNMH] *talked about enough … I don't think student midwives are that aware of just how common it is and how vigilant they actually need to be."* (MW16)

The above comment is suggestive of a lack of PNMH training/education in current midwifery training as MW16 felt student MWs lacked awareness of the prevalence of PNMH problems. Education and training were requested by the participants in the form of dedicated study days (as opposed to an hour given over to PNMH during mandatory updates and online training as stated in Phase 1 interviews and by MWs in Blue Area and Green Area) which covered topics such as PNMH disorders, managing women with PNMH problems, referral criteria and processes and use of screening tools. The interviews revealed that the MWs practicing in Blue Area expressed a desire for PNMH training/education as did their Green Area counterparts. This suggests that those MWs working in an area with specialist secondary PNMH service provision do not necessarily have increased knowledge and confidence when dealing with women's PNMH needs as illustrated below:

"… [we have] *mandatory updates* [on PNMH] *but it's limited. We would always look to* [specialist midwife] *for support because we haven't got the knowledge really. We've got basic knowledge and signs to look for but apart from that, that's it."* (MW3)

There was a marked difference between the professions regarding desire for training/education in PNMH; 15 out of 16 MWs wanted more training in PNMH compared to only 3 out of 8 HVs. Some HVs in Green Area wanted education/training by a specialist HV. They stated that having a specialist HV in post would also give them the opportunity to use the specialist HV for clinical supervision to discuss PNMH case studies and for de-briefing sessions:

"It's [de-briefing] *so important… you know carrying stuff in your head…*" (HV3)

"...it's not even training. It's much more of a peer support thing because other people do things in different ways and sometimes you think, that's brilliant you know … I think sometimes just having perhaps even like a peer support group about certain things where you could have discussions about certain, erm bring up certain cases." (HV2)

Using the specialist HV for clinical supervision[9] was discussed by HVs in Blue Area where they could confer with the specialist HV:

"So, we've got a perinatal mental health lead and I'd go to her [for advice]*. She's really lovely and she's the one that does our supervision. So, I'd definitely go to her. I'd also use my colleagues* [for advice]*."* (HV6)

Unlike the participating MWs (from both areas) who appeared to want generic training and education on PNMH in terms of PNMH disorders, use of tools and referral processes, HVs from Blue Area appeared to want a deeper level of training, suggesting they had an existing knowledge base on PNMH (perhaps because of their links with specialist PNMH services) and wanted to further that knowledge:

"It's always good to have updates. So extended knowledge. So maybe new research, new thoughts, new processes, … the extra bits." (HV7)

[9] Clinical supervision has been used in health-visiting practice for many years and is provided by organisations as a structured meeting following serious incidents using a framework for safeguarding supervision to improve quality and provide effective evaluation of the supervision process (Pettit and Stephen 2015). Safeguarding supervision is an important element in helping to mitigate the effects of vicarious trauma, combat stress and improve safeguarding practice (Pettit and Stephen 2015).

Importantly, one HV from Green Area pointed out that PNMH education has its limitations if the services are not available once PNMH problems have been identified:

"We can identify all we like, we can have all the education we like but, in the end, we haven't got anywhere to refer people to who have the expertise who can help them." (HV2)

The data appeared to suggest that of the two professions, HVs appeared more knowledgeable about PNMH than MWs, regardless of which geographical area they were working in.

The theme 'education, skills and training' encompasses factors such as targeting of limited resources, perceived by participants to be strongly related to the changes in service provision which presented challenges to MWs and HVs when assessing/referring women for PNMH problems. Using intuition in professional decision-making was highly valued among MWs' and HVs' when dealing with PNMH problems. This theme has highlighted that referral decision-making is a complex process that is compounded by a lack of education/knowledge relating to PNMH and a lack of specialist services for women.

5.12 Theme 3: Referral pathways

The first two themes contextualised participants' experiences of referring women for specialist PNMH care by offering insights into factors that influenced their professional decision-making such as continuity of carer, confidence/using intuition associated with PNMH and the need to target resources. The final theme addresses one of the aims of the research which was to explore any impact of having a local

specialist PNMH service on MWs' and HVs' approach to decision-making when deciding whether or not to refer women for PNMH care. The sub-themes generated from the data explores participants' experiences of using referral pathways in the different geographical areas, i.e. areas with and without specialist PNMH services and the referral options available to the MWs and HVs (as detailed in Chapter Four). Prior to deciding to refer women for PNMH care, MWs and HVs are required to screen women for risk of PNMH problems using validated tools such as the Whooley questions, GAD-2, PHQ-2 and the EPDS.

5.12.1 Use of screening tools

During the interviews, participants were asked if they used a screening tool as an aid to assess women for PNMH problems. Approximately a quarter of midwives in both areas were unaware of any screening tools for PNMH problems.

"*Erm, structured tools? No, I don't think that there are* [any]*."* (MW11)

"I know there used to be the Edinburgh scale didn't there for postnatal [depression] *but I don't know of any antenatal one* [tool]. *I've not seen any"* (MW14)

"We just normally ask the questions about how they're feeling and normally just sort of, what we normally do in the routine postnatal checklist when we've just examined them, it's sort of just asking them how they're feeling or whether they feel like they're coping well, if they've got support." (MW8)

Despite stating they were unaware of any screening tools, some MWs failed to recognise that the questions they were prompted to ask on their electronic records were screening tools.

Some MWs in Blue Area were less familiar with PNMH screening tools than HVs from Blue Area and less likely to carry out an assessment themselves. Instead, they would refer women they were 'concerned about' to the specialist PNMH MW for an assessment as mentioned previously, sometimes resulting in what the specialist MW deemed as inappropriate referrals. The data indicates there may be a number of reasons why MWs were making inappropriate referrals. These were, for example, not being cognisant with the referral criteria, not completing an accurate assessment of a woman's mental health in the first instance, not having the time to carry out an accurate assessment themselves and lack of confidence in their assessment tools and/or abilities (issues highlighted in previous sub-themes). Thus instead, MWs were making what appeared to be an arbitrary referral to specialist MWs to complete the PNMH assessment.

Some MWs from Green Area stated that screening tools were routinely used in practice:

"Well, part of the booking [appointment] *is the support questions … the four questions about current anxiety levels, current mood, current worries and that sort of thing…"* (MW15)

"Yeah so all our maternity records are electronic and erm, so we ask these standard questions erm… three times during the pregnancy" (MW13)

A notable difference between areas was that following screening for PNMH problems, Green Area participants had limited referral options and did not have the option of referring women for specialist PNMH care. The quote by MW13 reveals an awareness of PNMH risk factors but hints at an element of uncertainty about where to refer women with PNMH problems as illustrated below:

"So if there's history [of mental health], *so if she discloses* [PNMH problems] *and we have concerns, so if there's any reports of self-harm erm or previous depression that was medicated or secondary care team involvement, that's when we would think to do a referral … because there's a risk factor there… it depends on the level of care we feel that woman would need, erm we'd refer to the GP, erm or the crisis team. It really would depend on the level of need and I guess that is according to the individual midwife's concerns"* (MW13)

In the comment above MW13 describes her options as either the GP or crisis team, emphasising the lack of specialist PNMH care available in her area.

All HVs from Blue and Green Areas were aware of screening tools. However, whilst the majority of HVs used the Universal PNMH questions, some HVs preferred to use other tools not validated for PNMH screening, e.g. the promotional interviewing guide:

"We use the universal PNMH scoring system" (HV7)

"Yes, so if it's someone that actually is very low, I will use the GAD or the PHQ." (HV2)

"Well I ask the appropriate questions, the universal questions at the designated times, the universal times" (HV8)

"We ask them … your universal PNMH tools" (HV6)

"The promotional [interviewing] *guide is very much my tool* [used for assessing PNMH]*"* (HV1)

"We have our own Trust policy [for PNMH assessment tools] *that's quite clear cut really. You know, we have an antenatal and postnatal mental health policy that obviously follows the Trust format. It is evidenced based and erm … is based upon the NICE guidance."* (HV5)

"I've used the GAD as well" (HV3)

The HVs in Green Area expressed a preference for using the Solihull Approach (Douglas 2017) to assess women's mental health in the first instance but would then progress to using either the universal PNMH questions or GAD-7/PHQ-9:

"So that is very much my tool [promotional interviewing guide]*, as it encompasses everything so there's that, and the Solihull* [Approach]*. The Solihull is riddled through me, you know containment, reciprocity, and behavior management, you know the reflective tool as well as a teaching tool. So those two would be my two underpinning things* [tools] *I use."* (HV1)

"The GAD and things like that, that I would use if I had got positive answers to the Whooley questions, what professionally I was of the opinion, there's something here, I would go a bit further and put the GAD in there and actually explore it a bit deeper." (HV4)

There was no consensus amongst the HVs across both geographical areas regarding how valuable the tools were. Some HVs felt they were not effective at identifying potential PNMH problems, others valued them:

"No, I don't [think the universal questions are useful]*. I feel giving the mother a bit of paper actually allows her to express how she's feeling…. the questions are quite general… the EPDS* [Edinburgh Postnatal Depression Scale] *was more specific and we had a lot more positive results from that than we do from the universal* [questions]*."* (HV7)

"The other thing I use a lot when talking about tools, is the GAD and the PHQ… and I found that was really, really good in helping mums understand why they're feeling [anxious/low]*."* (HV1)

"Yeah I would say the tools do help me make a decision and help the woman make a decision to be honest, and help her realise I'm not where I want to be" (HV8)

"...I think, the universal PNMH questions would be more effective if we visited more because we would get to know the women." (HV6)

In the quotation above, HV6 appeared to be suggesting that the universal questions were not ineffective per se; rather, they would be more effective if HVs visited the women more and were thus able to build a relationship that would encourage disclosure amongst women when answering the universal questions. However, according to the interview data, the organisational changes in health-visiting services have resulted in less visiting and led some participants to question the effectiveness of the Universal questions as a result (HV6). Furthermore, the data suggested that some HVs from both areas preferred using the EPDS over the Universal PNMH questions (HV7 quoted above) but alluded to the EPDS not being used in current practice. They did not give an explanation as to why the EPDS was not the assessment tool of choice other than stating that they followed NICE guidelines and erroneously believed the EPDS was not 'recognised' as a tool to aid PNMH assessment, as indicated by HV3:

"I might use the EPDS, but the Edinburgh isn't really recognised anymore I think." (HV3)

Thus, although the EPDS can be used when assessing women's PNMH, it is only used following a positive response to the Universal PNMH questions. Therefore, the opportunity to use the EPDS would be eliminated by false negative responses from the Universal questions. However, HV5 suggests below that the success of the Universal PNMH questions is determined by the accompanying conversation a practitioner has with women regarding mental health and well-being. In HV5's opinion, it is important that HVs have a conversation with women about mental health before asking the questions; otherwise the questions are rendered useless:

"it's not just about asking those four questions, it's about how they [the HVs] *set their stall out. So, it's the conversation they have about mental health and well-being before they ever ask those questions. It's about being very clear about what it is you are asking… For me, you know, the biggest component for that universal assessment is the discussion you have about mental health and well-being and it's about setting your stall out* … *Just going into somebody and just launching into 'During the past month have you….' You might as well not bother."* (HV5)

Unlike the MWs and HVs, comments from the specialist PNMH HV and MWs revealed unanimous agreement that the Universal PNMH questions were useful for screening PNMH problems. The specialist HV from Blue Area viewed the Universal questions as a starting point from which to assess women's PNMH, where a positive response to the Universal questions would lead to a more in-depth and complex assessment. Similarly, a specialist MW from Blue Area concurred that the Universal questions were useful in identifying PNMH problems where MWs can then progress to using the GAD-7 and the PHQ-9 to complete a comprehensive assessment of women's mental health.

The Universal PNMH questions appear to be viewed by some participants as a barrier to identifying PNMH problems, i.e. where MWs/HVs did not have confidence in them as a tool in screening/identifying PNMH problems. By others it was seen as a facilitator, i.e. where, if used appropriately (with a preceding conversation about PNMH) it constitutes the first step in assessing women's PNMH. However, some MWs explained during the interviews that they did not feel confident using a tool to assess women's mental health and relied on the specialist MW to complete the assessment instead. The data suggests a disconnect between NICE guidelines and practice regarding the use of screening tools and PNMH referrals.

The sub-theme of ‘use of screening tools’ highlights apparent differences between MWs and HVs; MWs were less familiar with screening tools than HVs. Interestingly, some MWs failed to recognise that they used screening tools in their clinical practice in the form of the questions posed on their electronic records which perhaps implies that they did not understand the relevance of the questions. All HVs used screening tools in their assessment of women but there was discrepancies in which tools were used and how useful they were found to be.

5.12.2. Knowledge of referral pathways

Referral pathways (sometimes referred to as a care pathway) ensure all primary and secondary HCPs know how to access assessment, referral and treatment options for pregnant and postnatal women (NICE 2014). Secondary services, both specialist PNMH services (discussed in Chapter Four) and general mental health services oftentimes place specific eligibility criteria on referrals as discussed in Chapter 4. However, some participants stated they found their respective Trust referral pathways unclear and difficult to navigate despite practicing in an area that provided specialist PNMH services:

“Other than saying you need to go and see your GP, I would refer on [to the GP] *but I wouldn't be able to go any further than that.”* (MW8)

“I think a more straightforward referral pathway would be better.” (MW8)

“.. the trouble is, we are in a process of change at the moment and the guidelines need updating and they need to be easier to read...” (MW9)

HV8 from Blue Area gave an example of the where using Trust referral pathways presented ‘grey areas’ and in these situations the PNMH specialist HV was consulted for advice and support to aid clinical decisions:

"Yes coz you're meant to adhere to the pathway, yeah. But sometimes there can be a bit of a grey area, erm so I would seek supervision. We have a perinatal mental health professional lead. So I would ring her for a bit of supervision you know, or sort of, if the presentation was incongruence to, is different to you know, what the results show then I might, you know… maybe go to [PNMH specialist] *for supervision"* (HV8)

Some participants from Green Area echoed that they too found their referral pathways unclear:

"...there needs to be a clear pathway of referral and follow up that's fed back to the midwife." (MW12)

"I just think the referral system could be a little bit more streamlined." (MW13)

"I think the main barriers are … erm … a difficult care pathway to negotiate." (MW15)

For some participants the lack of a clear referral pathway was a barrier when assessing and referring women for secondary PNMH care. The responses from MWs 8 and 9 above suggest that although working in an area with specialist PNMH services, they viewed their pathways as unclear. To contextualise this, NICE (2014) recommends there are clear referral pathways of care; nevertheless, this does not appear to be evident by the responses from some participants from both geographical areas.

In addition to unclear pathways, participants in Green Area highlighted the lack of PNMH services and demonstrated confusion about where to refer women, e.g. "Oh my God, what can I do?" (HV2):

"I'd say it's availability of services definitely [that's a barrier to referring] *because there is a certain point that you sometimes think 'Oh my God, what can I do?', you know? You know we really want you to tell us* [about your mental health problems] *and we really want to be able to deal with these sorts of things and there's just nothing to offer you* [in terms of services]..." (HV2)

"…with regards who we refer to, and where we go, to be honest with you, because there's nothing [no PNMH services]*, they don't exist. There's no pathway because*

there's nowhere [to refer to]*…"* (HV 4)

"…we are stretched for resources but I think that's a nationwide problem isn't it, in terms of supporting women [for PNMH care] *…"* (MW15)

"I would refer to the GP. Erm, there are mental health teams in place in some Trusts aren't there... not in here [in this Trust]*…"* (MW16)

Participants from Green Area reported that their only option for women needing PNMH care was the GP or general secondary mental health care as specialist services did not exist in this area (at the time of the interviews). The comments from HV3 and MW15 indicate a sense of frustration at the lack of PNMH services.

"We don't have a good service provision here for women with mental health problems… we've only got the GP [to refer to]*... yes, I feel that I can identify when there's a mental health issue and I know that I can refer onto the GP. It's just very frustrating that there isn't more we can do…"* (HV 3)

"I think what you need to take away from this [interview] *is it is fine* [that mental health is being recognised] *but if there is no support in the background, it's just a nice conversation… So I think we just need a bit more robust support, but that would require finances and support…"* (MW15)

It was apparent from the interview data that some MWs working in the area with specialist PNMH services did not always follow the referral pathways correctly, resulting in inappropriate referrals to the PNMH clinic. As an illustration of this, MW1 explained that if she were concerned about a woman's PNMH, rather than personally assessing the woman she would refer her directly to the specialist MW for assessment:

"No, I don't think I would [use a tool] *…we've got a very open and easy access to erm* [specialist MW] *and I can just ring her up and say, I've got this lady…."* (MW1)

The above quotation appears to suggest that the availability of the specialist MW has

the potential to absolve MWs of their responsibility to carry out a PNMH assessment if MWs are arbitrarily referring women they are ‘concerned about’ to the specialist PNMH MW. This could potentially overwhelm the specialist PNMH practitioners with women who do not meet their referral criteria as they have not undergone the necessary screening beforehand.

Overall, the theme of Referral Pathway highlighted notable differences and similarities among the MWs and HVs across the two areas. Firstly, HVs appeared more familiar with PNMH screening tools than MWs. Secondly, there was a lack of consensus regarding the value of screening tools and which tool(s) to use among MWs and HVs. However, specialist PNMH MWs and HV agreed that the tools were useful in identifying PNMH problems. The data indicated a lack of knowledge and confidence in using screening tools which may suggest some participants would benefit from training/education in using tools. Irrespective of geographical area, many of the MWs and HVs perceived their referral pathways were unclear. The majority of professionals in Green Area wanted a clearer referral pathway (8 out of 9 professionals interviewed) and dedicated PNMH services for women. Data generated from the interviews indicated that some participants from Green Area felt frustrated and helpless due to the lack of specialist PNMH services in their area which consequently meant that women did not receive the specialist support and care they required.

5.13 Discussion

The interview data revealed that overall, MWs and HVs from both geographical areas experienced similar barriers and facilitators when making decisions about

whether or not to refer women with current and/or past PNMH problems. This is an important finding. One of the aims of this research was to explore the effect that local PNMH service provision had on MWs' and HVs' decision-making when deciding to refer women for secondary PNMH care. The barriers and facilitators experienced by MWs and HVs regarding clinical decision-making to refer women for PNMH care is a complex process compounded by factors related to changes to service delivery, outside of the control of the MWs and HVs. In addition, MWs and HVs personal abilities and competence present perceived barriers and facilitators when making decisions in clinical practice about referring women for PNMH care, such as using intuition to guide decision-making.

This research has established that for MWs/HVs to identify women's PNMH needs, there are key factors at play. MWs/HVs discussed the importance of continuity of carer which was perceived by some participants as vital to building relationships with women. This in turn aided disclosure of PNMH problems and also enabled MWs/HVs to monitor women's mental health over time to detect deteriorations. However, recent organisational changes had an impact on their capacity to give continuity of carer. Each of the geographical areas in this research included trusts that had recently undergone changes in service delivery. Changes to midwifery and health-visiting services in these geographical areas reflect the changes occurring in these professional groups at a national level. In the health-visiting service, commissioning of public health services moved from NHS to local authority control in 2015 which has resulted in a 30% reduction of the number of HVs from 2015 to 2019 (iHV 2019), a reduction in training of HVs, closure of services such as Children's Centres, the use of cheaper, less qualified workers in place of HVs and increasing caseload

numbers (Harris 2016; Vijayshankar 2018; Cowley *et al.* 2018). Similarly, rising birth rates, staff shortages and the increasingly complex and diverse needs of women impact on the delivery of maternity services (RCM 2015; Rouse 2019).

The changes to midwifery and health-visiting service delivery are manifested in the changes described by the participants of this research whereby services have been adapted to reflect the reduction in MW/HV numbers. For example, MW/HV contacts being delivered in a clinic environment for some of the mandated contacts instead of in women's homes, such as the MW pregnancy booking appointment and some postnatal contacts, and the HV antenatal and six-week contact. MWs/HVs perceived these changes in practice to be a barrier to building relationships with women. Cowley *et al.* (2018) suggests that changing services in this way jeopardises the features that make health visiting successful, i.e. organising services in a way that promotes HV-parent relationships, continuity, and the flexibility to allow HVs to practice autonomously. In midwifery services, Sandall *et al.* (2018) conducted a systematic review of midwifery-led continuity of care models, and found that continuity was highly valued in terms of women's satisfaction and birth outcomes and recommended in a review of maternity services (NHS England 2016a). The changes in service delivery appear counter-intuitive to the recommendations of Cowley *et al*. (2018) and Sandall *et al. (2018)*.

MWs/HVs explained that some of their contacts had previously been conducted in women's homes which was preferred by the majority of professionals who perceived it to be more conducive to assessing women's PNMH compared with the clinic

environment. In a UK-based study, Bhavnani and Newburn (2010) conducted a ten-year follow-up study of 1260 women on their satisfaction of postnatal care and found there has been a decline in women's satisfaction, particularly relating to having their emotional needs met. Women reported that the limited number of postnatal contacts was unsatisfactory and too few home visits affected their level of satisfaction (Bhavnani and Newburn 2010). Stewart-Moore *et al.* (2012) found similar results; they conducted qualitative interviews with women regarding their views on postnatal care and found women wanted more visits in the early postnatal period. Findings from previous research, coupled with the interview findings, indicate that women and professionals are dissatisfied with current postnatal service delivery. Likewise, the interview findings corroborate those of Higgins *et al.* (2018) whose study surveyed MWs and primary care nurses on the barriers to addressing mental health issues in the perinatal period and found the lack of continuity of carer between healthcare professionals and women was a barrier to identifying PNMH problems. The lack of continuity of carer was a result of organisational level changes that the participants stated led to reduced contacts and contact time with women (Higgins *et al.* 2018) as was the case for this research.

This research found that for the majority of HVs, continuity of carer was affected where some mandated contacts were carried out by CNNs instead of HVs. Although CNNs work closely with HVs to support women and families, it is an unregulated role and beyond their scope of practice to identify the mental health needs of women (Mann 2018). Consequently, it is a missed opportunity for HVs to assess women's mental health when CNN are conducting mandated contacts such as the nine-twelve month child health review and the two year child health review. Furthermore, although data are not routinely collected on who accompanies a child to their nine-

twelve month and two-year reviews, a qualitative study by Kendall *et al.* (2019) exploring parents' and HCPs' acceptability and understanding of the current recommended development assessment tool, found that although 'parents' were invited to take part in their study, only mothers participated in the interviews. If parallels are to be drawn from the study by Kendall *et al.* (2019) it could be argued that the mother is most likely to accompany their child to a health review and thus provides an opportunistic contact for HVs to assess women's mental health and wellbeing at this time. Anecdotally, the researcher can concur that when carrying out nine-twelve months and two-year reviews as a HV, fathers very rarely attended the appointment in the area she worked and almost never accompanied their child to the appointment without the mother. The nine-twelve month review is particularly pertinent in terms of assessing maternal mental health as it falls within the perinatal period which is a time of vulnerability for women's mental health (NICE 2014).

The term continuity of carer was raised by MWs (both hospital and community-based) from both geographical areas when discussing assessing and referring women with PNMH problems, but the term was not specifically used by HVs in this research; rather it was alluded to. This finding is consistent with an integrated review conducted by Noonan *et al.* (2017b) who examined 14 empirical studies on midwives' perceptions and experiences of caring for women with PNMH problems. Noonan *et al.* (2017b) found continuity of carer was an important factor for MWs when establishing a relationship and making decisions regarding a woman's PNMH. The concept of continuity of carer is high on the maternity services 'Better Births' agenda as a recent review of maternity services recommends that every woman should have one MW, who is part of a small team of MWs, to provide continuity of

care throughout the antenatal, intrapartum and postnatal period (NHS England 2016a). Thus, considering this recent recommendation, perhaps continuity of carer was highlighted by the MWs in this study as it is on their political agenda and therefore at the forefront of their minds. Additionally, some participants stated that some mandated midwifery contacts were taking place in a clinic, e.g. the pregnancy booking and postnatal contacts, which could potentially affect continuity of carer. For example, MW10 discussed 'booking clinics' where one MW conducts a pregnancy booking clinic and therefore women may not see that same MW again during their pregnancy. Thus, the opportunity to build a relationship and make decisions regarding a woman's PNMH could potentially be adversely affected.

Several MWs and HVs felt that a trusted relationship between themselves and women facilitated disclosure of PNMH problems, which mirrors the findings of the qualitative study by Darling and Viveiros (2018) which found a trusted relationship was key to women disclosing PNMH issues. However, some MWs/HVs in this study felt that regardless of a trusted relationship some women chose not to disclose. Stigma and the fear of the consequences of disclosure was posited by participants as reasons why women chose not to disclose. It was a commonly held view of MWs/HVs, that women feared that disclosure of PNMH problems could lead to removal of their child and was thought to be a key deterrent to women disclosing PNMH problems. The perception of fear of child removal is not unfounded, as previous research found that mothers with mental health problems were at an increased risk of having social services involvement (Howard *et al.* 2003; Green *et al.* 2008; Glangeaud-Freudenthal *et al.* 2013). Indeed, Monds-Watson *et al.* (2010) found that parental mental health problems were highly represented amongst

families subject to child protection or care proceedings. Similarly, in a USA-based study, Kohl *et al.* (2011) found that the number of children in foster placements was more than double for the children of mothers with mental illness.

Half of the participants (n= 7MWs; n= 5HVs) mentioned women's perceived stigma as a barrier to disclosure. This is in line with other research as Moore *et al.* (2016) agree that women with PNMH problems feel stigmatised. Earlier research by Byatt *et al*. (2013) who conducted qualitative focus-groups with women who had experienced PNMH problems, found that women were reluctant to disclose PNMH problems through fear of negative consequences. Some participants identified such consequences as a woman being seen as a failure as a parent. This reinforces the need for MWs/HVs to have a trusted relationship with women to ensure women feel they can be 'open and honest' (HV7) to disclose PNMH problems. Ayres *et al.* (2019) conducted a survey to explore women's engagement with PNMH services to identify the barriers and facilitators to women accessing PNMH services. Paradoxically, they found that stigma was not an identified barrier to engagement with PNMH services. However, according to Ayres *et al.* (2019) when PNMH problems were identified in women and the appropriate referrals were made, the evidence suggests that in high-risk women there were low levels of subsequent engagement with PNMH services. Thus, it appears that disclosure of PNMH problems is not a guarantee of engagement with PNMH services. It does, however, highlight the importance of identifying women who need referral for PNMH care; subsequent engagement with services is ultimately women's choice/prerogative. Nevertheless, it could be argued that engagement is more likely if women had a trusted relationship with their healthcare professional.

For one participant, stigma was perceived to exist among some fellow professionals as she witnessed negative attitudes towards colleagues with mental health problems. The literature suggests that peer support for MWs experiencing stress can have an impact on how the individual MW deals with stress and on their self-image (Halperin *et al.* 2011). Halperin *et al*. (2011), who conducted a qualitative study on Israeli MWs response to stressful situations associated with the job, found that midwifery colleagues were a key source of occupational esteem and emotional work support. However, MWs in Halperin's study who experienced stress did not always feel their colleagues showed empathy towards them and this response left the MWs with intense feelings of exclusion, rejection and loneliness. Although the lack of sympathy towards colleagues experiencing stress appeared only as the isolated opinion of one MW, it was not further explored during the interviews but does offer insight into potential attitudes of some professionals that may warrant future exploration. MW14, who discussed the lack of sympathy for colleagues regarding mental health problems, questioned whether MWs' lack sympathy amongst 'their own', suggested that they would lack sympathy towards women with mental health problems. This could be a potential barrier if professionals lack a sympathetic attitude regarding mental health issues and as a result do not make identification of PNMH problems a priority and/or make the necessary referrals for women requiring PNMH services. An integrated review by Noonan *et al.* (2017b) identified six studies out of the 22 reviewed where midwives had a negative attitude towards women with PNMH problems which translated to their practice. These MWs negatively stereotyped women with PNMH problems, avoided women with PNMH problems and viewed women with PNMH problems as being low in warmth and competence who should not be encouraged to have children (Noonan *et al*. 2017b). Thus, although

the interviews did not discover widespread negative attitudes regarding mental health amongst participants, previous research has shown this to be an issue suggesting it may not be an isolated incident.

A prominent factor that affected the relationship between MWs/HVs and women was 'time'. To build a trusted relationship MWs and HVs needed to invest time in the process of building relationships with women. MWs specifically cited lack of time to spend with women on the postnatal wards and during routine clinic appointments. HVs mentioned lack of time to conduct visits outside of the mandatory contacts and lack of time to conduct antenatal contacts for some women, e.g. multiparous women. Sixteen of the twenty-four professionals interviewed highlighted 'time' as an issue, with the lack of time having a negative impact on their relationship with women. Lack of time was discussed in terms of increased workload and reduced staffing levels as a consequence of service delivery changes. It is worthy of note that none of the mangers/clinical leads interviewed in Phase 1 of this research suggested that they would like to increase their MW/HV workforce. One manager from Blue Area expressed a desire for increased specialist MW hours and two managers from Green Area stated they wanted a specialist MW/HV in post but none suggested they wanted to increase their overall staffing levels. The barrier of time was not an unexpected finding and concurs with evidence from previous studies (Ashford *et al.* 2017; Higgins *et al*. 2018) that found time (or rather the lack of it) and workload could be barriers when assessing women's PNMH. Higgins *et al*. (2018) conducted a survey of the barriers to MWs and practice nurses when addressing PNMH issues, which found lack of time, and workload on the postnatal ward negatively affected MWs' ability to form relationships with women in their care. Ashford *et al.* (2017),

who conducted qualitative interviews with HVs, also found that supporting women with PNMH problems put a strain on an already heavy workload. Thus, this could potentially have negative consequences on the relationship between MWs/HVs and women in their care, resulting in reduced detection and/or disclosure of PNMH problems. Insight generated from these interviews suggests that the presence of specialist PNMH services does not mitigate against time pressures and heavy workload amongst the participants and the resultant impact this has on the ability for MWs/HVs to form relationships with women.

Some MW participants also reported that they did not have time to assess women for PNMH problems due to the increasing number of tasks they had to perform relating to women's physical health, as well as administrative tasks. Indeed, a study by Rebair and Hulatt (2017) to identify HCPs needs (n = 503) (MWs and HVs were included in this study) in relation to suicide awareness and prevention, found that lack of time and resources were barriers to participants engaging in suicide prevention. It is accepted in the literature that a lack of parity of esteem exists in contemporary healthcare services (Hilton 2016). According to Bailey *et al.* (2013), the principle of parity between mental and physical health is equality to access, quality and allocation of resources. Given that suicide is a leading cause of maternal deaths directly related to mental health in the perinatal period (Knight *et al.* 2018), it is a cause of concern that a lack of parity of esteem subsisted amongst some participants in this study. To illustrate the dire consequences of a lack of parity of esteem, Knight *et al.* (2015) found that of 11% of women who died by suicide in the perinatal period, there was either an inadequate enquiry or no enquiry at all made about their history or current mental health. To give context and a possible reason

for the lack of parity of esteem it is worthy of note that antenatal appointments include numerous physical health checks which MWs need to complete. Although NICE (2008) offer no set directives on length of antenatal appointment times, appointments can range from 5 minutes for a routine appointment (Manithip *et al.* 2013) to one hour for an antenatal booking appointment (NHS 2018). During the antenatal booking appointment, an hour is required as MWs will complete a full medical and family history with women, offer to measure height and weight, blood pressure, test urine, take blood samples for various tests as well as discussing healthy lifestyle measures, and the antenatal care pathway and enquiring about domestic violence, etc. (NHS 2018). A study by Waller *et al.* (2018) explored how long it takes to perform antenatal screening from women's and clinician's perspectives, found that on average, approximately an hour is needed to complete a screening for antenatal risk factors. Some of the MWs in the interviews reported that 30 minutes were allocated for an antenatal appointment and therefore MWs may take a pragmatic decision to complete physical checks during an antenatal contact. e.g. auscultating the fetal heart, checking women's blood pressure, and thus be unable to fulfil all physical and mental health checks in the allotted time. Recently (and after the interviews had taken place), the pregnancy hand held records[10] have been updated to include a box to be checked relating to maternal mental well-being at each antenatal contact; previously this information had not been included in the antenatal check and may be a possible reason why some MWs in this study did not address maternal mental well-being. As an extension to the lack of parity of esteem, some participants voiced their concerns that once a mental health problem had been identified, they either did not know where to refer women on to or, as in Green Area,

[10] Pregnancy notes are given to all pregnant women where their medical and pregnancy history, and details of antenatal contacts are recorded.

there were no PNMH services to which women could be referred. Therefore, even the presence of a specialist PNMH service did not counter the lack of time for MWs to address maternal mental health. Understanding the reasons why there may be a lack of parity of esteem may be beneficial in developing education/training packages and/or service provision.

It is noteworthy to mention that in Phase 1, the three midwifery managers stated that PNMH contacts did not form part of their Key Performance Indicator's (KPI's), whereas they did for the HV services. In the event that PNMH contacts should form part of the KPI's, MWs would have to complete this administration task, adding further burden to an already burgeoning workload.

Most participants appeared dissatisfied with the service they offered and perceived that the services they delivered were 'very stretched' (HV1), there was 'not enough staff' (MW8) and there was 'a decline in services' (HV7). The result of this meant that the MWs and HVs had to target services accordingly and consequently used their professional knowledge and skills to target resources to women they considered most in need. This presented a challenge to some participants as this was in direct contradiction to the commissioned, mandated contacts, and for HVs with the health visiting ethos of proportionate universalism (Cowley *et al.* 2018). For example, HVs are commissioned to conduct universal, antenatal contacts with all women. However, for some HVs in this study, the antenatal contact was offered to primiparous women only as staff shortages meant they did not have the capacity to offer all women an antenatal contact. Multiparous women were offered a telephone contact if the HVs

had the capacity. This is problematic as multiparous women may have current or past mental health problems and risk being overlooked/ignored with this approach to care. Furthermore, targeting primiparous women only does not follow proportionate universalism whereby health actions must be universal, not targeted, and tailored according to need (Cowley *et al*. 2018). There was a distinct sense from the participants that targeting only certain demographics/characteristics of women compromised the way in which they wanted to practice. There is also compelling evidence that early intervention improves later outcomes (Allen 2011; Marmot 2010) and are crucial to the development of infants (The Wave Trust 2014) a fact that did not go unnoticed by some participants. For example, HV7 acknowledged that failure to address mental health issues with women could have detrimental effects on the child. Thus, it is imperative for the well-being of women and children that PNMH problems are assessed and receive the appropriate referrals, and that professionals are permitted to use their clinical judgement to target services based on need rather than capacity and/or availability of services.

All participants interviewed said they would consider the clinical presentation of women when assessing their PNMH. However, for ten participants, intuition also facilitated their decision-making process. This was illustrated by HV2, who decided to continue visiting a woman, despite the fact she had responded negatively to PNMH screening questions, where her intuition was later validated by the outcome. It is recognised that although decision-making in clinical practice uses an evidenced-based, systematic and analytical approach (Muoni 2012), it is used alongside intuition, which is closely linked to a practitioner's experience (Muoni 2012; Jefford, Fahy and Sundin 2011). The participants had a range of experience (from 1 to 33

years post-qualification) with an average length of post-qualification of 19 years, suggestive of an experienced group of professionals. This finding is in line with the research by Daemers *et al*. (2017) who carried out qualitative interviews with MWs (mean length of qualification 19.6 years) on factors influencing their clinical decision-making and found intuition to be an important factor in this process. According to Barnfather (2013), intuitive knowledge is fundamental to midwifery practice and integral to decision-making. Further, it is long since established that intuition is a critical dimension of health-visiting practice (Goding 1997). According to Goding (1997), HVs use speed of thought, perceptual ability and responsiveness, leading to improved quality of care which influences the process of needs assessment. However, Benner (1984) suggests that tacit knowledge (or intuition) is a process of pattern recognition that is used subconsciously to summarise a situation quickly whilst undertaking an assessment and making a clinical judgement. This suggests that pattern recognition is repeated exposure to a situation over time. HV6 explains that she has been qualified for four years and used intuition in her practice. It was not clear from the interviews whether newly qualified practitioners relied on intuition in their clinical practice. The concept of intuition as part of the decision-making process amongst MWs/HVs was explored with the wider population of MWs/HVs in the final phase of the mixed methods research (discussed in Chapter Six) to further understand the complexities and attributes involved in professional decision-making. Importantly, for some participants in this study, intuition appeared to add to the practitioners' confidence when making decisions in clinical practice and in some cases, this took precedence over the use of tools.

NICE (2014) recommends MWs/HVs ask the Universal PNMH questions when identifying women's PNMH. However, participants were not unified in their views of how useful they were in identifying PNMH problems and/or what tools were recommended. Incidentally, NICE (2014) recommends asking the Universal PNMH questions in the first instance and offers guidance that practitioners can consider using the EPDS if women respond positively to the Universal PNMH questions. Some participants felt that the Universal PNMH questions, when asked following a general discussion around mental health, were fit for purpose at identifying PNMH problems, whilst others felt they were ineffectual and preferred using the EPDS. Many interview participants, particularly HVs, expressed a preference for using the EPDS. Some participants felt the EPDS was easy to administer and this finding was consistent with the literature (Buist *et al*. 2006). Some participants believed that giving women the EPDS to complete themselves allows women to express how they are feeling on paper as they may find verbalizing their thoughts and feelings difficult. Although the EPDS was originally developed to detect postnatal depression in primary care settings (Cox and Holden 2003), there is evidence it is a valid tool for use in the antenatal period where combined sensitivity and specificity is maximised at a cut-off value of 11 or higher (Levis *et al*. 2020). It has also been validated for use with pregnant women as it contains a separate subscale measuring anxiety rather than depressive symptoms, in both antenatal and postnatal women (Sinesi *et al*. 2019). However, when participants were asked what screening tools were used in the antenatal period, there was no indication that the EPDS was used antenatally. Moreover, some participants erroneously believed that the EPDS was obsolete in the postnatal period and not currently recommended for PNMH screening which may have negatively influenced its usage amongst these participants. Three out of the

eleven MWs from Blue Area (and all from the same Trust) were unfamiliar with the universal PNMH questions, which could suggest that these questions do not form part of their assessment criteria which is possibly indicative of individual practices. This finding is consistent with recent research by Carroll *et al.* (2018) who surveyed 438 MWs' knowledge, skills and practices of PNMH care and found that 70.2% (n=301) of the MWs did not use screening tools as part of their assessment of women's PNMH. Carroll *et al.* (2018) reported that participants employed a selective use of screening tools based on clinical judgement where only those women who were deemed to have mental health risk factors were screened. It would be useful to explore the screening practices of a larger population of MWs and HVs to determine which tools are commonly used in practice, how these tools are executed and whether the use of validated tools are valued amongst users in clinical practice.

During Phase 1 interviews, managers/clinical leads were asked what assessment tools were used by the MWs/HVs and only one of the five mangers interviewed provided a comprehensive answer regarding the PNMH screening tools used by practitioners. It could be argued that managers do not have clinical contact with women and therefore is a reason why some managers were not cognisant with the screening tools used in their area. However, the omission in managers knowledge regarding screening tools may be a possible reason why some practitioners were not aware of screening tools; if managers are not driving the use of recommended screening tools, practitioners are not encouraged to use them in their everyday practice. Another possible reason why some MWs from Blue Area were not aware/did not use the Universal PNMH questions is their reliance on the specialist MW within their Trust to carry out PNMH assessments. It could be argued that a

possible consequence of having a specialist PNMH MW is deskilling for other MWs. Nevertheless, it does highlight a disparity in national clinical guidelines (NICE 2014) and individual practices.

Conversely, three of the five MWs interviewed in Green Area (area without specialist MW in post) were aware of the universal PNMH questions. This suggests that MWs working in the area without PNMH services may have service deficits but some MWs do not have knowledge deficits regarding PNMH screening tools. MW1 from Blue Area confirmed that she would not use a tool in her assessment but would refer to the specialist MW to assess women she was 'concerned about' based on the woman's presentation alone. This suggests that MW1 relinquishes her responsibility to carry out an assessment of a woman's PNMH to the specialist MW. Although NICE (2014) guidance on using the Universal PNMH questions has been in effect for some years now, the practice of using validated tools does not appear to be widespread amongst many MWs and few HVs in this and previous research (Carroll *et al.* 2018). Challenges faced by MWs and HVs when following NICE guidelines relating to the Universal PNMH questions have been addressed by Lowenhoff (2017). According to Lowenhoff (2017), it is time for a review of NICE (2014) guidelines as they do not adequately address the challenges faced by healthcare professionals when providing PNMH care. Thus, findings demonstrated from this phase of the research support those by Carroll *et al.* (2018) and suggests the use of NICE (2014) guidelines are influenced by issues such as non-compliance, lack of confidence in their effectiveness and inadequate guidance on using them that could present a barrier to assessing women's PNMH.

Closely linked to the use of assessment tools was the response from participants regarding the use of referral pathways. Over a third of participants (four from Blue Area and five from Green Area) expressed that the referral pathways within their Trust were unclear or difficult to follow. Similar findings were reported by Higgins *et al.* (2018) and Carroll *et al.* (2018) where less than half of the 438 MWs they surveyed (40.5%) had pathways for women experiencing PNMH problems. Importantly, although each geographical area had referral pathways, the outcomes for those pathways differed according to the services available in that area. Nevertheless, MWs/HVs from both geographical areas expressed that their respective pathways were unclear.

In addition, inappropriate referrals (where referred women did not meet referral criteria) were also highlighted as an issue by some specialist PNMH practitioners, where some women with mild PNMH symptoms were being inappropriately referred to the PNMH clinic and women at high-risk of becoming mentally unwell in the perinatal period (who should have been referred) were not being referred. A recent metasynthesis by Smith *et al.* (2019) found a lack of PNMH knowledge among some HCPs led to poor recognition of symptoms and delayed referrals. Inappropriate referrals may be a result of unclear pathways but may also be due to MWs'/HVs' lack of knowledge and confidence with PNMH such as use of screening tools and lack of education in PNMH as discussed by the participants in this study. Indeed, during Phase 1 interviews, one manager from Green Area recommended improved training in PNMH for MWs during midwifery training and post qualifying. There is a wide body of research that suggests MWs/HVs lack knowledge and confidence when managing women's PNMH (Byatt *et al*. 2012; Jomeen *et al*. 2013; Hauck *et al*. 2015; Higgins *et*

al. 2018; Smith *et al.* 2019). A recent survey of MWs and HVs educational priorities in PNMH found that professionals requested the following components for PNMH education: knowledge about PNMH issues including prevalence, causes and risk factors, medication and its impact and use during pregnancy, cultural differences in mental health, skills development in counselling, communication skills in opening conversations about mental health and clinical interviewing, use of screening tools, skills in recognising the presence of PNMH issues, guidance on referral pathways, follow up procedures and procedures in the event of an emergency (Higgins *et al*. 2017a). Importantly, data from Phases 1 and 2 indicate that MWs and HVs predominately received annual one hour training or one hour training every two years. This is in line with recent research that surveyed 140 maternity services in UK and found that on average, MWs had 1.27 hours of PNMH training annually (Ledger *et al.* 2018). Arguably, the above PNMH training content could not be delivered in this timeframe. The potential consequences of inappropriate referrals are thus: if professionals make referrals into secondary PNMH care for women with mild symptoms, services could become overwhelmed with inappropriate referrals affecting the availability of services for high-risk women and those with moderate to severe symptoms in need of secondary PNMH care. On the other hand, women who require referral to secondary PNMH services may not receive the referral they need. This highlights a potential training need amongst some professionals when utilising PNMH care pathways.

In sum, it appears from the data that PNMH service provision does not necessarily impact on professional decision-making when deciding whether or not to refer women for PNMH care. Rather, the barriers and facilitators associated with referring

women for secondary PNMH care are influenced by the changes in service delivery that are experienced by both groups of professionals, regardless of whether they practice in areas that have PNMH service provision, for example, the ability to provide continuity of carer. In addition, MWs from both areas voiced their desire for more education/training in PNMH; MWs working in an area with PNMH service provision did not appear more knowledgeable or confident about referring women with PNMH problems than their 'no PNMH services' counterparts. Of the two professional groups, HVs from both areas appeared confident and knowledgeable about referring women with PNMH problems. The primary difference between HVs in Blue and Green Areas, was that once PNMH problems were identified, HVs in Blue Area had the appropriate services to which women could be referred, whereas HVs from Green Area did not have the option of referring women for specialist PNMH care.

5.14 Strengths

This research is the first to capture qualitative data on MWs and HVs decision-making in relation to referring women for secondary PNMH care, and to explore the impact that local PNMH services has on the decision-making process. It is a new area of research that has not previously been explored adding new knowledge to existing literature. Perhaps the gap in this area of research is due to the difficulties in conducting this research, both in terms of recruiting busy HCPs such as MWs and HVs and gaining access to research sites within the NHS. Participants selected for this research have unprecedented access to women in the perinatal period and are key professionals in assessing and referring women for PNMH care; thus, are fundamental to women with PNMH problems receiving the care they require. Selecting two geographical areas offering different levels of PNMH service provision

and two different professional groups for this research, afforded platforms for comparisons between them when analysing the data thereby providing diverse and thorough insight into the complexities of professional decision-making.

The researcher holds current registration as a MW and HV with the NMC and has extensive clinical experience working in both acute and primary care settings. Consequently, as the researcher belongs to both professional groups, she has the practical advantage of having a shared language, knowledge of professional practices and the related cultures of both professions and therefore may have been more readily accepted by participants. Furthermore, by sharing her professional background with NHS Trusts R and D departments, the researcher was able to demonstrate she was familiar with the culture and working practices of both acute hospital settings and primary care settings, and may be a possible reason why NHS Trusts agreed to participate in the research.

5.15 Limitations

CMWs from Blue Area were under-represented. Although recruitment strategies were equally targeted at hospital-based and CMWs, only one CMW from Blue Area took part in this research. Despite the researcher's attempts to aid recruitment with all participants (flexible interview times, reminder email and posters), no further CMWs were recruited into the study, therefore a pragmatic decision to cease recruitment was made as it was felt that data saturation had been achieved with the participants already recruited into the study. It may be useful to consider other methods of recruitment to encourage participation among CMWs, such as via social media/adverts in professional journals, in future research projects. Thus, due to the

under-representation of CMWs, it is acknowledged as a limitation as a larger sample of CMWs may have generated further data.

Some of the participants were in a specialist PNMH role, i.e. one per Trust in geographical Blue Area, therefore, to maintain their anonymity and ensure they could not be identified, verbatim quotes from specialist practitioners that had the potential to identify them as specialist practitioners were not used as in doing so may have compromised their anonymity. Instead, general comments which summarised salient points they made during the interviews were included in the findings. However, data obtained from the specialist practitioners were not lost as their transcripts were utilised in the TA process.

The length of the interviews ranged from 14 minutes to one hour and 21 minutes depending on participant availability which the researcher had no control over. It could be argued that issues raised during shorter interviews were not able to be fully explored due to length of the interview; perhaps longer interviews may have yielded more depth to the data. Telephone interviews were, on average, eleven minutes longer than face-to-face interviews and conducting all interviews via telephone may have had more fruitful results in terms of length of interview and thus, may have elicited different themes. When conducting the interviews, both face-to-face and telephone, the researcher found that some participants went ‘off topic’ and experienced difficulty in steering participants back to the interview guide. This is acknowledged as a limitation in the researchers interviewing skills; however, following advice from the researchers supervisory team on interview techniques and

reflecting on the researchers approach to conducting interviews, as the interviews progressed the researcher became more adept at keeping participants focussed on the interview guide and/or guiding them back on topic.

It is worthy of note that sample bias may have occurred during this research in two ways; firstly, this research was subject to ‘gatekeeper’ bias (Tuckett 2004) whereby the gatekeeper controlled who the invitation to participate was sent to, which the researcher had no control over. Additionally, the sample may have been biased to include those MWs/HVs that had an interest or professional role in PNMH care producing a response bias and thus limiting generalisability.

Since the two geographical areas provided different levels of specialist PNMH services, their respective referral pathways reflected the differences in service provision/referral options for the MWs and HVs. Consequently, some questions in the interview guide relating to referral pathways may not have been relevant for participants working in Green Area and could have placed limitations on any subsequent data gathered.

Finally, since this research recruited two different professional groups working in areas that provided different PNMH service provision, it may have yielded rich and diverse qualitative data through use of focus group discussions. Focus group discussions may capture different data than that obtained in the semi-structured interviews on the differences and similarities between MWs and HVs when deciding whether or not to refer women for PNMH care. The heterogeneous nature of

participants may generate interesting data and engender thought provoking discussions about their respective experiences when deciding to refer women for PNMH care between the different professional groups. This in turn may produce recommendations for practice particularly in relation to multidisciplinary working. However, these methods were not employed due to time and logistic constraints.

5.16 Conclusion

There were considerable similarities between the perceived barriers and facilitators of MWs and HVs when deciding whether or not to refer women for secondary PNMH care from both geographical areas. Fundamental to the decision-making process was the relationship between MWs/HVs and women. Where a trusted relationship existed, aided by continuity of carer, participants perceived this as a facilitator in identifying the PNMH needs of women and for women to disclose PNMH problems to their MW/HV. However, changes in service delivery, for both professional groups, meant continuity of carer was not always possible in practice. MWs from both geographical areas voiced a desire for further PNMH training and were less familiar with screening tools and/or less likely to use screening tools in clinical practice than HVs. Both professional groups relied on their intuition to guide clinical decision-making, sometimes over and above the use of screening tools. Regardless of geographical area, the majority of participants perceived their respective referral pathways as unclear. A notable difference between areas was that once MWs/HVs decided to refer women for PNMH care, Green Area participants had limited referral options and these did not include referrals to specialist PNMH services.

The majority of themes generated from this research are confirmatory with extant studies; however, this research identified new knowledge that warranted further inquiry. The next step of this PhD involved the development of a bespoke questionnaire. Phase 3, i.e. the questionnaire, informed by the qualitative interviews, builds on the interview findings, where a larger, representative sample allowed statistical comparisons between respondents with different levels of specialist PNMH provision, and between MWs and HVs. Phase 3 also allowed for examination of factors that may be associated with respondent's views about referral decision-making such as length of time since qualified and PNMH training received. Furthermore, the quantitative phase provided triangulation of the findings and are discussed in Chapter Six.

CHAPTER SIX

Phase 3: Questionnaire study to measure factors that impact on PNMH referral decision-making among midwives and health visitors

6.1 Introduction

The previous two chapters presented the methods, findings and preliminary discussions from the qualitative, semi-structured interviews which sought to explore MWs' and HVs' decision-making in relation to referring women for secondary mental health care in the perinatal period among MWs and HVs working in two geographical areas with different levels of PNMH services. This chapter aims to examine the themes identified in Phase 2. A broader understanding of the data is provided through use of a self-reported questionnaire to examine PNMH referral decisions among MWs and HVs. By recruiting a larger sample from across the population, statistical comparisons between professional groups and geographical areas are made and the findings from the quantitative data are examined with a view to producing findings with enhanced generalisability. This chapter presents the methods used for the third phase of the research including details of the questionnaire development, rationale for the data analysis, along with the results and discussion from the questionnaire.

6.2 Methods

6.2.1 Research Design

A cross-sectional survey design was used for this phase. Cross-sectional studies are commonly used when exploring attitudes, practices, needs assessment and

evaluations (Denscombe 2017) and provide a ‘snapshot’ of what might be occurring in a sample population at a particular time (Maltby *et al*. 2010). Cross-sectional data was appropriate for this study as it was not the aim of this research to explore changes in practices over time. Cross-sectional studies are descriptive in nature and are useful to point out associations between variables (Bowling 2014).

6.2.2 Questionnaire development

A search of the literature revealed that no existing questionnaire was available that accurately reflected the research question and aims. Using a previously validated questionnaire saves both time and resources and allows for comparisons to be made between studies (Boynton and Greenhalgh 2004). However, where a validated questionnaire does not exist that reflects the research question, a bespoke questionnaire will need to be constructed (Boynton and Greenhalgh 2004). This requires extensive planning for the design and execution in order to yield meaningful results (Jones *et al*. 2013; Williams 2003). For this study a bespoke questionnaire was devised using information gained from the literature review (outlined in Chapter Two) and informed by the findings of the semi-structured interviews from Phase 1 and 2 (detailed in Chapters Four and Five respectively). An example of how the questionnaire items were developed from the interview findings and the literature can be seen in Table 6.1. In generating the questions for the questionnaire, interview transcripts were read and then questions were developed based on the verbatim quotes in order to preserve the meaning expressed by the interviewees. Once all questions had been developed, each question was examined to ensure that it reflected the aims of the research.

Table 6.1: Table showing examples of questions included in the questionnaire and example sources of data from which each question was developed

Theme title	**Example of quote from qualitative interviews**	**Example question included in the questionnaire**
Identifying need	*".. you can find out a lot through development checks. We don't really do those anymore; our community nursery nurses do practically all of our routine erm clinics..."*	How much of a potential barrier do you consider the following to you being able to identify PNMH needs of women in your care/on your caseload? Please rate your response from 1 (not a barrier at all) to 5 (a major barrier): Delegating contacts with women to other staff, e.g. community nursery nurses, maternity support worker, etc.
Education, skills and experience	*"Probably knowledge would be a big one* [barrier to assessing women with PNMH problems]*. Yes. Because we don't see it every day. We only see them* [women] *for a short period of time at delivery and just after. I mean we do do it* [PNMH] *in the study days once a year, on the mandatory training but perhaps we should have a bit more…* [training]*."*	How frequently do you feel you need to receive PNMH training/education? Please tick one option. __As a one off training session __Once a year __Once every two years __PNMH training/education not needed __Other
Referral pathways	*"I think for women with higher risk problems and concerns or pre-existing or past history, or admission for suicide* [attempt] *or psychosis and things like that, I think there needs to be a clearer pathway".*	How much of a potential barrier do you consider the following to referring women with PNMH difficulties? Please rate your response from 1 (not a barrier at all) to 5 (a major barrier): Lack of knowledge of referral pathway to refer women who are currently well but at high risk of becoming unwell, e.g. 'Red Flags' such as women with previous history of postpartum psychosis/bipolar disorder.
Theme Title	**Example of theme derived from the literature**	**Example question included in the questionnaire**
Identifying need	Data obtained from quantitative and qualitative studies showed inconsistencies in MWs and HVs use of screening tools in terms of what tools were used, how they were used and the frequency of use (Jomeen *et al*. 2013; Beauchamp 2014; Bosanquet *et al*. 2015; Higgins *et al*. 2018).	Do you use a screening tool to assess a woman's PNMH? _Yes, always _Yes, sometimes _No, never If you answered Yes, always/Yes, sometimes, which tool(s) do you use? Please specify_____

Key: PNMH= perinatal mental health

The questionnaire (Appendix 19) consisted of 14 main questions which contained a total of 45 individual items to answer including closed and open questions, and was divided into four sections: demographic information; questions relating to identifying PNMH need; education and skills; and referral pathways. Based on the literature regarding questionnaire development, a closed question approach dominated the

questionnaire so that it was quicker to complete which is important for busy HCPs (Boynton and Greenhalgh 2004; Williams 2003). Although closed questions have been criticised for limiting depth of responses where researchers are unable to probe or clarify responses (Safdar *et al*. 2017), this was mitigated by the inclusion of open text responses. The option of open-ended questions allowed for qualitative responses where respondents had the opportunity to share their own views on a topic (Williams 2003) and the freedom to answer in their own way without being restricted by options provided by the researcher (Pallant 2016).

Likert scales are commonly used where respondents are asked to indicate how strongly they agree or disagree with a series of statements (Denscombe 2017). Although there is no definitive answer to how many response options there should be in a Likert scale (Polit and Beck 2012), most scales typically use five or seven points that provide ordinal level data (Bowling 2014). However, variability can be enhanced by offering numerous response options (Polit and Beck 2012). Following piloting feedback (discussed in section 6.2.3), where initially a 10-point Likert scale was used, this questionnaire used a 5-point Likert scale where the response scale ranged from 1: Not a major barrier/facilitator to 5: A major barrier/facilitator. A 6th option of unsure/not applicable was also available for respondents if required. The option of unsure/not applicable response was placed to the far right of the scale to deter respondents from routinely selecting this response by making it less noticeable in the questionnaire (De Vaus 2002).

6.2.3 Questionnaire Piloting

The questionnaire underwent two phases of piloting. Firstly, a link to the online version was emailed to academics in psychology and midwifery, PhD students and registered practitioners currently working in midwifery and health visiting. Those who agreed to pilot the questionnaire were asked to test the online functionality, comment on the layout and clarity of questions (and relevance of questions to MW/HV practitioners), ease of completing the questionnaire and how long it took to complete. It was important to include practising MWs and HVs here as piloting is best done with the same type of people who will be used in the main study in order to ensure respondents can understand the questionnaire and respond appropriately (Pallant 2016). The feedback was mostly positive; minor issues were raised with the online functionality and on average it took 10 minutes to complete. It was acknowledged that completion could take MWs and HVs longer than 10 minutes as pilot respondents did not fully complete the open text boxes, instead giving one-word responses to test functionality. Therefore, based on the pilot feedback, the Participant Information Sheet (PIS) advised respondents that it would take approximately 15 minutes to complete which allowed for extra time to complete the optional, open text boxes. The pilot questionnaire included 10-point Likert scales. There was widespread agreement amongst pilot respondents that the 10-point scale made the questionnaire cumbersome to complete on a tablet or mobile phone as respondents needed to scroll across the screen in order to select their desired response. Since this questionnaire was targeted at busy professionals who would invariably use mobile devices for work, the Likert scale was reduced to 5 points that could be viewed on a smaller screen which eliminated the need to scroll across it and thus reduced the time taken to complete the questionnaire. Additionally, some questions were reworded to ensure conciseness which ultimately made the

questionnaire more time efficient to read. Minor typographical errors were corrected following the feedback.

Secondly, the pilot questionnaire was reviewed by experts in perinatal psychiatry and experienced researchers where feedback was given on the quality and clarity of the questions and any areas they perceived needed to be addressed in the questions. Constructive comments from expert reviewers resulted in three amendments. First, the addition of an option of unsure/not applicable was added to the Likert scale resulting in a 6-point Likert scale. Second, another potential referral facilitator option was added to include MWs'/HVs' prior experience in PNMH. The third and the final amendment resulted in clarification of questions relating to uncertainty around referral pathways for women indicated to be high risk of PNMH problems. Following the piloting phases, the questionnaire was finalised and could be completed online or via hard copy.

6.3 Questionnaire format

The online questionnaire was hosted by Jisc (formerly Bristol Online Surveys) and remained open for eight weeks from mid-January to mid-March 2020. Online administration of the questionnaire was a suitable approach as MWs and HVs readily have access to technology and the internet (Sue and Ritter 2012). Furthermore, the anonymous nature of the questionnaire mitigated the potential of social desirability bias (Safdar *et al.* 2017) and the online version had the added advantage of being economical to administer to the sampling population (Bowling 2014). However, since all HVs were community-based, as were some MWs, hardcopy questionnaires were provided in the event of internet failure/connection issues on mobile devices (such as

smart phones/tablets) and/or respondents preferred to complete a hardcopy version of the questionnaire.

For respondents completing the online questionnaire, only the consent statement was set as compulsory (discussed in section 6.5); respondents could skip any of the other questions they did not want to answer. Dècieux *et al*. (2015) advises against making questions compulsory to answer and refers to this as 'forced answering', as although it avoids missing data, it may come at a cost of the quality of the data or increase participant dropout rate. Instead, the online questionnaire settings alerted respondents to missing questions to reduce the chance of accidentally skipping items on the questionnaire (Dècieux *et al.* 2015). The paper questionnaire contained the same questions as the online version and only differed in the instructions on how to complete the questionnaire.

6.4 Sample

This phase of the research aimed to recruit all MWs and HVs from four NHS Trusts (that participated in Phases 1 and 2) that were located across two geographical areas that were selected for participation based on the PNMH services provided by the Trusts. Namely, Blue Area comprising three NHS Trusts providing the following provision: Specialist PNMH CMHTs, In-patient Mother and Baby Unit, Out-patient Parent and Baby Day Unit, specialist MWs and Specialist HVs and Consultant Perinatal Psychiatrists; and Green Area, comprising one NHS Trust, which did not have any specialist PNMH services at the inception of this PhD. However, after conducting the first two phases, from April 2019 Green Area obtained a PNMH CMHT. This team consisted of a team manager, consultant psychiatrist, clinical

psychologist, community mental health nurses, a nursery nurse, an occupational therapist and an administrator. This third and final phase of the research was conducted from January 2020 to March 2020. Thus, the PNMH CMHT in Green Area had been in operation for less than a year before the completion of Phase 3.

6.5 Ethical approvals

This study was granted ethical approval from the University of Worcester Health, Life & Environmental Sciences Research Ethics Panel (SH17180018-R, 12/11/19) and the Health Research Authority (HRA) (235568, 30/12/19) (See Appendix 20) as an amendment following submission of the final version of the questionnaire. Along with the invitation to participate email, participants were provided with a PIS (See Appendix 21). Consent was gained by asking respondents to agree to a consent statement embedded within the online questionnaire prior to completing it. The hard copy version asked respondents to tick the exact consent statement at the beginning of the questionnaire (See Appendix 22).

6.6 Recruitment

Recruitment commenced following favourable approvals from UW Ethics Committee and HRA. Research and Development (R and D) departments from each of the four NHS Trusts were contacted in order to gain permission to conduct the final phase of the research. Once R and D approval had been obtained, gatekeepers from the four Trusts were approached, and agreed to email the invitation to participate (Appendix 21) to all MWs and HVs working in the Trusts which included a link to complete the online questionnaire and to distribute paper copies of the questionnaire. To promote the research, each Trust was given copies of a poster to advertise the research with the aim of boosting recruitment (Appendix 23) which the gatekeepers agreed to

display. Two weeks following the initial invitation email, gatekeepers agreed to send a reminder email to the MWs/HVs to garner further responses (Appendix 24).

The invitation to participate email (Appendix 21) included the PIS, and also included an online URL link to complete the questionnaire. The email also contained an attached hardcopy version of the questionnaire in case respondents preferred to print off the questionnaire to complete. Respondents were reminded that hardcopy questionnaires were not to be emailed back to the researcher as the questionnaire was anonymous. Instead, the researcher provided the gatekeeper for each Trust with a stamped-addressed envelope in which to collect and return completed paper questionnaires. MWs/HVs accessed the return envelope from a location agreed locally with each gatekeeper from their respective Trusts. Instructions were included with the return envelopes on what to do with hardcopy questionnaires, i.e. place completed questionnaires in the envelope (ensuring it did not have respondents name on it) and post to the researcher at UW.

In addition to the online and hardcopy versions, all gatekeepers to the Trusts were posted 20 paper copies of the questionnaire (with a hardcopy of the PIS), which they agreed to distribute, in case respondents preferred to complete the paper version and did not have access to printing facilities. Stamped addressed envelopes were provided for each gatekeeper as outlined above in which to collect and return completed questionnaires as a courtesy measure so that the Trusts would not have to incur postage costs. Gatekeepers were informed they could request further paper copies from the researcher if needed.

6.7 Data Analysis

6.7.1 Quantitative data analysis

Quantitative questionnaire data were analysed using the statistical package SPSS version 26. Prior to data analysis the data set was cleaned using the recommendations by Pallant (2016) which involved a two-step process: checking for errors, and finding and correcting the error in the data file using SPSS. For example, errors noted related to incorrect professional group assigned to a particular Trust.

Due to the modest sample size and the resultant small number of responses for each option when stratified by geographical area and professional group, a decision was made to collapse Likert item variables from six options (1 – 6) down to two options (Not a major barrier/facilitator versus A major barrier/facilitator) for questions 5, 6, 7, 8, 11 and 13 (See Appendix 19 for questionnaire). This was achieved by coding options 1, 2, 3 and 6 (Unsure/Not applicable) as not a major barrier/facilitator and options 4 and 5 as a major barrier/facilitator. A conservative decision was made to group option 6 (Unsure/Not applicable) with the not a major barrier/facilitator group as it was felt that this best reflected the strength of feeling of option 6. As recommended by Grimbeek *et al*. (2005) the collapsing strategy was consistent across items and had a clear conceptualisation behind the decision to collapse the data. Although it is acknowledged that collapsing data can result in loss of information and can lead to a loss of statistical power (Grimbeek *et al*. 2005) it had the benefit of both simplifying the data and maximising the number of responses in each of the different cells/options resulting in what Grimbeek *et al*. (2005) describe as ‘less is better’ approach.

Data were reported descriptively and through use of tables and graphs. Data were grouped by geographical area/professional groups, i.e. within all MWs comparing Blue Area with Green Area and within all HVs comparing Blue Area with Green Area, and by whole sample population/geographical area i.e. MWs/HVs and Blue Area and Green Area. Missing data were accounted for by using the value 99 and only pairwise data (i.e. excluding the person's data only if they were missing the data required for the specific analysis) was excluded as recommended by Pallant (2016). This is the preferred way of handling missing data as it only eliminates data required for specific analysis whilst preserving any other data which are available (Kang 2013). Categorical data were compared between groups (Blue Area MWs and HVs and Green Area MWs and HVS) and between professions/areas (MWs and HVs/Blue Area and Green Area) using chi-squared tests. Where it was not appropriate to use chi-squared, i.e. when the frequency within any cell of 2x2 analysis was five or fewer, then Fisher's Exact Test (FET) was used to test the significance of difference in proportions (Polit and Beck 2012). *P*-values ≤.05 were considered statistically significant.

Remaining items where data were collapsed were where respondents were asked to state (in years) how long they had been qualified. Answers ranged from 1 – 44 years. Due to the variance in length of qualification, a decision was made to categorise these responses into two categories: qualified for 10 years or fewer versus 11 years or more. The decision to aid recategorisation of the data was based on a combination of the researchers experience as a HCP and the literature. The researcher decided that over 10 years post qualification was deemed an experienced HCP. This is supported by Mizrachi *et al*. (2017) who categorised MWs

in their study as <2 years = inexperienced, 2 -10 years = moderately experienced and > 10 years = highly experienced.

The final example where the Likert options were collapsed related to the question "Have you received training/education in PNMH in the following contexts?". The 10 options provided were collapsed into four categories to capture where training had been received and could highlight any potential differences between training provided by PNMH specialist or not by a PNMH specialist. The 10 options were recategorized as follows: 1) 'Part of professional training' including training received during nurse, MW and/or HV training; 2) 'Self-directed' training defined as self-directed study, standalone module at university/college and other study; 3) 'In-practice training by PNMH specialist' defined as in-practice training by PNMH specialist MW, HV or psychiatrist; and 4) 'In-practice training *not* by PNMH specialist'.

6.7.2 Qualitative data analysis

Qualitative data from the open text responses (See Appendix 25) were analysed broadly based on the concept of content analysis as recommended by Hsieh and Shannon (2005) and Erlingsson and Brysiewicz (2017). Content analysis is described as a systematic coding of large amounts of textual data into an efficient number of themes to determine trends and patterns of words that summarise the key results (Hsieh and Shannon 2005; Erlingsson and Brysiewicz 2017). Content analysis does not seek to attribute causality, it is a way of exploring and understanding qualitative data while at the same time being able to quantify the data (Vaismorandi *et al.* 2013). A process of 'directed content analysis' was used where

the prior research findings from Chapter Five were used to validate and extend theory (Hsieh and Shannon 2005). The initial step of the directed content analysis began by reading and re-reading the open text responses in order to become familiar with the data. Existing themes and sub-themes, developed from the interviews in Chapter 5, were used to manually highlight words/phrases in the open text responses. The next step involved coding highlighted words/phrases into the pre-existing themes. According to Hsieh and Shannon (2005) findings from directed content analysis offer supporting evidence which can be presented by showing codes with exemplars and through use of descriptive evidence. However, much of the open text comments were short phrases and/or one word responses which did not lend themselves to rich, descriptive qualitative data, therefore, the open text comments were counted and the frequency of the themes were noted which can be seen in the results section 6.8.

6.8 Results

A total of 99 responses were received from a sampling population of 755 MWs and HVs. The overall response rate was 13.1%. The sample consisted of 60 MWs (response rate 11.1%, 60/539) and 39 HVs (response rate 18.0%, 39/216); 56 respondents from Blue Area (response rate 8.72%, 56/642) and 43 respondents from Green Area (response rate 38.0%, 43/113) (See Table 6.2 for number of respondents by area and professional group).

Table 6.2: Phase 3: Number of respondents by area and professional group

Geographical Area	MW or HV	Number Employed	Number of Respondents	% Response	Total n (%) Response by Area
Blue Area	MW	457	38	8.32	56/642 (8.72)
	HV	185	18	9.73	
Green Area	MW	82	22	26.8	43/113 (38.0)
	HV	31	21	67.7	

Key: Blue = Area with specialist PNMH services; Green = Area without specialist PNMH services

6.8.1 Characteristics of respondents

The majority of MWs were hospital based (78.3%, n47), 15% (n9) were based in both hospital and community settings and 6.7% (n4) were based solely in the community, hereafter referred to as Community MWs (CMWs). All HVs (n39) were based solely in the community. See Table 6.3 for comparisons of responses by base of work. There was not a significant difference in the proportions of respondents based in hospital/community/both between Blue Area and Green Area. Statistically significantly more HVs were based in the community compared to MWs.

Table 6.3: Phase 3: Comparisons of response rates by base of work

Base of work	**Blue Area**		**Green Area**		**X^2 P-value**	**MW n60 (%)**	**HV n39 (%)**	**X^2 (p-value)**	**Blue Area n56 (%)**	**Green Area n43 (%)**	**X^2 (p-value)**
	MW n38 (%)	HV n18 (%)	MW n22 (%)	HV n21 (%)							
Hospital	30 (78.9)	0 (0)	17 (78.9)	0 (0)	83.931 **(.000)**	47 (78.3)	0(0)	83.805 **(.000)**	30 (53.6)	17 (39.5)	3.152 (.207)
Community	2 (5.3)	18 (100)	2 (9.1)	21 (100)		4 (6.7)	39(100)		20 (35.7)	23 (53.5)	
Both	6 (15.8)	0 (0)	3 (13.6)	0 (0)		9 (15)	0(0)		6 (10.7)	3 (7.0)	

Key: n= number; ()= % of respondents; **bold** type= statistically significant result

See Table 6.4 for time since qualification by area and professional group. A significantly greater proportion of MWs (48.3%) had been qualified for ≤10 years than the HVs (17.9%, p=0.002). There was not a significant difference in the proportions of respondents qualified for ≤10 years/≥11 years between Blue Area and Green Area. Figure 6.1 shows time since qualification for MWs and HVs. Across professional groups significantly more respondents in Blue Area had been qualified for ≥11 years than Green Area.

Table 6.4: Phase 3: Time since qualification by area and professional group

Time since qualification	Blue Area MW n38	Blue Area HV n18	Green Area MW n22	Green Area HV n21	X² (p-value)	MW n60	HV n39	X² (p-value)	Blue Area n56	Green Area n43	X² (p-value)
10 years or fewer	16 (42.1)	1(5.6)	13 (59.1)	6 (28.6)	13.386 **(0.004)**	29 (48.3)	7 (17.9)	9.430 **(0.002)**	17 (30.4)	19 (44.2)	2.010 (.156)
11 years and over	22 (57.9)	17(94.4)	9 (40.9)	15 (71.4)		31 (51.7)	32 (82.1)		39 (69.6)	24 (55.8)	

Key: n= number; ()= % of respondents; bold type = statistically significant result

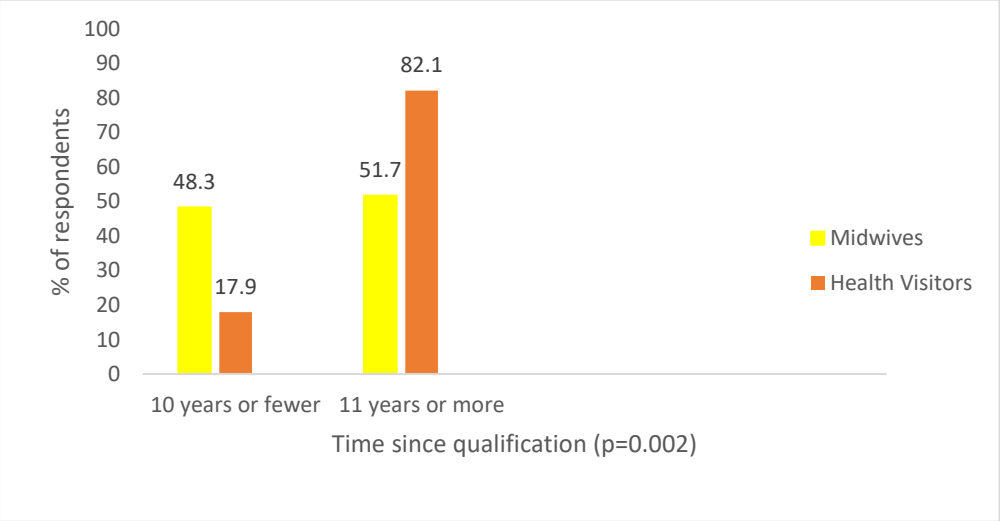


Figure 6.1: Time since qualification of MWs and HVs in percentages

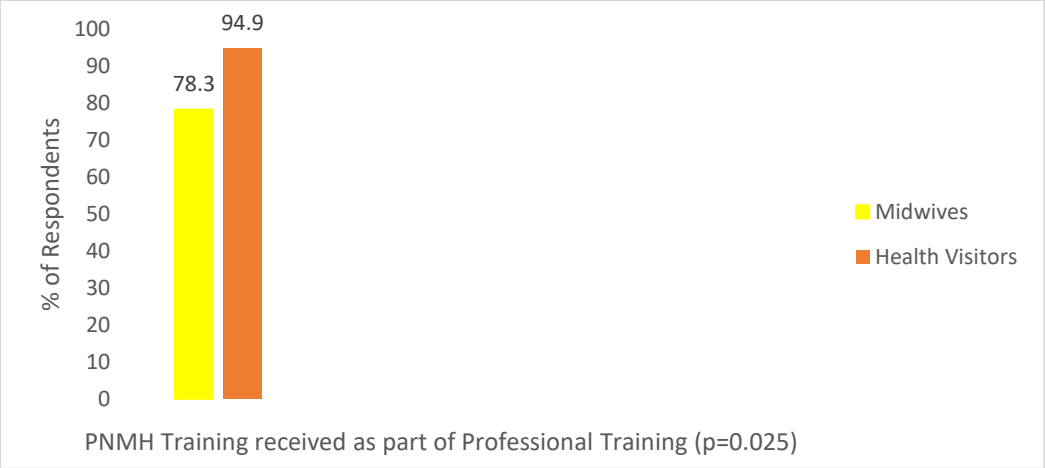


Figure 6.2: Percentage of MWs and HVs in Phase 3 who reported receiving PNMH Training as part of professional training

The majority of respondents (78.3% of MWs, and 94.9% of HVs) received PNMH training as part of their professional training, i.e. nurse, MW and/or HV training, and this difference was significant (p=0.025) as illustrated in Figure 6.2 above and shown in Table 6.5. below. However, there was not an overall significant difference in the proportions of respondents in Blue Area vs Green Area who received PNMH training as part of their professional training. Table 6.5 shows that significantly more respondents in Blue Area (67.9%) received in-practice training by a PNMH specialist compared to 27.9% of respondents in Green Area (p<0.001) and illustrated in Figure 6.3, but there was not a significant difference overall between MWs and HVs. In contrast, significantly more respondents in Green Area received in-practice training *not* provided by a PNMH specialist (39.5%) compared to only 7.1% of respondents in Blue Area (p<0.001), illustrated in Table 6.5 and Figure 6.3; again, there was not a significant difference overall between MWs and HVs. None of the respondents reported having an NMC registrable mental health qualification.

Table 6.5: Training/education received by area and professional group

Where have you received training/education in PNMH?		**Blue Area**		**Green Area**		**X^2 (p-value)**	**MW n60 (%)**	**HV n39 (%)**	**X^2 (p-value)**	**Blue Area n56 (%)**	**Green Area n43 (%)**	**X^2 (p-value)**
		MW n38 (%)	HV n18 (%)	MW n22 (%)	HV n21 (%)							
Part of professional training, n (%)	Yes	32(84.2)	17(94.4)	15(68.2)	20(95.2)	7.818 (.050)	47(78.3)	37(94.9)	5.029 **(.025)**	49(87.5)	35(81.4)	.705 (.401)
Self-directed, n (%)	Yes	21(55.3)	6(33.3)	15(68.2)	10(47.6)	5.138 (.162)	36(60.0)	16(41)	3.413 (.065)	27(48.2)	25(58.1)	.961 (.327)
In-practice training by a PNMH specialist, n (%)	Yes	21(55.3)	17(94.4)	8(36.4)	4(19)	24.320 **(.000)**	29(48.3)	21(53.8)	.287 (.592)	38(67.9)	12(27.9)	15.530 **(.000)**
In-practice training *not* by a PNMH specialist, n (%)	Yes	3(7.9)	1(5.6)	6(27.3)	11(52.4)	19.363 **(.000)**	9(15.0)	12(30.8)	3.517 (.061)	4(7.1)	17(39.5)	**(.000)***

Key: *= Fisher's Exact Test; ()=% of respondents; Bold type= statistically significant result

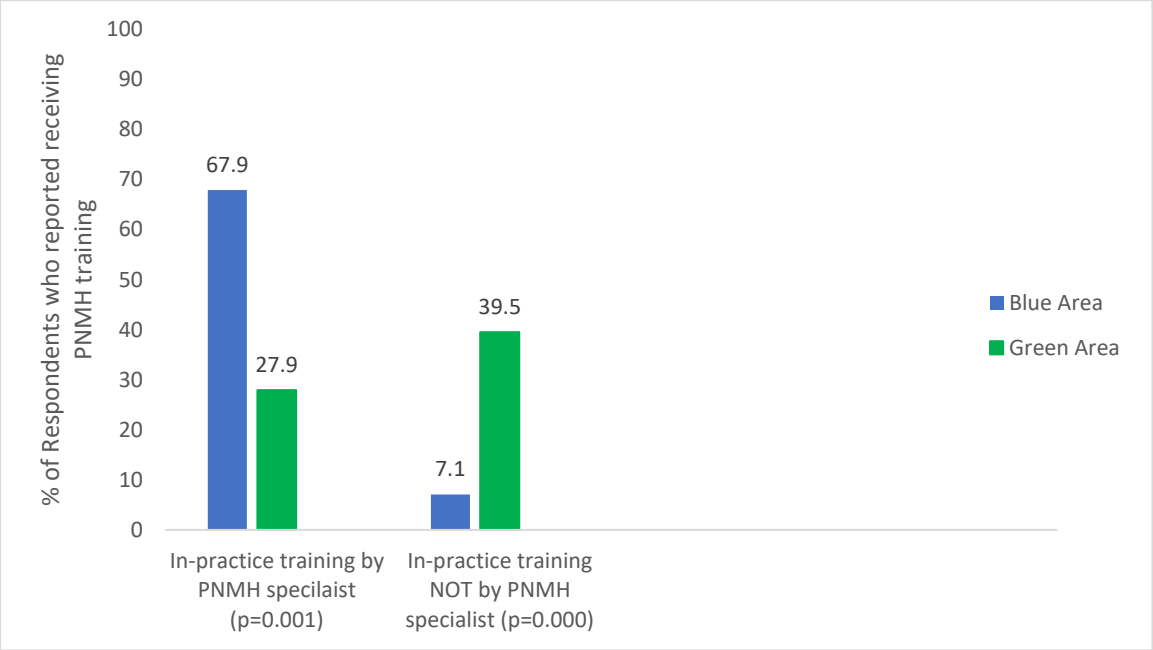


Figure 6.3: Type of PNMH Training received by area in percentage

6.8.2 Barriers and facilitators to identifying the perinatal mental health needs of women

This section presents a summary of respondents' perceptions of the potential barriers/facilitators to identifying PNMH needs of women in their care.

6.8.2.1 Reduced number of overall contacts with women

Table 6.6 shows that HVs from both Blue and Green Areas were statistically significantly more likely to perceive reduced number of contacts with women as 'a major barrier' to identifying PNMH needs of women than their midwifery counterparts. Overall, 82.1% of HVs reported that reduced number of contacts with women was 'a major barrier' compared to 43.5% of MWs ($p<0.001$) as illustrated in Figure 6.4. However, there was not a significant difference overall between respondents in Blue Area and Green Area.

Table 6.6: Potential barriers to identifying PNMH needs of women by area and professional group

How much of a potential barrier do you consider the following to you being able to identify PNMH needs of women in your care/on your caseload?		Blue Area		Green Area		X^2 (p-value)	MW n 60 (%)	HV n 39 (%)	X^2 (p-value)	Blue Area n 56 (%)	Green Area n 43 (%)	X^2 (p-value)
		MW n38 (%)	HV n18 (%)	MW n22 (%)	HV n21 (%)							
Reduced number of contacts with women	**0**	19 (50.0)	4 (22.2)	15 (68.2)	3 (14.3)	16.754 **(.001)**	34 (56.7)	7 (17.9)	14.604 **(.000)**	23 (41.1)	18 (41.9)	.006 (.937)
	1	19 (50.0)	14 (77.8)	7 (31.8)	18 (85.7)		26 (43.3)	32 (82.1)		33 (58.9)	25 (58.1)	
Lack of contacts in the home environment	**0**	20 (52.6)	5 (27.8)	11 (50.0)	6 (28.6)	5.368 (.147)	31 (51.7)	11 (28.2)	5.326 **(.021)**	25 (44.6)	17 (39.5)	260 (.610)
	1	18 (47.4)	13 (72.2)	11 (50)	15 (71.4)		29 (48.3)	28 (71.8)		31 (55.4)	26 ((60.5)	
Delegating contacts with women to other staff, e.g. CNN, MSW, etc.	**0**	24 (63.2)	7 (38.9)	16 (72.7)	12 (57.1)	5.033 (.169)	40 (66.7)	19 (48.7)	3.162 (.075)	31 (55.4)	28 (65.1)	.962 (.327)
	1	14 (36.8)	11 (61.1)	6 (27.3)	9 (42.9)		20 (33.3)	20 (51.3)		25 (44.6)	15 (34.9)	
Having generic clinics, e.g. booking, PN, 6- 8-week clinics, etc. instead of personally seeing women in your care/on your caseload	**0**	20 (52.6)	8 (44.4)	13 (59.1)	6 (28.6)	4.671 (.198)	33 (55.0)	14 (35.9)	3.459 (.063)	28 (50.0)	19 (44.2)	.330 (.566)
	1	18 (47.4)	10 (55.6)	9 (40.9)	15 (71.4)		27 (45.0)	25 (64.1)		28 (50.0)	24 (55.8)	
Physical health checks/tasks taking up contact time with women allowing little or no time to conduct a mental health assessment	**0**	20 (52.6)	14 (77.8)	7 (31.8)	19 (90.5)	18.218 **(.000)**	27 (55.0)	33 (84.6)	15.537 **(.000)**	34 (60.7)	26 (60.5)	.001 (.980)
	1	18 (47.4)	4 (22.2)	15 (68.2)	2 (9.5)		33 (45.0)	6 (15.4)		22 (39.3)	17 (39.5)	
Lack of confidence in your ability to identify key risk factors for women at high risk of developing PNMH difficulties	**0**	32 (84.2)	16 (88.9)	18 (81.8)	19 (90.5)	.886 (.829)	50 (83.3)	35 (89.7)	(.556)*	48 (85.7)	37 (86.0)	.002 (.962)
	1	6 (15.8)	2 (11.1)	4 (18.2)	2 (9.5)		10 (16.7)	4 (10.3)		8 (14.3)	6 (14.0)	
Lack of confidence in your ability to identify women who are experiencing PNMH health difficulties	**0**	32 (84.2)	17 (94.4)	18 (81.8)	19 (90.5)	1.873 (.599)	50 (83.3)	36 (92.3)	1.669 (.237)*	49 ((87.5)	37 (86.0)	.045 (.832)
	1	6 (15.8)	1 (5.6)	4 (18.2)	2 (9.5)		10 (16.7)	3 (7.7)		7 (12.5)	6 (14.0)	

Key: 0= not a major barrier; 1 = a major barrier; ()= %of respondents; CNN = Community Nursery Nurse; MSW: Maternity Support Worker; PNMH: Perinatal Mental Health; * = Fisher's Exact Test ; **Bold** type= statistically significant results

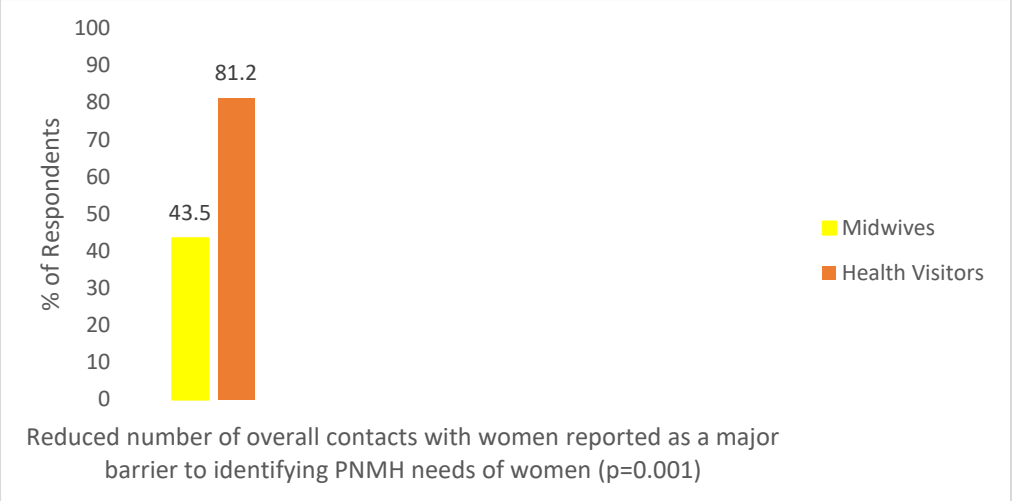


Figure 6.4: Percentage of MWs and HVs reporting reduced number of overall contacts with women perceived as a major barrier to identifying the PNMH needs of women

To examine whether the difference between HVs and MWs may be related to base of work (all HVs were based in the community compared to only 6.7% MWs), the responses of hospital-based MWs and CMWs were compared. However, no significant difference was found between the proportions of hospital-based MWs and CMWs who felt that reduced contacts was ‘a major barrier’ to identifying women with PNMH needs (75.0% (3/4) of CMWs vs 55.4% (31/56) of hospital-based MWs, (FET) p=0.414).

To examine whether the difference between HVs and MWs may be related to receiving specific training in PNMH as part of professional training (significantly more HVs than MWs had received training), the number of respondents who had versus those who had not received this type of training were compared across the whole sample. However, no significant difference was found, with 39.3% (33/84) of those who had received PNMH training as part of professional training reporting that

reduced contacts with women were ‘not a major barrier’ to identifying PNMH needs of women compared to 53.3% (8/15) of those who had not received PNMH training as part of professional training (X^2= 1.035, p=0.309).

As a larger proportion of HVs had been qualified for longer than MWs (82.1% of HVs qualified ≥11 years compared to 51.7% of MWs, p=0.002), data were examined to explore whether there was a relationship between duration of time since qualification and reduced contacts being reported as ‘a major barrier’ to identifying PNMH needs of women. However, no statistically significant difference was found, with 61.9% (39/63) of those qualified for ≥11 years compared to 52.8% (19/36) of those qualified for ≤10 years reporting that reduced contacts were ‘a major barrier’ to identifying PNMH needs of women (X^2=0.787, p=0.375).

6.8.2.2 Lack of home contacts

There was not a statistically significant difference between the proportion of respondents in Blue Area (55.4%) versus Green Area (60.5%) who considered lack of home-based contacts as ‘a major barrier’ to identifying PNMH needs of women (X^2=0.260, p=0.610) as shown in Table 6.6 above. However, significantly more HVs perceived lack of number of contacts in the home as ‘a major barrier’ to identifying PNMH needs of women (71.8%) compared to MWs (48.3%, X^2=5.326, p=0.021) as illustrated in Figure 6.5.

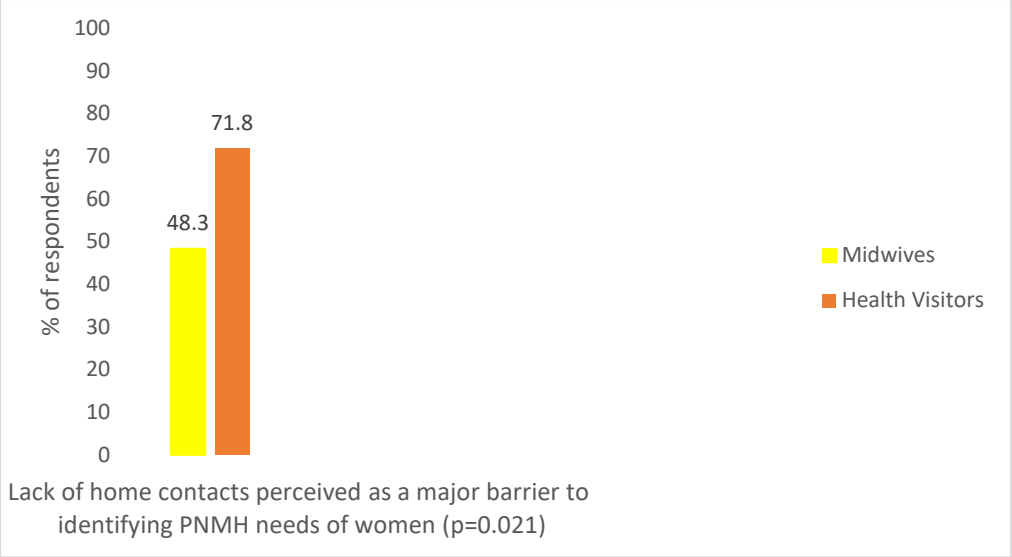


Figure 6.5: Percentage of MWs/HVs reporting lack of home contacts perceived as a major barrier to identifying PNMH needs of women

To examine whether the difference between HVs and MWs may be related to base of work, the responses of hospital-based MWs and CMWs were compared. However, no statistically significant difference was found, with 75.0% (3/4) of CMWs reporting that lack of contacts in the home was 'not a major barrier' to identifying PNMH needs of women compared to 50.0% (28/56) of hospital-based MWs (FET p=0.613).

In order to examine whether the difference between HVs and MWs may be related to significantly more HVs than MWs having received specific training in PNMH as part of professional training (See Table 6.6 above), those who had versus those who had not received training across the whole sample were compared. However, no statistically significant difference was found, with 41.7% (35/84) of those who had received PNMH training as part of professional training reporting that lack of contacts in the home was 'not a major barrier' to identifying PNMH needs of women

compared to 46.7% (7/15) of those who had not received PNMH training as part of professional training (X^2=0.130, p=0.718).

Data were also examined to explore whether there was a relationship between time since qualification and lack of contacts in the home being reported as ‘a major barrier’ to identifying PNMH needs of women. However, no statistically significant difference was found with 60.3% (38/63) of those who had been qualified for ≥11 years compared to 52.8% (19/36) of those who had been qualified for ≤10 years reporting that lack of contacts in the home was ‘a major barrier’ to identifying PNMH needs of women (X^2=0.533, p=0.465).

6.8.2.3 Delegating contacts with women to other staff

As shown in Table 6.6, overall, nearly half of respondents in Blue Area (44.6%) and 34.9% respondents in Green Area reported that delegating contacts with women to other staff (such as Community Nursery Nurses and Maternity Support Workers) was ‘a major barrier’ to identifying PNMH needs of women, and this difference was not statistically significant (X^2=0.962, p=0.327). There were no statistically significant differences between the proportions of MWs and HVs in Areas Blue and Green (X^2=5.033, p=0.169) and professional groups (X^2=3.162, p=0.075) who reported delegating contacts with women to other staff was ‘a major barrier’ to identifying PNMH needs of women.

6.8.2.4 Generic clinics

Having generic clinics (e.g. midwifery booking/postnatal clinics, health visiting 6- 8-week clinics, etc.) rather than personally seeing women in their care/on their

caseload was identified as ‘a major barrier’ to identifying PNMH needs of women for approximately half of the sample overall as shown in Table 6.6, but there were no statistically significant differences between professional groups or areas. Overall, 50.0% respondents in Blue Area and 55.8% respondents in Green Area reported that having generic clinics was ‘a major barrier’ to identifying PNMH needs of women (X^2=0.330, p=0.566), and 45.0% MWs and 64.1% HVs felt this was ‘a major barrier’ (X^2=3.459, p=0.063).

6.8.2.5 Physical health checks

As shown in Table 6.6 above and illustrated in Figure 6.6, MWs were significantly more likely to perceive physical health checks taking up contact time with women as ‘a major barrier’ to identifying the PNMH needs of women (45.0%) compared to HVs (15.4%, p<.0001). However, there was no statistically significant difference between Blue Area and Green Area, with 39.3% and 39.5% respondents respectively reporting this as ‘a major barrier’.

Figure 6.6: Physical health checks taking up contact time perceived as a major barrier by MWs and HVs in percentages

As in previous analysis, to examine whether the difference between HVs and MWs may be related to base of work, the responses of hospital-based MWs and CMWs were compared. However, a statistically significant difference was not found, with 25% (1/4) of CMWs reporting that physical health checks taking up time with women was ‘a major barrier’ to identifying PNMH needs of women compared to 57.1% (32/56) of hospital-based MWs (FET p=0.318).

To examine whether the difference between HVs and MWs may be related to receiving specific training in PNMH as part of professional training those who had versus those who had not received training across the whole sample were compared. However, no statistically significant difference was found, with 38.1% (32/84) of those who had received PNMH training as part of professional training reporting that physical health checks taking up contact time with women was ‘a major barrier’ to identifying PNMH needs of women compared to 46.7% (7/15) of those who had not received PNMH training (X^2=0.392, p=0.531).

As a larger proportion of MWs than HVs had been qualified for ≤10 years, data were examined to explore whether there was a relationship between time since qualification and physical checks taking up contact time being reported as ‘a major barrier’ to identifying PNMH needs of women. Significantly more respondents who had been qualified for ≤10 years (55.6%, 20/36) compared to those who had been qualified for ≥11 years (30.2%, 19/63) reported that physical health checks taking up contact time was ‘a major barrier’ to identifying PNMH needs of women (X^2=6.189, p=0.013) (See Figure 6.7).

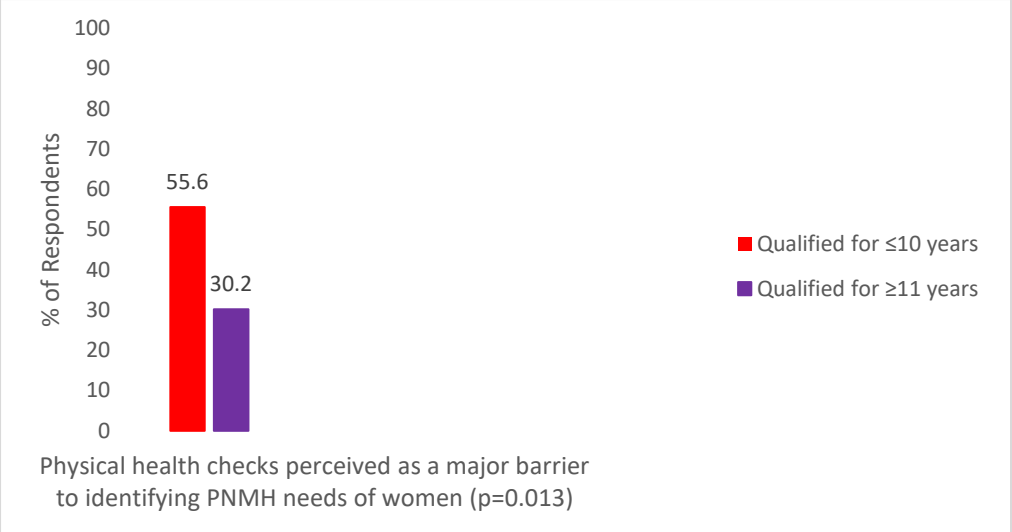


Figure 6.7: Physical health checks perceived as a major barrier to identifying PNMH needs of women by respondent length of qualification (in %)

6.8.2.6 Lack of confidence to identify key risk factors

Most respondents reported that lack of confidence in identifying key risk factors for women at high risk of developing PNMH difficulties was 'not a major barrier' to identifying PNMH needs of women (Blue Area: 84.2% of MWs and 88.9% of HVs; Green Area: 81.8% of MWs and 90.5% of HVs; see Table 6.6 above). There was no statistically significant difference between MWs and HVs overall, with only 16.7% and 10.3% respondents respectively reporting this as 'a major barrier' (FFT p=0.556). Likewise, there was not a statistically significant difference overall between Blue Area (14.3%) and Green Area (14.0%) in their reporting of this as 'a major barrier' (X^2=0.002, p=0.962).

6.8.2.7 Lack of confidence in ability to identify women experiencing perinatal mental health difficulties

As shown in Table 6.6 most respondents reported that lack of confidence when identifying women experiencing PNMH difficulties was 'not a major barrier' (Blue Area: 84.2% MWs and 94.4% HVs; Green Area: 81.8% MWs and 90.5% HVs).

There was no statistically significant difference between MWs and HVs overall, with only 16.7% and 7.7% respondents respectively reporting this as ‘a major barrier’ (FET p=0.237) and between Blue Area (12.5%) and Green Area (14.0%) overall reporting this as ‘a major barrier’ (X^2=0.045, p=0.832).

6.8.2.8 Open text comments related to barriers to identifying perinatal mental health needs of women

Following the closed questions described above, respondents were asked if there were other barriers to them identifying women’s PNMH needs. As shown in Table 6.7, a total of 21 responses were provided; some respondents provided more than one barrier. The majority of the comments echoed barriers referred to in the closed questions, namely reduced contacts with women, with a comparatively even spread of comments reported across Blue and Green Areas (Blue Area: 7/15; Green Area: 8/15). Reduced contacts with women included comments such as a lack of home visits, lack of continuity of carer and a lack of time with women at each contact.

A further seven barriers not specifically asked about in the closed questions were recorded by respondents, and included comments related to language barriers, women not disclosing mental health concerns due to stigma (covered in later closed questions, see section: 6.8.3.5), presence of partners resulting in a lack of privacy to discuss mental health, a lack of communication skills on the part of the HCP to address PNMH with women and lack of knowledge regarding where, to whom and when to refer women (covered in later closed questions, see section: 6.8.7).

Table 6.7: Open text comments related to barriers to identifying PNMH needs of women by area and professional group

Number of comments	Barriers identified by respondents	Blue Area		Green Area	
		MW	HV	MW	HV
15	Reduced Contacts with women	5	2	2	6
1	Language barrier	1	-	-	-
1	Delegation of job role to CNN	-	-	-	1
1	Stigma	-	1	-	-
1	Identifying PNMH not part of clinical role	1	-	-	-
1	Presence of partners/no privacy	-	-	1	-
1	Lack of communication skills	1	-	-	-
1	Lack of knowledge regarding where and when to refer women	1	-	-	-

Key: CNN= Community Nursery Nurse; PNMH= perinatal mental health

Now turning to examine perceived facilitators to identifying PNMH needs of women, three potential facilitators were included in the closed items on the questionnaire as follows in the section below.

6.8.2.9 Relying on gut instinct/intuition

Table 6.8 below shows that the majority of respondents from both areas reported that relying on gut instinct/intuition was ‘very important’ to them in identifying women who are experiencing PNMH difficulties (Blue Area: MWs 84.2%, HVs 77.8%; Green Area: MWs 86.4%, HVs 85.7%). There was no statistically significant difference between MWs and HVs overall, with 85.0% and 82.1% of respondents respectively reporting this as ‘very important’ (p=0.697). Similarly, there was not a statistically significant difference overall between Blue Area (82.1%) and Green Area (86.0%) reporting that gut instinct/intuition was ‘very important’ (p=0.601).

6.8.2.10 Relying on prior experience

As shown in Table 6.8 and illustrated in Figure 6.8, relying on prior experience of PNMH issues/difficulties/needs when identifying women in need of PNMH care was reported to be ‘very important’ by a significantly greater proportion of HVs compared to MWs (92.3% of HVs, vs 70.0% of MWs, FET p=0.011). No statistically significant difference was found between respondents in Areas Blue and Green, with 76.8% and 81.4% respectively reporting this as ‘very important’ (X^2=0.309, p=0.578).

Table 6.8: Potential facilitators to identifying PNMH needs in women by area and professional group

Qu.6: How important do you consider the following potential facilitators to identifying PNMH needs in women in your care/on your caseload?		Blue Area		Green Area		X² (p-value)	MW n60 (%)	HV n39 (%)	X² (p-value)	Blue Area n56 (%)	Green Area n43 (%)	X² (p-value)
		MW n38 (%)	HV n18 (%)	MW n22 (%)	HV n21 (%)							
Relying on your gut instinct/intuition to identify women who are experiencing PNMH difficulties	0	6 (15.8)	4 (22.2)	3 (13.6)	3 (14.3)	.650 (.885)	9(15.0)	7(17.9)	.152 (.697)	10(17.9)	6 (14.0)	.274 (.601)
	1	32 (84.2)	14(77.8)	19(86.4)	18(85.7)		51(85.0)	32(82.1)		46(82.1)	37(86.0)	
Relying on your prior experience of PNMH issues/difficulties/needs	0	11 (28.9)	2 (11.1)	7 (31.8)	1 (4.8)	7.340 (.062)	18(30.0)	3(7.7)	**(.011)***	13(23.2)	8 (18.6)	.309 (.578)
	1	27 (71.1)	16(88.9)	15(68.2)	20(95.2)		42(70.0)	36(92.3)		43(76.8)	35(81.4)	
Using an assessment tool to identify perinatal mental health difficulties	0	11 (28.9)	2 (11.1)	14 (63.6)	4 (19.0)	15.670 **(.001)**	25(41.7)	6(15.4)	7.591 **(.006)**	13(23.2)	18(41.9)	3.932 **(.047)**
	1	27 (71.1)	16(88.9)	8 (36.4)	17(81.0)		35(58.3)	33(84.6)		43(76.8)	25(58.1)	

Key: 0 = not very important; 1 = very important; PNMH = Perinatal Mental Health; ()= % of respondents; * = Fischer's Exact Test; Bold type= statistically significant result

Figure 6.8: Relying on prior experience when identifying women in need of PNMH care perceived as very important by MWs and HVs in percentages

To examine whether the difference between HVs and MWs may be related to base of work, the responses of hospital-based MWs and CMWs were compared. However, no statistically significant difference was found, with 50.0% (2/4) of CMWs reporting that relying on prior experience was ‘very important’ in identifying PNMH needs of women compared to 71.4% (40/56) of hospital-based MWs (FET p=0.576).

To examine whether the difference between HVs and MWs may be related to receiving specific training in PNMH as part of professional training, the responses of respondents who had, versus those who had not received training were compared across the whole sample. However, no statistically significant difference was found, with 82.1% (69/84) of those who had received PNMH training as part of professional training reporting that relying on prior experience was ‘very important’ to identifying

PNMH needs of women compared to 60.0% (9/15) of those who had not received PNMH training as part of professional training (X^2=3.734, p=0.053).

Data were also examined to explore whether there was a relationship between time since qualification and relying on prior experience being reported as 'very important' to identifying PNMH needs of women. However, no significant difference was found, with 84.1% (53/63) of those who had been qualified for ≥11 years compared to 69.4% (25/36) of those who had been qualified for ≤10 years reporting this as 'very important' (X^2=2.955, p=0.086).

6.8.2.11 Using an assessment tool

As shown in Table 6.8, most respondents, except the MWs in Green Area, reported use of an assessment tool as being 'very important' to identifying women in need of PNMH care (88.9% of HVs in Blue Area, and 81.0% of HVs in Green Area, compared to 71.1% of MWs in Blue Area, and 36.4% of MWs in Green Area; X^2=15.670, p <0.001). Overall, 84.6% of HVs reported that using an assessment tool was 'very important' compared to 58.3% of MWs (X^2=7.591, p=0.006) as illustrated in Figure 6.8. There was a statistically significant difference overall between respondents in Blue Area and Green Area (Blue Area: 76.8%; Green Area: 58.1%, p=0.047) (See Figure 6.9).

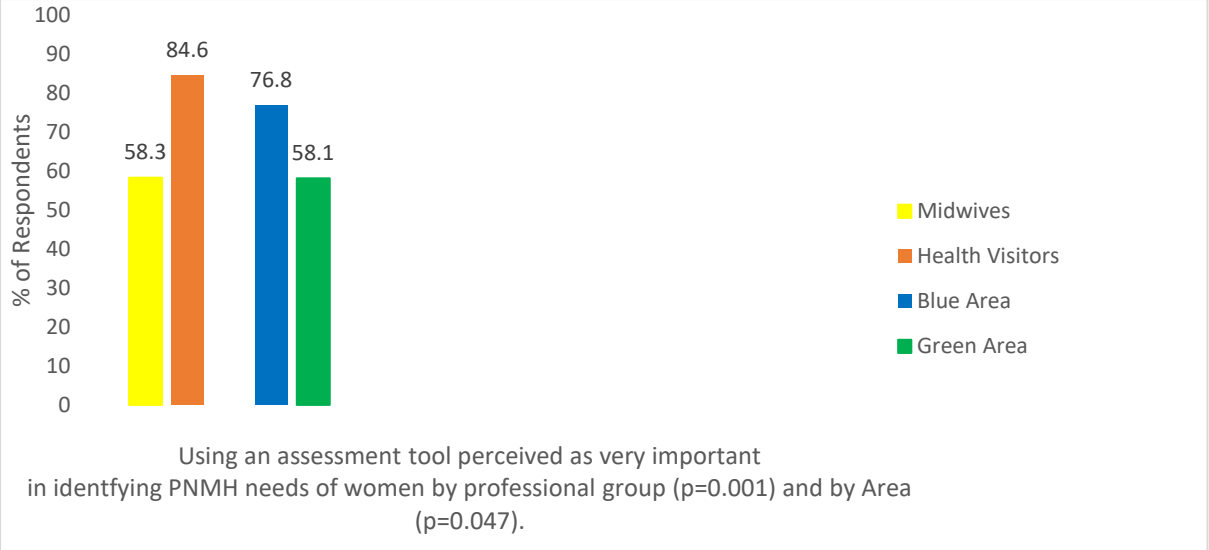


Figure 6.9: Percentage of respondents perceived using an assessment tool as very important in identifying women in need of PNMH care by MWs/HVs/Areas

To examine whether the difference between HVs and MWs may be related to base of work, the responses of hospital-based MWs and CMWs were compared. No statistically significant difference was found, with 50.0% (2/4) of community-based MWs reporting using an assessment tool as 'very important' compared to 58.9% (33/56) of hospital-based MWs (FET p=0.726).

Time since qualification was found to be associated with reporting the use of an assessment tool as 'very important' with 76.2% (48/63) of all respondents who were qualified for ≥11 years reporting that using an assessment tool was 'very important' compared to 55.6% (20/36) of those respondents qualified for ≤10 years, and this was statistically significant (X^2=4.535, p=0.033) (See Figure 6.10).

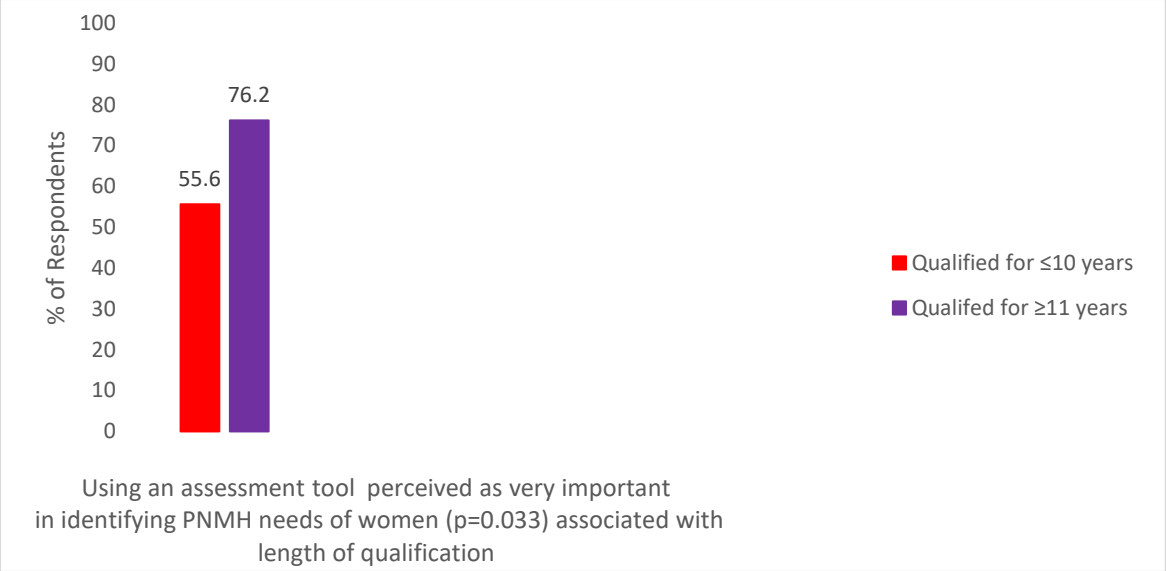


Figure 6.10: Percentage of respondents perceived that using an assessment tool as very important in identifying PNMH needs of women associated with length of qualification

Reporting use of an assessment tool as 'very important' was not significantly associated with having received PNMH training within professional training as 70.2% (59/84) of respondents who received such training felt that using an assessment tool was 'very important' to identify PNMH difficulties in women, compared to 60.0%, (9/15) of respondents who had not received PNMH training (X^2=0.620, p=0.431).

Blue Area respondents were statistically significantly more likely to report using an assessment tool as 'very important' compared to Green Area. Therefore, in order to examine whether this difference was related to the significant difference in the proportions of respondents in each area who had received in-practice training by a PNMH specialist or not, the responses of those who had versus those who had not received this type of training were compared across the whole sample. The data showed that 82.0% (41/50) of respondents who received in-practice training by a

PNMH specialist reported using a tool was ‘very important’ compared to 55.1% (27/49) who had not and this was statistically significant (X^2=8.325, p=0.004) (See Figure 6.11).

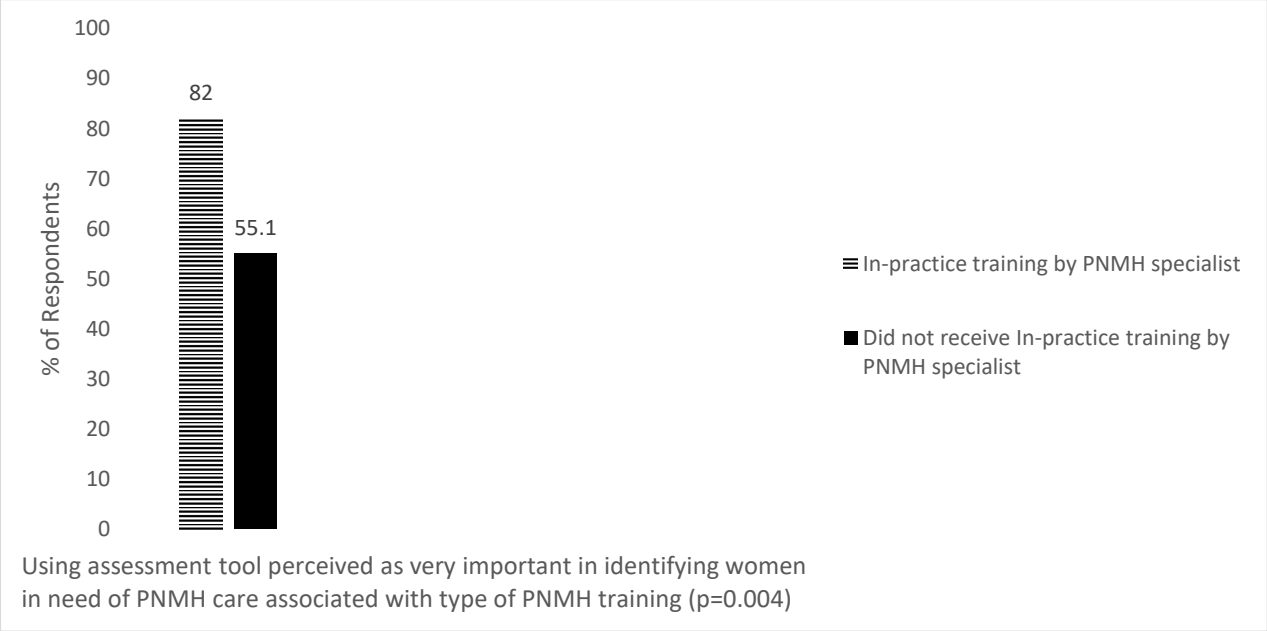


Figure 6.11: Perception that using an assessment tool as very important in identifying women in need of PNMH care associated with type of PNMH training

Reporting the use of an assessment tool as ‘very important’ was not significantly associated with receiving in-practice training *not* by a PNMH specialist as 52.4% (11/21) of respondents who received this training felt that using an assessment tool was ‘very important’ to identify PNMH difficulties in women, compared to 73.1%, (57/78) of respondents who had not received this type of training (X^2=3.295, p=0.069).

6.8.2.12 Open text comments related to facilitators to identifying perinatal mental health needs of women

Respondents were asked if there were other facilitators to aiding their identification of women's PNMH needs. A total of 23 individual responses were recorded, none of which specifically referred to the facilitators in the closed questions. The most commonly reported facilitator was described as multidisciplinary team (MDT) working/communication between agencies (n7) and included comments about having a specialist midwife to act as a source of advice for MWs and information sharing between the MDT. The second most common response concerned continuity of carer and related to issues such as knowledge of women's previous mental ill-health history and how continuity of carer facilitates relationship building between women and HCP which in turn may aid identification of PNMH needs. Three respondents from Blue Area commented on the communication skills of practitioners and having the confidence to ask the right questions. One comment from a HV in Blue Area related to needing clarity on the referral process. The remaining open text comments and by whom can be seen in Table 6.9.

Table 6.9: Open text comments related to facilitators to identifying PNMH needs of women by area and professional group

Number of comments	Facilitators identified by respondents	Blue Area		Green Area	
		MW	HV	MW	HV
7	MDT working/communication	4	-	1	2
6	Continuity of carer	2	-	2	2
4	Family/partner input	2	-	1	1
3	Communication skills	1	2	-	-
2	Presentation of woman	-	-	1	1
1	Clarity regarding referral process	-	1	-	-

6.8.2.13 Summary of barriers and facilitators to identifying perinatal mental health needs of women

The most frequently reported views by respondents were the importance of relying on prior experience and gut instinct in identifying the PNMH needs of women. On the whole, the majority of respondents felt that using assessment tools was important. Very few respondents felt they lacked confidence in their ability to identify women experiencing PNMH difficulties or those at high risk of doing so.

The majority of respondents reported that reduced contacts with women, particularly in the home environment, were a major barrier to identifying the PNMH needs of women. Significantly more HVs than MWs reported this was perceived as a major barrier to identifying PNHM needs, and significantly more HVs reported the importance of relying on their previous PNMH experience. These differences between HVs and MWs did not appear to be related to the base of work (all HVs were based in the community, majority of MWs were hospital-based), or time since qualification (HVs had been qualified for longer), or that more HVs had received PNMH training as part of their professional training. Significantly more HVs than MWs felt that using an assessment tool was very important, but this was significantly related to length of time since qualification and more HVs had been qualified for longer. The feeling that physical health checks left little time for mental health assessments was also related to length of time since qualification, with respondents who had been qualified for <10 years more likely to report this than those qualified for >11 years.

There were very few significant differences overall between respondents in Blue and Green Areas. One significant difference was that more respondents in Blue Area reported that using an assessment tool was very important, and this was significantly related to having received PNMH in-practice training delivered by a PNMH specialist which was also more common in Blue Area.

Other important factors in identifying PNMH needs of women that were reported by the respondents in the open text questions, and not addressed in any of the closed questions in the survey, were the lack of privacy to have confidential discussions with women about their mental health without the presence of family members; communication between the MDT to enable information sharing; liaison between professionals and care planning for women with PNMH difficulties; and MWs/HVs having the appropriate communication skills to ask women questions to facilitate their disclosure of PNMH difficulties.

6.8.3 Barriers and facilitators to women disclosing perinatal mental health difficulties

The following results relate to questions concerning MWs' and HVs' perceptions of potential barriers/facilitators to women disclosing PNMH difficulties.

6.8.3.1 Trusted relationship between midwife/health visitor and woman

As shown in Table 6.10, when asked if a trusted relationship between MW/HV and woman was important to women disclosing PNMH difficulties, the vast majority of respondents reported perceiving this as 'very important' for facilitating disclosure of PNMH difficulties, however there were no statistically significant differences found

Table 6.10: Potential facilitators to women disclosing PNMH difficulties by area and professional group

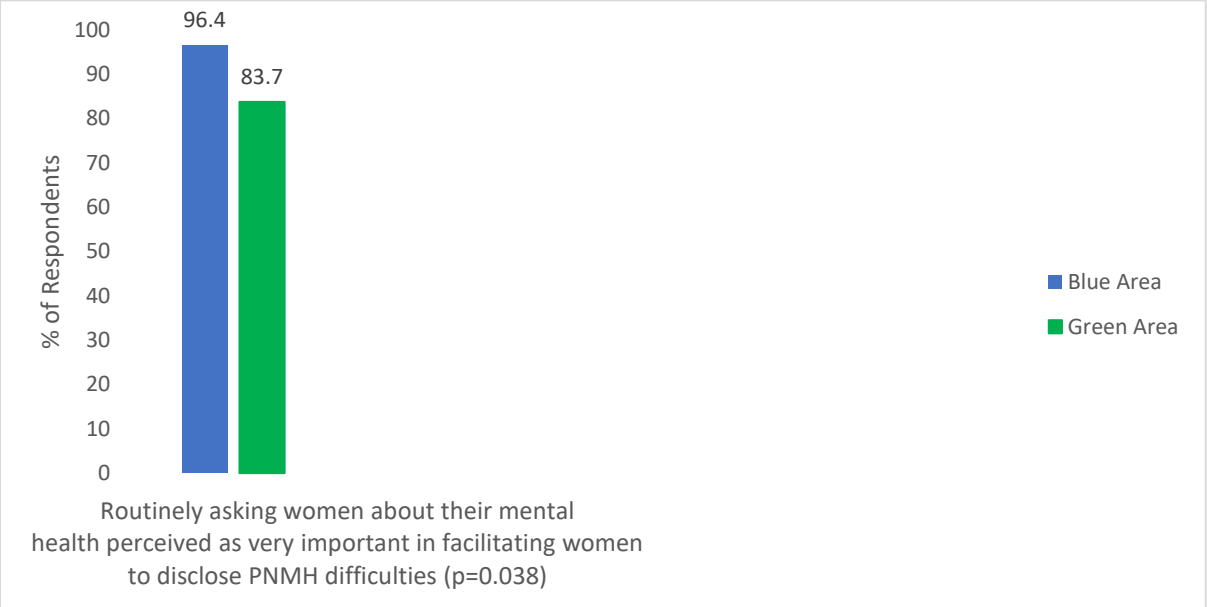
Qu.7: How important do you consider the following potential facilitators to women disclosing PNMH difficulties?		**Blue Area MWs n38 (%)**	**Blue Area HVs n18 (%)**	**Green Area MWs n22 (%)**	**Green Area HVs n21 (%)**	**X² (p-value)**	**MW n60 (%)**	**HV n39 (%)**	**X² (p-value)**	**Blue Area n56 (%)**	**Green Area n43 (%)**	**X² (p-value)**
A trusted relationship between the woman and MW/HV	**0**	2 (5.3)	0(0.0)	0 (0.0)	1 (4.8)	2.109 (.550)	2 (3.3)	1 (2.6)	(.100)*	2 (3.6)	1 (2.3)	.128 (.100)*
	1	36(94.7)	18(100)	22(100)	20(95.2)		58(96.7)	38(97.4)		54(96.4)	42(97.7)	
MW/HV routinely asking women about their mental health	**0**	1 (2.6)	1 (5.6)	6 (27.3)	1 (4.8)	11.467 **(.009)**	7 (11.7)	2(5.1)	(.476)*	2 (3.6)	7 (16.3)	4.753 **(.038)***
	1	37(97.4)	17(94.4)	16(72.7)	20(95.2)		53(88.3)	37(94.9)		54(96.4)	36(83.7)	

Key: 0 = not very important; 1 = very important; PNMH = Perinatal Mental Health; * = Fisher's Exact Test; Bold type = statistically significant result

between MWs and HVs in Blue and Green Areas (Blue Area: 94.7% MWs and 100% HVs; Green Area: 100% MWs and 95.2% HVs, p=0.550) and overall between professional groups (MWs: 96.7%, HVs: 97.4%, FET p=1.000). Furthermore, no difference was found overall between areas (Blue Area: 96.4%, Green Area: 97.7%, FET p=1.000).

6.8.3.2 Routinely asking women about their mental health

As shown in Table 6.10, routinely asking women about their mental health was perceived to be 'very important' in facilitating women to disclose PNMH difficulties by the majority of respondents. Although significantly fewer of the MWs in Green Area perceived this as 'very important' compared to the remainder of the respondents (Blue Area: 97.4% MWs and 94.4% HVs; Green Area: 72.7% MWs and 95.2% HVs; p=0.009), there was not a statistically significant difference found between MWs and HVs overall (MWs: 88.3% and HVs: 94.9%, FET p=0.476). However, there was a significant difference overall between respondents in Blue Area and Green Area (Blue Area: 96.4%; Green Area: 83.7%, FET p=0.038) (See Figure 6.12).



Routinely asking women about their mental health perceived as very important in facilitating women to disclose PNMH difficulties (p=0.038)

Figure 6.12: Routinely asking women about their mental health perceived as very important in facilitating women to disclose PNMH difficulties by Area (in percentage)

The number of respondents who had received in-practice training by a PNMH specialist versus those who had not received this type of training was compared across the whole sample in order to examine whether the difference between Areas Blue and Green may be related to having received in-practice training by a PNMH specialist. No statistically significant difference was found, with 94.0% (47/50) of those who had received in-practice training by a PNMH specialist reporting that routine questioning was perceived to be 'very important' to women disclosing PNMH difficulties compared to 87.8% (43/49) of those who had not received this type of training (FET=0.318).

Likewise, in order to examine whether the difference between Areas Blue and Green may be related to receiving in-practice training *not* by a PNMH specialist, the number of respondents who had versus those who had not received this type of training was compared across the whole sample. However, no statistically significant difference was found, with 90.5% (19/21) of those who had received in-practice training *not* by a PNMH specialist reporting that routine questioning was perceived to be 'very important' to women disclosing PNMH difficulties compared to 91.0% (71/78) of those who had not received this type of training (FET=1.000).

6.8.3.3 Open text comments related to perceived facilitators to women disclosing perinatal mental health difficulties

Respondents were asked if there were other perceived facilitators to women disclosing PNMH difficulties. A total of 22 responses were recorded. Similar to previous open text comments, the majority of the comments related to continuity of

carer. Comments regarding continuity of carer referred to having the same MW/HV providing the care which would facilitate relationship building and/or increase identification of mental health needs due to familiarity with women.

Similar to previous sections in the questionnaire, some of the open text comments referred to having a private space for women to discuss their mental health. Some respondents reported that HCPs need to show a genuine interest in enquiring about a woman's mental health rather than treating it as a 'tick box' exercise. MWs and HVs from both areas mentioned normalising mental health discussions with women where mental health is afforded parity of esteem with physical health. Further facilitators relating to women disclosing PNMH difficulties and by whom can be seen in Table 6.11 and included comments such as the ability to offer 'real help' to women and not just making a referral.

Table 6.11: Open text comments on perceived facilitators to women disclosing PNMH difficulties by area and professional group

Number of comments	**Facilitators identified by respondents**	**Blue Area**		**Green Area**	
		MW	**HV**	**MW**	**HV**
7	Continuity of carer	3	3	1	-
4	Privacy/environment	1	1	2	-
4	Genuine interest of HCP	1	1	-	2
4	Normalising PNMH	1	1	1	1
2	Fear of disclosure *	1	-	-	1
1	Ability to offer real help	-	-	1	-

*barrier to disclosure

The following section presents a summary of respondents perceptions of the potential barriers to women disclosing PNMH problems.

6.8.3.4 Women fearing their child will be removed from them/their care

As shown in Table 6.12 below, most respondents, except HVs from Blue Area, perceived that women fearing their child being removed from them was 'a major barrier' to women disclosing PNMH difficulties (Blue Area: 89.5% MWs, 50.0% HVs and Green Area 77.3% MWs, 95.2% HVs; $p<0.001$). There was no statistically significant difference overall between professional groups ($p=0.189$) or between areas ($p=0.246$).

6.8.3.5 Perceived stigma associated with mental health difficulties

As shown in Table 6.12, perceived stigma associated with mental health difficulties was felt to be 'a major barrier' to women disclosing PNMH difficulties by the majority of respondents (Blue Area: 78.9% MWs and 77.8% HVs; Green Area: 86.4% MWs and 90.5% HVs) and there was no statistically significant difference overall between professional groups ($X^2=0.144$, $p=0.704$) or overall between Blue Area and Green Area ($X^2=1.643$, $p=0.200$).

6.8.3.6 Open text comments related to perceived barriers to women disclosing perinatal mental health difficulties

Respondents were asked if there were other perceived barriers to women disclosing PNMH difficulties. A total of 35 responses were recorded. Many of the comments reflected barriers referred to in the closed questions, namely perceived fear of child removal, the associated stigma of mental health/fear of being judged by HCPs and family members. Some respondents commented on 'normalising the abnormal' where women receive misleading advice from friends/family/other women where mental health symptoms are wrongly attributed to 'baby blues'. Further barriers to

Table 6.12: Potential barriers to women disclosing PNMH difficulties by area and professional group

Qu.8:How much of a barrier do you consider the following are to women when disclosing PNMH difficulties?		**Blue Area**		**Green Area**		**X^2 P-value**	**MW (n60)**	**HV (n39)**	**X^2 p-value**	**Blue Area (n56)**	**Green Area (n43)**	**X^2 p-value**
		MW(n38)	HV(n18)	MW(n22)	HV(n21)							
Women fearing their child will be removed from them/their care, n (%)	**0**	4 (10.4)	9 (50.0)	5 (22.7)	1 (4.8)	15.853 **(.001)**	9 (15.0)	10(25.6)	1.726 (.189)	13(23.2)	6(14.0)	1.345 (.246)
	1	34 (89.5)	9 (50.0)	17 (77.3)	20 (95.2)		51(85.0)	29(74.4)		43(76.8)	37(86.0)	
Perceived stigma associated with mental health difficulties, n (%)	**0**	8(21.1)	4 (22.2)	3(13.6)	2 (9.5)	1.782 (.619)	11(18.3)	6(15.4)	.144 (.704)	12(21.4)	5(11.6)	1.643 (.200)
	1	30(78.9)	14 (77.8)	19(86.4)	19 (90.5)		49(81.7)	33(84.6)		44(78.6)	38(88.4)	

Key: 0 = not a major barrier; 1 = a major barrier; PNMH = Perinatal Mental Health; Bold type = statistically significant result

women disclosing PNMH difficulties not referred to in this section were recorded by respondents and included lack of treatment options for women and a lack of PNMH training for HCPs, see Table 6.13.

Table 6.13: Open text comments on perceived barriers to women disclosing PNMH difficulties by area and professional group

Number of comments	Barriers identified by respondents	Blue Area		Green Area	
		MW	HV	MW	HV
10	Fear of disclosure	3	3	2	2
6	Lack of continuity of carer	5	-	-	1
6	Lack of privacy	1	2	3	-
4	Stigma	1		1	2
3	Lack of time (of HCP)	2	-	1	-
3	Normalising the abnormal	1	-	1	1
1	Lack of information about treatment options	-	-	-	1
1	Lack of training (of HCP)	-	-	1	-
1	Lack of family support	-	-	1	-

Key: HCP= Health Care Professional

6.8.3.7 Summary of perceived barriers and facilitators to women disclosing perinatal mental health difficulties

Almost all respondents felt that a trusted relationship between MWs/HVs and women was ‘very important’ in facilitating women’s disclosure of PNMH difficulties. Similarly, the vast majority of respondents perceived that routine questioning about mental health facilitated disclosure. Blue Area respondents were statistically significantly more likely to perceive that routinely enquiring about women’s mental health was very important in facilitating womens’ disclosure of PNMH difficulties compared to those in Green Area, and this did not appear to be associated with having received in-practice training by a PNMH specialist or by a non-specialist. Perceived facilitators generated from the open text comments reiterated the importance and value of continuity of carer and included suggestions such as having a private space to

conduct confidential conversations and for HCPs to show a genuine interest in women's mental health as opposed to treating it as a 'tick box' exercise.

The most frequently reported view by respondents was that the perceived stigma associated with mental health was a major barrier to women disclosing PNMH difficulties and there were no statistically significant differences between professional groups or by area. The majority of respondents perceived that women fearing having their child removed as a result of disclosing PNMH difficulties was a major barrier. Open text comments of perceived barriers also repeated that fear of child removal and lack of privacy for women were barriers to disclosure. MWs from Blue Area also reported a lack of continuity of carer as a major barrier to women disclosing PNMH difficulties.

6.8.4 Exploration of reduced aspects of job to allow for management of women's mental health

Table 6.14 below shows that when asked if there were aspects of their job role/workload that could be reduced to enable MWs and HVs to have more time to manage women's mental health needs (including assessing women's mental health, making PNMH referrals, management of mental health and follow up), approximately half of all respondents (50.0% of MWs and 51.2% of HVs, X^2=0.016, p=0.901) indicated 'Yes'. There was no statistically significant difference between the proportion of respondents in Blue Area (46.4%) and Green Area (55.8%) who reported that aspects of their job could be reduced (p=0.355).

Table 6.14: Exploration of reduced aspects of job to allow for management of women's mental health by area and professional group

Qu.9: Are there aspects of your job role/ workload that could be reduced?		Yes	No	X^2 (p-value)
Blue Area	**MW (n38)**	19 (50.0%)	19 (50.0%)	2.069 (.558)
	HV (n18)	7 (38.9%)	11 (61.1%)	
Green Area	**MW (n22)**	11 (50.0%)	11 (50.0%)	
	HV (n21)	13 (61.9%)	8 (38.1%)	
MW (60)		30 (50.0%)	30 (50.0%)	.016 (.901)
HV (39)		20 (51.2%)	19 (48.8%)	
Blue Area (n56)		26 (46.4%)	30 (53.6%)	.857 (.355)
Green Area (n43)		24 (55.8%)	19 (44.2%)	

6.8.4.1: Open text comments relating to aspects of job role/workload that could be reduced

Respondents were asked to provide details on the aspect(s) of their job role/workload they perceived could be reduced to enable them to have more time to manage women's mental health needs. A total of 41 responses were recorded; some respondents provided more than one aspect of their job role that could be reduced. The most frequently reported views by respondents from both areas were related to administrative tasks/paperwork (n25) as shown in Table 6.15. Respondents mentioned issues such as slow and ineffective IT systems and duplication of paperwork. In addition, some comments related to the incompatibility of IT systems between agencies, for example, hospitals use different IT systems from GP surgeries and/or secondary care services. Fourteen respondents also mentioned the desire for more staff and/or appropriate staff to whom they could delegate administrative tasks giving MWs/HVs more time to spend in a clinical capacity; the

majority of the comments for increased staffing were reported by MWs in Green Area. The remaining comments related to receiving unnecessary referrals as a result of lack of continuity of carer and/or unclear referral paperwork. One HV from Green Area suggested removing the antenatal contact as women are already under the care of the MWs at this time and proposed reinstating a previous contact at 3-4 months postnatal. One HV from Blue Area suggested caseload numbers could be reduced.

Table 6.15: Open text comments on aspects of job role that could be reduced by area and professional group

Number of comments	Aspects of job role that could be reduced to enable MWs/HVs to manage women's PNMH	Blue Area		Green Area	
		MW	HV	MW	HV
25	Administrative tasks/paperwork	7	8	5	5
14	Increased staff/delegation of admin tasks	2	3	8	1
2	Receiving unnecessary referrals	2	-	-	-
1	Easier referral process	-	-	1	-
1	Remove antenatal contact	-	-	-	1
1	Reduced caseload numbers	-	1	-	-
1	Slow/ineffective IT system	-	1	-	-
1	Incompatibility of IT system between agencies	1	-	-	-

6.8.5 Education, skills and experience

This section presents a summary of respondents' preferences on frequency of PNMH training and how well they felt the training they had received had equipped them to manage women's PNMH.

6.8.5.1: Reported preference of frequency for perinatal mental health training/education among midwives and health visitors

Respondents were asked how frequently they felt they needed PNMH training /education. All respondents indicated that PNMH training/education was needed and Table 6.16 shows that over three quarters of MWs (76.7%) selected the option to have PNMH training once a year compared to just over half of HVs (51.3%). More HVs (35.9%) than MWs (18.3%) requested training every two years and this was statistically significant (p=0.010) as illustrated in Figure 6.13. However, there was not a significant difference in the preference for frequency of PNMH training overall between respondents in Blue Area and Green Area.

Table 6.16: Preference for frequency of PNMH training/education by area and professional group

Qu.11: How often do you feel you need to receive PNMH training?		Not needed	One off Training	Once a Year	Every two years	Other	X^2 (p-value)
Blue Area	**MW n38 (%)**	0	1 (2.6)	34 (89.5)	3 (7.9)	0 (0.0)	28.091 **(.001)**
	HV n18 (%)	0	1 (5.6)	9 (50.0)	8 (44.4)	0 (0.0)	
Green Area	**MW n22 (%)**	0	0 (0.0)	12 (54.5)	8 (36.4)	2 (9.1)	
	HV n21 (%)	0	4 (19.0)	11 (52.4)	6 (28.6)	0 (0.0)	
MW n60 (%)		0	1 (1.7)	46 (76.7)	11 (18.3)	2 (3.3)	11.324 **(.010)**
HV n39 (%)		0	5 (12.8)	20 (51.3)	14 (35.9)	0 (0.0)	
Blue Area n56 (%)		0	2 (3.6)	43 (76.8)	11 (19.6)	0 (0.0)	7.510 (.057)
Green Area n43 (%)		0	4 (9.3)	23 (53.5)	14 (32.6)	2 (4.7)	

Key: Bold type= statistically significant result; ( ) = % of respondents

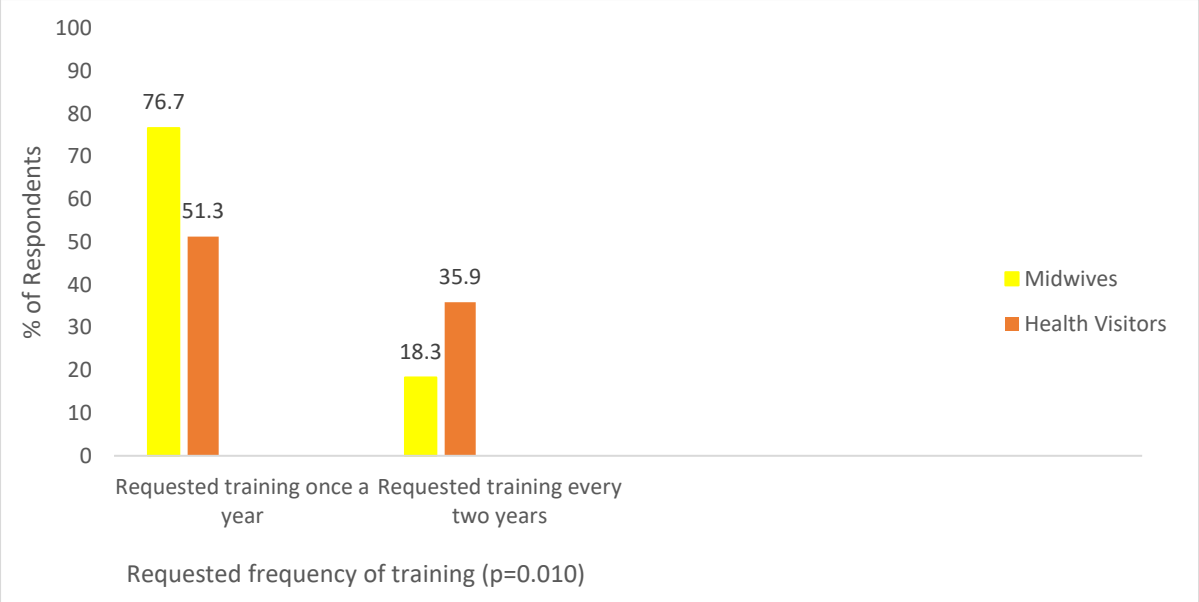


Figure 6.13: Percentage of MWs/HVs that requested PNMH training once a year/every two years

Data were examined to explore whether there was a relationship between time since qualification and preference for PNMH training. No statistically significant difference was found between those who had been qualified for ≥11 years compared to those who had been qualified for ≤10 years in reporting a preference for training once a year or every two years respectively (every year: ≥11 years: 61.9% (39/63) compared to ≤10 years: 75.0% (27/36); every two years: ≥11 years: 30.2% (19/63) compared to ≤10 years: 16.7% (6/36), X^2=2.425, p=0.489).

To examine whether preference for frequency of training was related to receiving PNMH training as part of professional training, the number of respondents who had, versus those who had not received this type of training was compared across the whole sample. However, no statistically significant difference was found, with 65.5% (55/84) of those respondents who had received this training requesting training every

year compared to 73.3% (11/15) of those who had not, or every two years 25.0% (21/84) compared to 26.7% (4/15), X^2=1.560, p=0.668).

Two MWs from Green Area selected the 'Other' option (See Table 6.16). Unfortunately, these MWs did not elaborate on what they considered 'Other' to be in the open text box. However, there were four comments in the open text box regarding the 'Other' option for training/education suggestions which are summarised below:

- Initial training with annual updates
- Initial training with ad hoc updates in response to new findings/research
- Supervision drop-in sessions – either face-to-face or online
- Training needed when referral process/guidelines change

6.8.5.2 Midwives' and health visitors' training/education to identify women experiencing perinatal mental health difficulties

Table 6.17 shows that for those professionals who had received PNMH training/education (n97, two MWs, one from Blue Area and one from Green Area, had not received any specific PNMH training and therefore were excluded from the analysis), significantly more HVs than MWs felt that their training equipped them 'very well' to identify women experiencing PNMH difficulties (76.9% HVs vs 48.3% MWs, p=0.032). Significantly more respondents from Blue Area than Green Area felt that their training had equipped them 'very well' to identify women experiencing PNMH difficulties (Blue Area: 73.2% vs Green Area: 41.9%, p=0.011) (See Figure 6.14).

Table 6.17: MWs and HVs (n=97) perception of how well PNMH training/education equipped them to identify and refer women with PNMH problems by area and professional group

Qu. 11a-c: How well has the training/education in PNMH…		Blue Area		Green Area		X² (p-value)	MW n58 (%)	HV n39 (%)	X² (p-value)	Blue Area n55 (%)	Green Area n42 (%)	X² (p-value)
		MW n37 (%)	HV n18 (%)	MW n21 (%)	HV n21 (%)							
...equipped you to identify women who are experiencing perinatal mental health difficulties?	**1**	3 (7.9)	0 (0.0)	7 (31.8)	2 (9.5)	26.353	10(16.7)	2(5.1)	8.832	3 (5.4)	9 (20.9)	11.065
	2	11 (28.9)	0 (0.0)	8 (36.4)	7 (33.3)	**(.002)**	19(31.7)	7(17.9)	**(.032)**	11(19.6)	15(34.9)	**(.011)**
	3	23 (60.5)	18 (100)	6 (27.3)	12(57.1)		29(48.3)	30(76.9)		41(73.2)	18(41.9)	
...equipped you to identify women who are at high risk of developing perinatal mental health difficulties?	**1**	3 (7.9)	0 (0.0)	5 (22.7)	3 (14.3)	23.211	8(13.3)	3(7.7)	8.553	3 (5.4)	8(18.6)	10.641
	2	11 (28.9)	0 (0.0)	10 (45.5)	6 (28.6)	**(.006)**	21(35)	6(15.4)	**(.036)**	11(19.6)	16(37.2)	**(.014)**
	3	23 (60.5)	18 (100)	2 (27.3)	12(57.1)		29(48.3)	30(76.9)		41(73.2)	18(41.9)	
...helped you with your decision-making about whether or not a woman requires referral to secondary mental health services?	**1**	4 (10.5)	0 (0.0)	6 (27.3)	3 (14.3)	28.448	10(16.7)	3(7.7)	10.076	4(7.1)	9(20.9)	12.636
	2	13 (34.2)	0 (0.0)	11 (50)	8 (38.1)	**(.001)**	24(40)	8(20.5)	**(.018)**	13(23.2)	19(44.2)	**(.005)**
	3	20 (52.6)	18 (100)	4 (18.2)	10(47.6)		24(40)	28(71.8)		38(67.9)	14(32.6)	

Key:1=not at all; 2=somewhat; 3=very well; Bold type= statistically significant result; ()= % of respondents

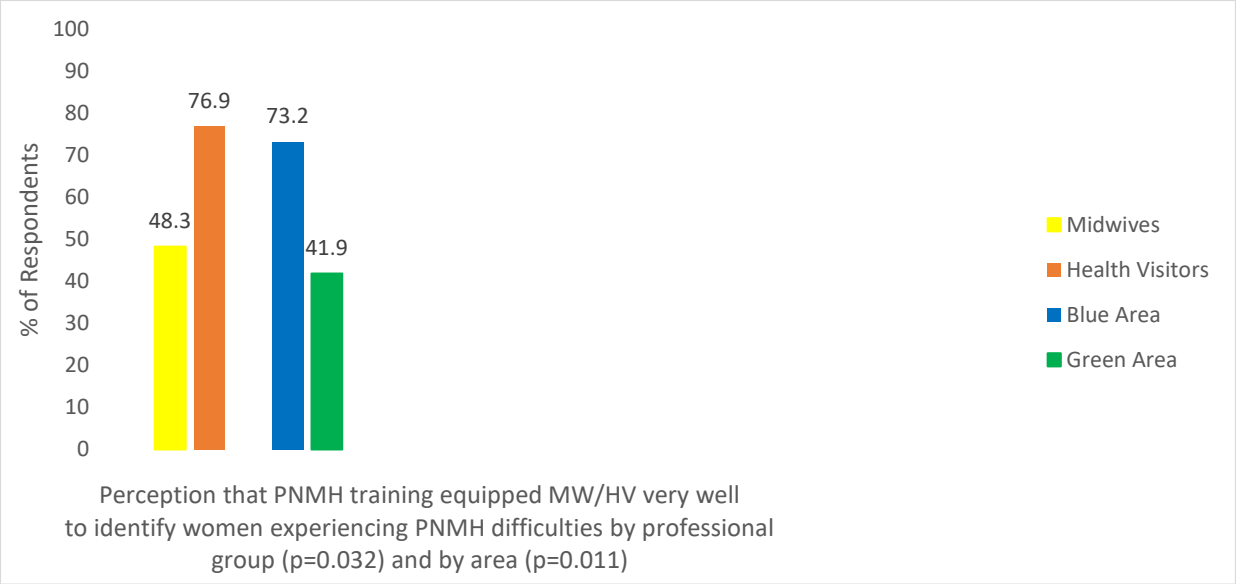


Figure 6.14: Percentage of MWs/HVs reported PNMH training equipped them very well to identify women experiencing PNMH difficulties

To examine whether the difference between HVs and MWs may be related to receiving specific training in PNMH as part of professional training (as previously mentioned, significantly more HVs than MWs had received training), the number of respondents who had versus those who had not received training was compared across the whole sample. Respondents who had received PNMH training as part of their professional training were statistically significantly more likely to report that their training had equipped them 'very well' to identify women experiencing PNMH difficulties (65.5%, 55/84) compared to those who had not had this particular training (26.7%, 4/15, X^2=12.005, p=0.007) (See Figure 6.15).

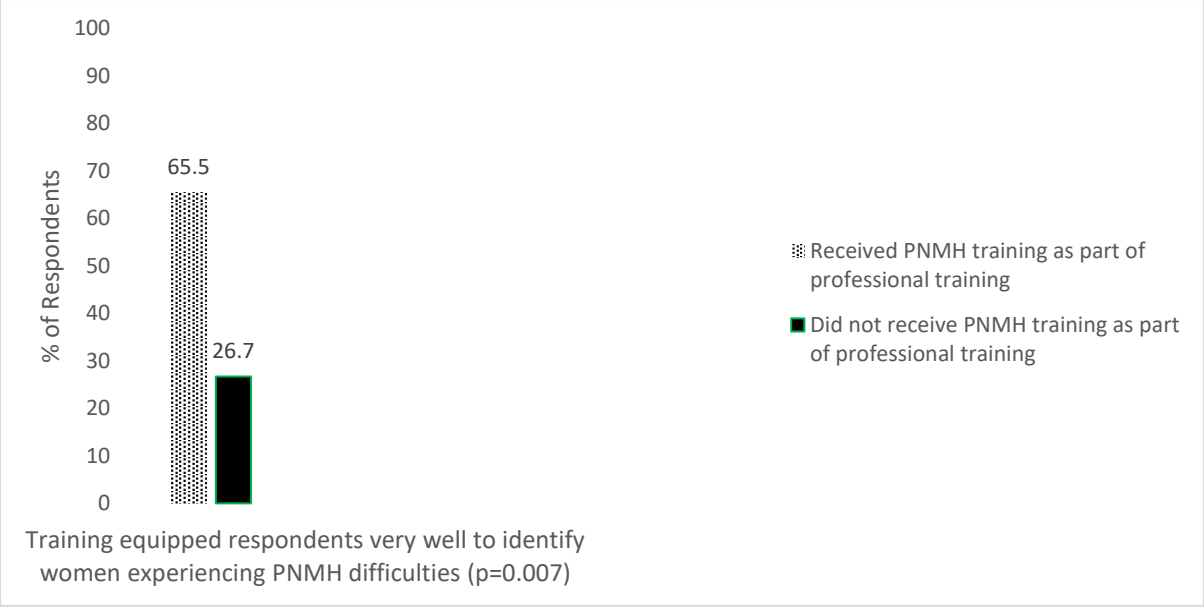


Figure 6.15: Percentage of respondents reporting training equipped them very well to identify women experiencing PNMH difficulties associated with type of training

Data were also examined to explore whether there was a relationship between time since qualification and whether respondents reported that their training had equipped them 'very well' to identify women experiencing PNMH difficulties. However, no statistically significant difference was found between those who had been qualified for 11 years and over compared to those who had been qualified for 10 years or fewer reporting that their training had equipped them 'very well' (≥11 years: 65.1% (41/63) compared to ≤10 years: 50.0% (18/36), X^2=4.917, p=0.178).

Similarly, data were examined to explore whether there was a relationship between those respondents having received in-practice training by a PNMH specialist and reporting that the training had equipped them 'very well' compared to those respondents who had not received this type of training. No statistically significant

difference was found between those who had received training by a PNMH specialist and those who had not (70.0%, 35/50 vs 49.0%, 24/49, X^2=5.990, p=0.112).

Data were further examined to explore whether there was a relationship between those respondents having received in-practice training *not* by a PNMH specialist and reporting that the training had equipped them 'very well' compared to those respondents who had not received this type of training. No statistically significant difference was found between those who had received training *not* by a PNMH specialist and those who had not (64.1%, 50/78 vs 42.1%, 9/21, X^2=4.267, p=0.234).

6.8.5.3 Midwives' and health visitors' training/education to identify high risk women

Table 6.17 above and Figure 6.16 shows that significantly more HVs (76.9%) than MWs (48.3%) reported that their training had equipped them 'very well' to identify women at high risk of developing PNMH difficulties (p=0.036). Blue Area respondents were statistically significantly more likely to report that their training had equipped them 'very well' compared to those in Green Area (Blue Area: 73.2% vs Green Area: 41.9%, p=0.014) (See Figure 6.16).

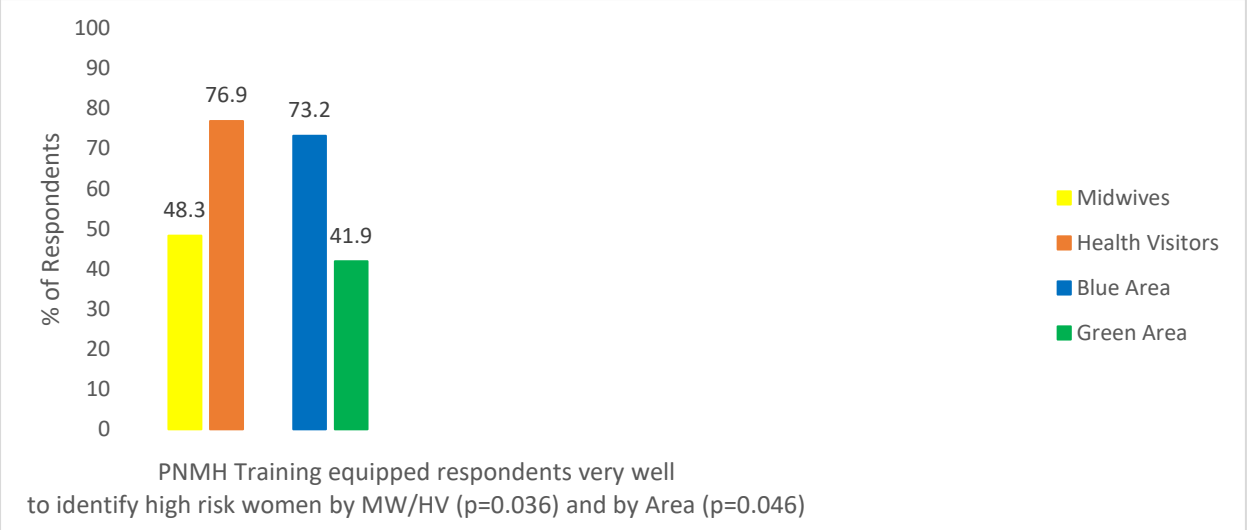


Figure 6.16: Percentage reporting that PNMH training equipped them very well to identify high risk women by professional group and area

To examine whether the difference between HVs and MWs may be related to having received specific training in PNMH as part of professional training, the number of respondents who had versus those who had not received this form of training was compared across the whole sample. Of the 84 respondents who had received PNMH training as part of their professional training, 64.3% (54/84) reported that their training had equipped them 'very well' to identify women at high risk of developing PNMH difficulties compared to 33.3% (5/15) of respondents who had not received this training, and this was statistically significant (X^2=8.023, p=0.046) (See Figure 6.17).

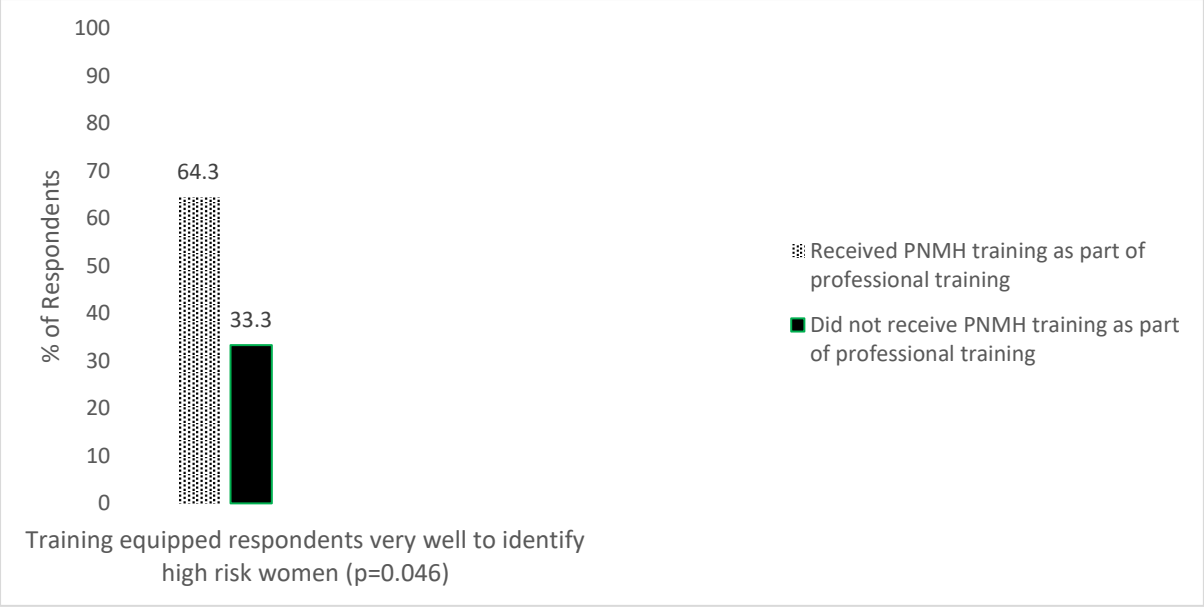


Figure 6.17: Percentage of respondents reporting training equipped them very well to identify high risk women associated with type of training

Data were also examined to explore whether there was a relationship between time since qualification and whether respondents reported that their training had equipped them 'very well' to identify women at high risk of developing PNMH difficulties. However, no statistically significant difference was found between those who had been qualified for 11 years and over compared to those who had been qualified for 10 years or fewer reporting that their training had equipped them 'very well' (: ≥11 years: 71.2% (42/63) compared to ≤10 years: 47.2% (17/36), X^2=5.788, p=0.122).

To examine whether the difference between Blue and Green Areas may be related to receiving in-practice training by a PNMH specialist, the number of respondents who had versus those who had not received this form of training was compared across the whole sample. Of the 50 respondents who had received this form of training, 70.0% (35/50) reported their training had equipped them 'very well' to

identify women at high risk of developing PNMH difficulties compared to 49.0% (24/49) of respondents who had not received this form of training but this was not statistically significant (X^2=6.647, p=0.084).

Data were also examined to explore whether there was a relationship between those respondents having received in-practice training *not* provided by a PNMH specialist and reporting that the training had equipped them 'very well' to identify high risk women compared to those respondents who had not received this type of training. Similar to the previous analysis, no statistically significant difference was found between those who had received training *not* by a PNMH specialist and those who had not (52.4%, 11/21 vs 61.5%, 48/78, X^2=4.757, p=0.191).

6.8.5.4 Midwives' and health visitors' training/education to help with decision-making about whether women require referral to secondary mental health services

As shown in Table 6.17, HVs were more likely to report their training had equipped them 'very well' to help them with their decision-making regarding whether or not a woman requires a referral to secondary PNMH services compared to MWs (HVs: 71.8% vs MWs: 40.0%, p=0.018). Respondents in Blue Area were statistically significantly more likely to report their training equipped them 'very well' compared to Green Area (Blue Area: 67.9% vs Green Area: 32.6%, p=0.005) (See Figure 6.18).

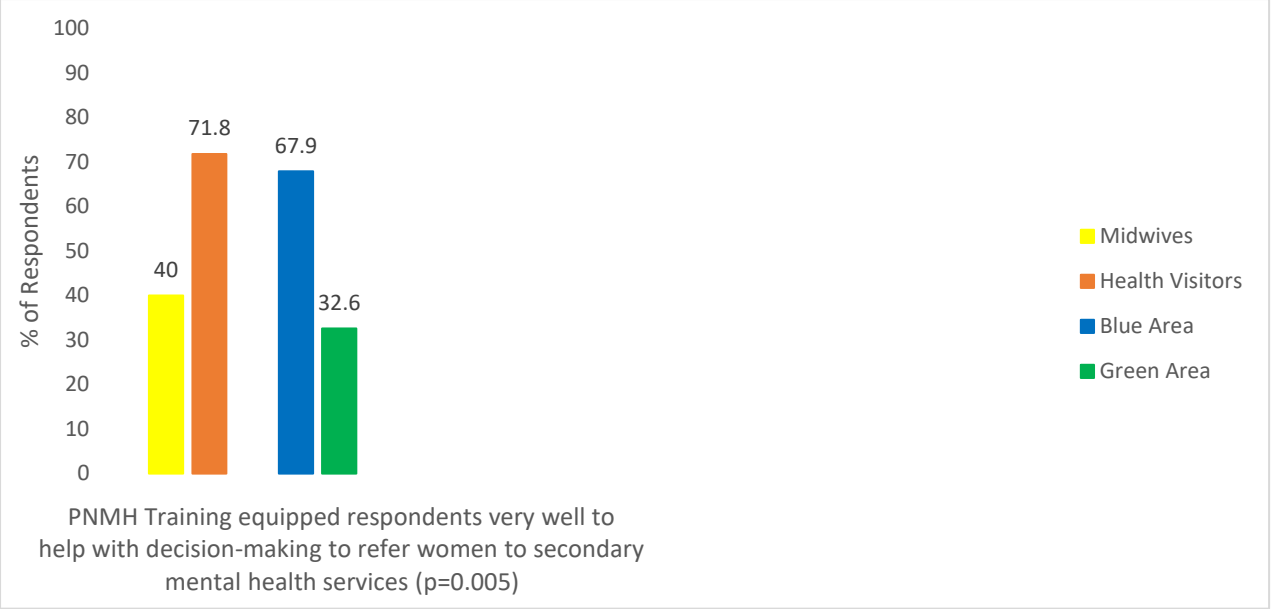


Figure 6.18: Percentage reporting that training equipped them very well to help with decision-making about referring women for secondary mental health services by professional group and area

To examine whether the difference between HVs and MWs may be related to receiving specific training in PNMH as part of professional training, the number of respondents who had versus those who had not received this form of training was compared across the whole sample. Of the 84 respondents who had received PNMH training as part of their professional training, 57.1% (48/84) reported that their training had equipped them 'very well' to identify women who require referral to secondary PNMH services compared to 26.7% (4/15) of respondents who had not received this training, however, this was not statistically significant (X^2=6.929, p=0.074).

Data were also examined to explore whether there was a relationship between time since qualification and whether respondents reported that their training had equipped them ‘very well’ to refer women who require secondary PNMH services. However, no statistically significant difference was found between those who had been qualified for ≥11 years compared to those who had been qualified for ≤10 years reporting that their training had equipped them ‘very well’ (: ≥11 years: 60.3% (38/63) compared to ≤10 years: 38.9% (14/36), X^2=6.391, p=0.094).

Data were also examined to explore whether the difference between Blue Area and Green Area may be related to receiving in-practice training by a PNMH specialist, the number of respondents who had versus those who had not received this form of training across the whole sample were compared. Of the 50 respondents who had received this form of training, 64.0% (32/50) reported their training had equipped them ‘very well’ with their decision-making to identify women requiring referral to secondary mental health services compared to 40.8% (20/49) of respondents who had not received this form of training but this was not statistically significant (X^2=7.183, p=0.066).

Data were also examined to explore whether the difference between Blue and Green Areas may be related to receiving in-practice training *not* by a PNMH specialist, the number of respondents who had versus those who had not received this form of training across the whole sample were compared. Of the 21 respondents who had received this form of training, 42.9% (9/21) reported their training had equipped them ‘very well’ with their decision-making to identify women requiring referral to

secondary mental health services compared to 55.1% (43/78) of respondents who had not received this form of training but this was not statistically significant (X^2=3.336, p=0.347).

6.8.5.5 Open text comments relating to suggestions for perinatal mental health training/education for midwives and health visitors

Respondents were asked if they had any further comments or suggestions regarding PNMH training/education. A total of 18 responses were recorded. The most frequently reported views by respondents were an acknowledgement that general mental health training is needed, all HCPs need training (respondent comments did not specify which HCPs should receive training) and training was requested by a PNMH specialist. Two MWs from Blue Area requested training on referral processes/options. Two MWs from Green Area stated they were dissatisfied with the current PNMH training/care. One respondent suggested that training in PNMH needs to include communication training around having difficult conversations and around risk. Respondents suggested that training updates on current research could lead to further opportunities of ‘train the trainer’ and training from a PNMH specialist could include clinical supervision around mental health issues (See Table 6.18).

Table 6.18: Respondent suggestions for PNMH training/education

Number of comments	Suggestions/comments on PNMH training/education	Blue Area		Green Area	
		MW	HV	MW	HV
4	General mental health training needed	3	-	-	1
3	Training delivered by PNMH specialist	1	-	-	2
3	All HCPs need training	1	1	1	-
2	Training on referral process/options	2	-	-	-
2	On-line training option	2	-	-	-
2	Dissatisfied with current training/PNMH care	-	-	2	-
1	Training on new research in PNMH	-	1	-	-
1	Training on communication/having difficult conversations/risk	1	-	-	-
1	1 full day training per year	1	-	-	-

Key: HCPs= Healthcare Professionals

6.8.5.6 Summary of education, skills and experience and open text comments

All respondents felt that PNMH training was needed. The majority of respondents expressed a preference for annual PNMH training and this was not associated with time since qualification nor having received PNMH training as part of their professional training. Significantly more HVs than MWs expressed a preference for less frequent training than annually. Just over a third (35.9%) HVs preferred training every two years compared to fewer than one in five MWs (18.3%). This difference was not explained by more HVs having been qualified for longer or by more HVs having received PNMH training during their professional training.

The views of 97 respondents (two MWs had not received any PNMH training at all) revealed that significantly more HVs than MWs felt that their training had equipped them ‘very well’ across a range of PNMH scenarios, i.e. women experiencing PNMH difficulties, women at high risk of developing PNMH difficulties and women requiring referral to secondary PNMH services. This may be explained by more HVs than

MWs having received PNMH training as part of their professional training but did not appear to be related to more HVs than MWs being qualified for more than 10 years.

Across the areas, Blue Area respondents were significantly more likely to report their training had equipped them ‘very well’ to identify women experiencing PNMH difficulties, high risk women and referring women for secondary care compared to respondents from Green Area. This difference between respondents in the two areas did not seem to be explained by more respondents in Blue Area having received PNMH training by a PNMH specialist and more in Green Area having received training *not* by a PNMH specialist.

Respondents provided a range of suggestions regarding PNMH training including a request that all HCPs receive PNMH training (not just MWs/HVs), a preference for training to be delivered by a PNMH specialist and that training should encompass communication skills and training on referral options.

6.8.6 Referral pathway

This section presents a summary of MWs’ and HVs’ clinical practices and experiences of referring women with PNMH difficulties. Screening is integral to the referral process and therefore this section includes data related to screening practices.

6.8.6.1 Midwives' and health visitors' reported use of screening tool(s)

As shown in Table 6.19 below, HVs from both Blue Area and Green Area were statistically significantly more likely to always use a screening tool to assess women's PNMH compared to their midwifery counterparts (Blue Area: 77.8% HVs compared to 28.9% MWs and Green Area: 52.4% HVs compared to 9.1% MWs; $p<0.001$). Overall, 64.1% HVs reported always using a screening tool compared to 21.7% MWs, and none of the HVs reported never using a screening tool compared to 35.0% of MWs who reported never using a screening tool and this was statistically significant ($p<0.001$) (See Figure 6.19). However, there was not a significant difference overall between areas with 44.6% respondents in Blue Area reporting always using a screening tool compared to 30.2% in Green Area ($p=0.227$).

Table 6.19: Reported use of screening tools by professional group and area

Qu.12: Do you use a screening tool?	Blue Area		Green Area		X^2 (p-value)	MW n60 (%)	HV n39 (%)	X^2 (p-value)	Blue Area n56 (%)	Green Area n43 (%)	X^2 (p-value)
	MW n38 (%)	HV n18 (%)	MW n22 (%)	HV n21(%)							
Yes, always	11 (28.9)	14(77.8)	2 (9.1)	11 (52.4)	36.343 **(.000)**	13 (21.7)	25 (64.1)	25.063 **(.000)**	25 (44.6)	13 (30.2)	2.962 (.227)
Yes, sometimes	18 (47.4)	4(22.2)	8 (36.4)	10 (47.6)		26 (43.3)	14 (35.9)		22 (39.3)	18 (41.9)	
No, never	9 (23.7)	0(0.0)	12 (54.5)	0 (0.0)		21 (35.0)	0 (0.0)		9 (16.1)	12 (27.9)	

Key: Bold type= statistically significant result; ()= % of respondents

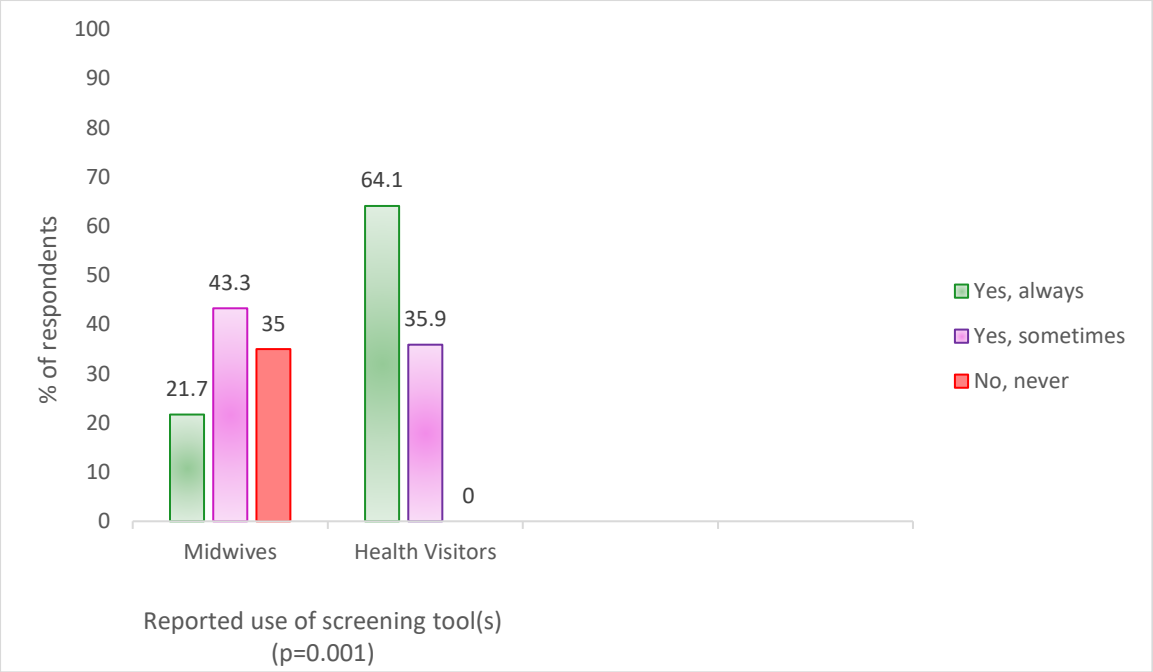


Figure 6.19: Midwives and Health Visitors reported use of screening tool(s)

Data were examined to explore whether the difference between MWs and HVs reporting always using a screening tool may be related to receiving PNMH in-practice training as part of professional training, the number of respondents who had versus those who had not received this form of training across the whole sample were compared. Of the 84 respondents who had received this form of training, response results are as follows: 40.5% (34/84) reported always using a screening tool compared to 26.7% (5/15) of respondents who had not received this form of training; 40.5% (34/84) reported sometimes using a screening tool compared to 40.0% (6/15) of respondents who had not received this form of training and 19% (16/84) reported never using a screening tool compared to 33.3% (5/15) of

respondents who had not received in-practice training as part of their professional training and this was not statistically significant (X^2=1.858, p=0.395).

Data were also examined to explore whether the difference between MWs and HVs reporting always using a screening tool may be related to length of time since qualification. Of the 63 respondents who had been qualified for 11 years or more, 41.3% (26/63) reported always using a screening tool compared to 33.3% (12/36) of respondents who had been qualified for 10 years or fewer but this was not statistically significant (X^2=1.558, p=0.459).

To examine whether the difference between HVs and MWs may be related to base of work, the response of hospital-based MWs and CMWs were compared. A statistically significant difference was found where 75.0% (3/4) of CMWs reported always using a screening tool compared to 17.9% (10/56) of hospital MWs (X^2= 7.606, p= 0.022) (See Figure 6.20).

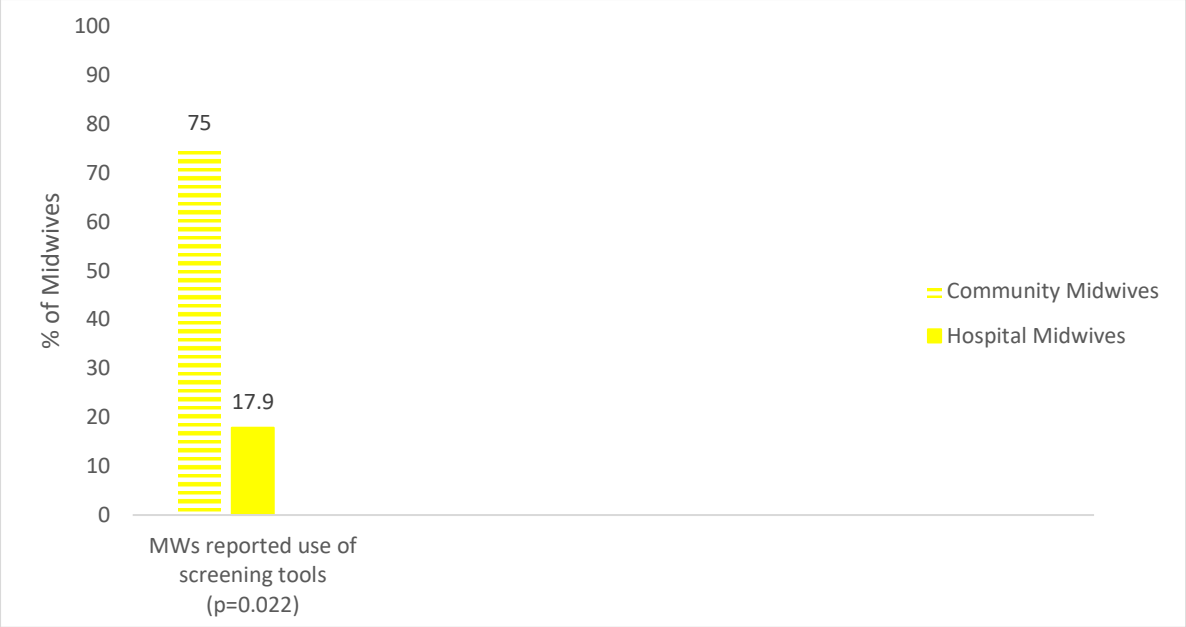


Figure 6.20: Percentage of MWs reported to use screening tools (by base)

6.8.6.2 Open text comments on screening tool(s) used

Those respondents who reported using a screening tool all or some of the time were asked to specify which tool(s) they used. Sixty-two responses were recorded. GAD and PHQ tools were the most commonly reportedly used tools. HVs in both areas provided the most answers to this question and used the Whooley Questions and EPDS in addition to the GAD and PHQ. MWs from both areas referred to using the prompt questions on their electronic records. One HV from Blue Area used the HAD. Table 6.20 shows the tool(s) the respondents reported using always or some of the time.

Table 6.20: Open text comments on which tool(s) used by MWs and HVs

Number of comments	Suggestions/comments on PNMH training/education	Blue Area		Green Area	
		MW	HV	MW	HV
28	GAD	5	16	3	5
22	PHQ	2	14	-	4
20	Whooley Questions	6	3	3	8
11	EPDS	2	1	3	5
11	Question prompts on electronic records	4	-	7	-
2	Booking questions	-	-	2	-
1	HADS	-	1	-	-

Key: GAD=Generalised Anxiety Disorder; PHQ=Patient Health Questionnaire; EPDS=Edinburgh Postnatal Depression Scale; HADS=Hospital Anxiety and Depression Scale.

6.8.6.3 Reasons given by midwives and health visitors for not always/ever using a screening tool

Respondents were asked to explain the reason(s) why they did not always/ever use a screening tool. A total of 35 responses were recorded; some respondents gave more than one reason. As shown in Table 6.21 the main reasons given by respondents in the open text comments for not always/never using a screening tool were: no awareness of screening tools, not in their role to screen women as in a managerial position and no training/guidelines on using a tool. Six respondents from both areas stated they preferred to use their professional judgement. MWs from both areas reported that they were not aware of screening tools; none of the HVs reported this. Also, only MWs from Blue Area reported that PNMH screening was not part of their role.

Table 6.21: Open text comments of reasons for not always/never using a screening tool

Number of comments	Reasons for not always/never using a screening tool	Blue Area		Green Area	
		MW	HV	MW	HV
10	Not aware of screening tool	4		6	
7	No training/guidelines on using tool	5	-	2	-
6	Not in role to screen for PNMH	6	-	-	-
6	Prefer to use professional judgement	2	2	-	2
4	Too prescriptive	1	1	-	2
1	Language barrier	-	1	-	-
1	Refer directly to PNMH team	1	-	-	-
1	Women may not respond well/be truthful when asked regimented questions	1	-	-	-
1	Lack of confidence in tool	-	-	1	-

Key: PNMH= perinatal mental health

6.8.7 Potential barriers to referring women with perinatal mental health difficulties

This section presents a summary of respondent potential perceived barriers to referring women with PNMH difficulties.

6.8.7.1 Lack of confidence in results of screening tool

Most respondents reported that lack of confidence in the results of a screening tool was not a major barrier to them referring women with PNMH difficulties (See Table 6.22). There was very little difference between the proportion of respondents in each area reporting a lack of confidence in screening tool results as a major barrier (Blue Area: 21.4%, Green Area: 23.3%) and this was not statistically significant (p=0.828). There was no significant difference between MWs and HVs overall, with 26.7% and 15.4% of respondents respectively reporting this as a major barrier (p=0.187).

Table 6.22: Reported barriers to referring women with PNMH difficulties by area and professional group

Qu.13: How much of a barrier do you consider the following to referring women with PNMH difficulties?		Blue Area		Green Area		X² P-value	MW (n60)	HV (n39)	X² p-value	Blue Area (n56)	Green Area (n43)	X² p-value
		MW(n38)	HV(n18)	MW(n22)	HV(n21)							
Lack of confidence in the results of a screening tool, n (%)	**0**	28 (73.7)	16(88.9)	16 (72.7)	17(81.0)	2.247 (.523)	44(73.3)	33(84.6)	1.741 (.187)	44(78.6)	33(76.7)	.047 (.828)
	1	10 (26.3)	2 (11.1)	6 (27.3)	4 (19.0)		16(26.7)	6(15.4)		12(21.4)	10(23.3)	
Lack of time to use a screening tool, n(%)	**0**	17 (44.7)	15(83.3)	15 (68.2)	18(85.7)	14.041 **(.003)**	32(53.3)	33(84.6)	10.258 **(.001)**	32(57.1)	33(76.7)	4.144 **(.042)**
	1	21 (55.3)	3 (16.7)	7 (31.8)	3 (14.3)		28(46.7)	6(15.4)		24(42.9)	10(23.3)	
Lack of secondary care available for women who require referral, n (%)	**0**	15 (39.5)	12(66.7)	4 (18.2)	6 (28.6)	10.828 **(.013)**	19(31.7)	18(46.2)	2.119 (.145)	27(48.2)	10(23.3)	6.473 **(.011)**
	1	23 (60.5)	6 (33.3)	18 (81.8)	15(71.4)		41(68.3)	21(53.8)		29(51.8)	33(76.7)	
Lack of knowledge of referral pathway when referring women with moderately severe mental health difficulties e.g. moderate depressive illness or anxiety states, n (%)	**0**	22 (57.9)	16(88.9)	11 (50.0)	20(95.2)	16.173 **(.001)**	33(55)	36(92.3)	**(.000)***	38(67.9)	31(72.1)	.207 (.649)
	1	16 (42.1)	2 (11.1)	11 (50.0)	1 (4.5)		27(45)	3(7.7)		18(32.1)	12(27.9)	
Lack of knowledge of referral pathway to refer women who are currently well but at high risk of becoming unwell e.g. 'Red Flags' such as women with previous history of PP/BPD, n (%)	**0**	25 (65.8)	14(77.8)	11 (50.0)	16(76.2)	4.620 (.202)	36(60)	30(76.9)	3.046 (.081)	39(69.6)	27(62.8)	.514 (.473)
	1	13 (34.2)	4 (22.2)	11 (50.0)	5 (23.8)		24(40)	9(23.1)		17(30.4)	16(37.2)	
Lack of knowledge of referral pathway when referring women with severe mental ill-health who you suspect requires admission, n (%)	**0**	22 (57.9)	15(83.3)	12 (54.5)	17(81.0)	6.949 (.074)	34(36.7)	32(82.1)	6.854 **(.009)**	37(66.1)	29(67.4)	.021 (.886)
	1	16 (42.1)	3 (16.7)	10 (45.5)	4 (19.0)		26(43.3)	7 (17.9)		19(33.9)	14(32.6)	

Key: 0 = not a major barrier; 1 = a major barrier; PP = Postpartum Psychosis; BPD = Bipolar Disorder; * = Fisher's Exact Test; Bold type = statistically significant result

6.8.7.2 Lack of time to use screening tool

As shown in Table 6.22 above and illustrated in Figure 6.21 below, MWs from both Blue and Green Areas were statistically significantly more likely than HVs to perceive lack of time to use a screening tool as a major barrier to referring women with PNMH difficulties (Blue Area: 55.3% MWs compared to 16.7% HVs and Green Area: 31.8% MWs compared to 14.3% HVs; p=0.003). Overall, 46.7% MWs reported that lack of time to use a screening tool was a major barrier compared to 15.4% HVs (p=0.001). There was a significant difference overall between areas as 42.9% of Blue Area respondents reported lack of time as a major barrier compared to 23.3% of Green Area respondents (p=0.042).

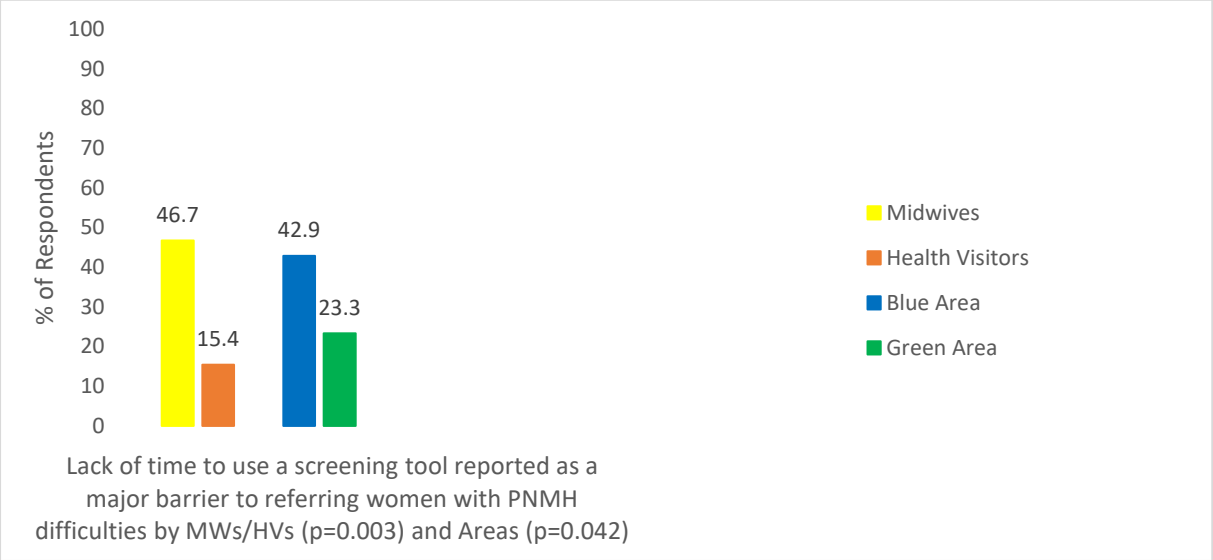


Figure 6.21: Percentage reporting that lack of time to use a screening tool was a major barrier to referring women with PNMH difficulties by professional group and area

A significant difference in opinion regarding the lack of time to use a screening tool was reported between respondents in Blue Area and Green Area. In order to

examine whether this difference was related to the significant differences in the proportions of respondents in each area who had received in-practice training by a PNMH specialist, the responses of those who had and those who had not received this type of training was compared across the whole sample. However, no statistically significant difference was found between those respondents having received in-practice training by a PNMH specialist as 41.2% (14/50) of respondents who had received this type of training reported lack of time to use a screening tool as a major barrier compared to 58.8% (20/49) who had not received in-practice training by a PNMH specialist (X^2=1.803, p=0.179).

To examine whether the difference between respondents in Blue Area and Green Area may be related to having received in-practice PNMH training *not* by a PNMH specialist, the responses of those who had versus those who had not received this type of training was compared across the whole sample. However, no statistically significant difference was found between those respondents having received training *not* by a PNMH specialist as 23.8% (5/21) of respondents who had received this type of training reported lack of time to use a screening tool as a major barrier compared to 37.2% (29/78) who had not (X^2=1.312, p=0.252).

To examine whether the difference between HVs and MWs may be related to having received PNMH training as part of professional training (more HVs had received this type of training on PNMH), the responses of those who had versus those who had not received this type of training was compared across the whole sample. However, no statistically significant difference was found between those respondents having

received PNMH training as part of their professional training as 34.5% (29/84) of respondents who had received this type of training reported lack of time to use a screening tool as a major barrier compared to 33.3% (5/15) who had not (X^2=0.008, p=0.929).

To examine whether the difference between HVs and MWs may be related to base of work, the responses of hospital-based MWs and CMWs were compared. However, no statistically significant difference was found, with only 25.0% (1/4) of CMWs reporting lack of time to use a screening tool as a major barrier to referring women compared to 48.2% (27/56) of hospital-based MWs (FET p=0.616).

Data were also examined to explore whether there was a relationship between time since qualification and whether respondents reported a lack of time to use a screening tool as a major barrier. No statistically significant difference was found between those respondents qualified for ≥10 years, 41.7% (15/36) compared to ≤11 years 30.2% (19/63) reporting a lack of time to use a screening tool as a major barrier (X^2=1.345, p=0.246).

6.8.7.3 Lack of secondary PNMH care available for women who require referral

Table 6.22 shows respondents from Green Area were significantly more likely to report a lack of secondary care available as a major barrier to referring women compared to those in Blue Area (Green Area: 76.7% vs Blue Area: 51.8%, p=0.011) (See Figure 6.22). There was no significant difference overall between the

proportion of MWs and HVs who reported this as a major barrier (MWs: 68.3% vs HVs: 53.8, p=0.145).

Figure 6.22: Percentage of respondents by Area reporting lack of secondary care available to women who require referral as a major barrier

To examine whether the difference between respondents in Blue and Green Areas may be related to having received in-practice PNMH training by a PNMH specialist, the responses of those who had versus those who had not had this training were compared across the whole sample. A statistically significant difference was found between those respondents having received PNMH training by a PNMH specialist as 50.0% (25/50) of respondents who had received this type of training reported lack of available secondary care as a major barrier to referring women compared to 75.5% (37/49) who had not (X^2=6.881, p=0.009) (See Figure 6.23).

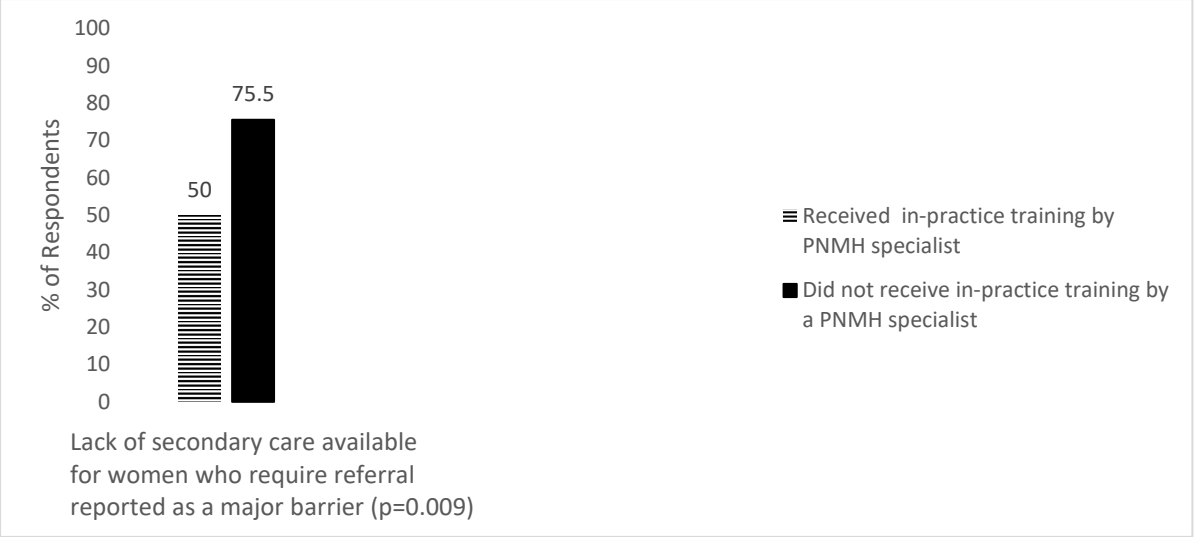


Figure 6.23: Percentage of respondents reporting lack of secondary care available to women who require referral as a major barrier associated with type of PNMH training

To examine whether the difference between respondents in Blue and Green Areas may be related to having received in-practice PNMH training *not* by a PNMH specialist (Green Area more likely to receive this type of training), the responses of those who had versus those who had not had this training were compared across the whole sample. No difference was found between those respondents having received PNMH training *not* by a PNMH specialist as 66.7% (12/21) of respondents who had received this type of training reported lack of available secondary care as a major barrier to referring women compared to 61.5% (48/78) who had not (X^2=0.186, p=0.666).

6.8.7.4 Lack of knowledge of referral pathway for women with moderately severe mental health difficulties

Table 6.22 shows that lack of knowledge of referral pathways for referring women with moderately severe mental health difficulties was perceived to be a major barrier to referring such women for more MWs than HVs across both areas (Blue Area: MWs 42.1% compared to HVs 11.1% and Green Area: MWs 50% compared to HVs

4.5%; p=0.001) and this result was statistically significant. Overall, MWs were significantly more likely than HVs to perceive a lack of knowledge of referral pathways for referring women with moderately severe mental health difficulties as a major barrier (MWs: 45.0% vs HVs: 7.7%; p<0.001) (See Figure 6.24). However, there was not a significant difference overall between areas (Blue Area: 32.1% vs Green Area: 27.9%, p=0.649).

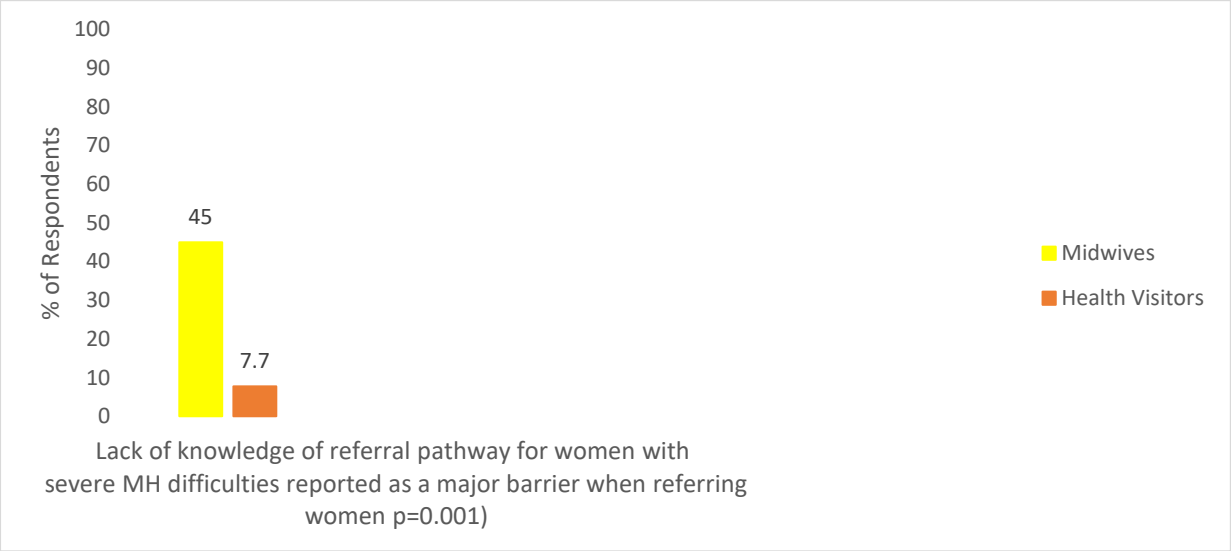


Figure 6.24: Percentage of MWs/HVs reporting lack of knowledge of referral pathway for women with moderately severe mental health difficulties as a major barrier when referring women

To examine whether the difference between HVs and MWs may be related to base of work (all HVs were based in the community compared to only 6.7% MWs), the responses of hospital-based MWs and CMWs were compared. However, no statistical difference was found, with 75.0% (3/4) of CMWs reporting lack of knowledge of referral pathway when referring women with moderately severe mental health difficulties was a major barrier to referring women compared to 42.9% (24/56) of hospital-based MWs (FET p=0.318).

To examine whether the difference between HVs and MWs may be related to receiving specific training in PNMH as part of professional training, the number of respondents who had versus those who had not received training was compared across the whole sample. Of those who had received PNMH training as part of professional training, 29.8% (25/84) reported that a lack of knowledge of referral pathways for women with moderately severe mental health difficulties was a 'major barrier' to referring women compared to 33.3% (5/15) of those who had not received PNMH training as part of professional training (X^2= 0.077, p=0.782).

Data were also examined to explore whether there was a relationship between time since qualification and whether respondents reported that a lack of knowledge of referral pathway for women with moderate mental health difficulties was a major barrier to referring women. However, no statistically significant difference was found between those who had been qualified for 11 years and over compared to those who had been qualified for 10 years or fewer reporting that lack of knowledge of referral pathway for women with moderate mental health difficulties was a 'major barrier' (≥11 years: 27.0% (17/63) compared to ≤10 years: 36.1% (13/36), X^2=0.904, p=0.342).

6.8.7.5 Lack of knowledge of referral pathway for women at high risk of perinatal mental ill-health

As shown in Table 6.22, there was no statistically significant difference between the proportion of respondents in each area reporting a lack of knowledge of referral pathways for women at high risk of becoming unwell as a major barrier (Blue Area: 30.4%, Green Area: 37.2%) (p=0.473). Overall, the majority of respondents did not

report this as a major barrier to them referring women and there was no statistically significant difference between MWs and HVs reporting this as a major barrier (40.0% MWs vs 23.1% HVs, p=0.081).

6.8.7.6 Lack of knowledge of referral pathways for women with severe mental ill-health who require admission

As shown in Table 6.22 lack of knowledge of referral pathways when referring women with severe mental ill-health who require admission was reported as a 'major barrier' to referring women with severe mental ill-health by significantly more MWs compared to HVs (MWs 43.3% vs HVs 17.9%; p=0.009) (See Figure 6.25). However, there was not a significant difference overall between respondents in Blue Area and 2 (Blue Area: 33.9% vs Green Area: 32.6%, p=0.886).

Figure 6.25: Percentage of MWs/HVs reporting lack of knowledge of referral pathways for women with severe mental ill-health as a major barrier to referring women

To examine whether the difference between HVs and MWs may be related to base of work (all HVs were based in the community compared to only 6.7% MWs), the responses of hospital-based MWs and community-based MWs were compared. However, no statistical difference was found, with 25.0% (1/4) of CMWs reporting lack of knowledge of referral pathway when referring women with severe mental ill-health who require admission was 'not a major barrier' to referring women compared to 58.9% (33/56) of hospital-based MWs (FET p=0.307).

To examine whether the difference between HVs and MWs may be related to receiving specific training in PNMH as part of professional training, the number of respondents who had versus those who had not received training was compared across the whole sample. Of those who had received PNMH training as part of professional training, 32.1% (27/84) reported that a lack of knowledge of referral pathways for women requiring admission was a 'major barrier' to identifying PNMH needs of women compared to 40.0% (6/15) of those who had not received PNMH training as part of professional training (X^2= 0.354, p=0.552).

Data were also examined to explore whether there was a relationship between time since qualification and whether respondents reported that a lack of knowledge of referral pathways when referring women with severe mental ill-health was a major barrier to referring women. However, no statistically significant difference was found between those who had been qualified for 11 years and over compared to those who had been qualified for 10 years or fewer reporting that lack of knowledge was a

‘major barrier’ (≥11 years: 28.6% (18/63) compared to ≤10 years: 41.7% (15/36), X^2=1.768, p=0.184).

6.8.7.7 Open text comments on barriers to referring women with perinatal mental health needs and perinatal mental health referral pathways

Respondents were asked if they had any further comments/suggestions regarding barriers to referring women with PNMH needs and/or comments regarding referral pathways. A total of 31 responses were recorded. Some respondents provided more than one comment on barriers/suggestions to referring women with PNMH needs. The majority of open text comments (n5 from Blue Area; n7 from Green Area) suggested more PNMH services are needed. Respondents from both areas also reported that tight criteria/referral threshold was a barrier to referring women for PNMH care (See Table 6.23). Other comments included desire for more PNMH training, a lack of MDT working, the need for support services for women with ‘low level’ mental health needs and practical issues that prevent women attending referral appointments, such as a lack of transport.

Table 6.23: Open text comments on barriers to referring women with PNMH needs and PNMH referral pathways

Number of comments	Barriers to referring women with PNMH needs and PNMH referral pathways	Blue Area		Green Area	
		MW	HV	MW	HV
12	More PNMH services needed	5	-	4	3
8	Not meeting referral criteria/threshold	1	2	2	3
3	Long waiting times	1	-	-	2
3	More PNMH training needed	1	-	1	1
3	Lack of MDT working	1	1	-	1
1	Lack of referral pathways	1	-	-	-
1	Women refusing referral	-	-	-	1
1	Women unable to attend referral – no transport	-	-	1	-
2	Need for low level support	1	-	1	-

Key: MDT= Multidisciplinary team

6.8.7.8 Summary of midwives' and health visitors' perceived potential barriers to referring women with perinatal mental health difficulties

HVs were statistically significantly more likely to use screening tools compared to MWs. Data showed 100% of HVs used screening tools all or some of the time whereas over a third of MWs reported never using a screening tool. Using a screening tool did not appear to be associated with having received PNMH training as part of professional training nor length of time since qualification. However, it was associated with base of work whereby CMWs were more likely to use a screening tool than hospital MWs suggesting community-based practitioners are more likely to use screening tools. The most common reasons given by MWs for not using a tool were that they were not aware of any screening tools, not in their job role to screen e.g. based on delivery suite and/or in a managerial role and no guidance/training on using screening tools. The GAD and the PHQ were the most frequently reported tools used in the open text comments. Other popular tools used were the Whooley Questions, the EPDS and prompt questions on the MWs' electronic records.

Most respondents did not perceive lack of confidence in the results of a screening tool as a 'major barrier' to referring women with PNMH difficulties. MWs were significantly more likely to report a lack of time to use a screening tool as a 'major barrier' to referring women with PNMH difficulties than HVs and this was not explained by fewer MWs than HVs having had specific PNMH training during professional training, and more MWs than HVs having fewer than 10 years professional experience and being hospital- rather than community-based.

Respondents in Green Area were statistically significantly more likely to report a lack of secondary care as a ‘major barrier’ to referring women with PNMH difficulties compared to respondents in Blue Area and this appeared to be associated with more respondents in Blue Area having had in-practice PNMH training by a PNMH specialist but was not explained by more respondents in Green Area having had PNMH in-practice training *not* by a PNMH specialist.

Fewer HVs reported a lack of knowledge of referral pathways across a range of referral scenarios, such as referring women with moderately severe mental ill-health and referring women with severe mental ill-health who require admission, as a ‘major barrier’ compared to MWs and this did not appear to be associated with time since qualification, base of work or training received. There were no statistically significant differences between respondents in Blue Area and Green Area regarding knowledge of referral pathways.

Most frequently reported open text comments from respondents revealed a desire for more PNMH services from both areas. The second most common open text comment related to this question was referrals not meeting referral criteria/thresholds.

6.8.8 Overall summary of questionnaire results

This section summarises results from the questionnaire representing potential factors that impact on MWs’ and HVs’ decision-making about referring women for secondary mental health care. It presents results that are statistically significant

($p<0.05$) and issues highlighted as being important to MWs' and HVs' clinical practice as indicated by the qualitative data obtained from the questionnaire.

The factor most commonly reported overall (97%) by MWs and HVs that affect their decision-making about deciding to refer women for PNMH care was that a trusted relationship between MWs/HVs and women was 'very important' in facilitating women's disclosure of PNMH difficulties. Interestingly, the most consistently reported response in the open text comments related to continuity of carer. Respondents' comments revealed that a lack of continuity of carer was perceived as a barrier to identifying women with PNMH difficulties and to women disclosing PNMH difficulties and was thus central to the ability to build relationships between MWs/HVs and women.

The second most commonly reported factor overall was that the majority of respondents (91%) felt that routinely asking women about their mental health was 'very important' in facilitating women's disclosure of PNMH difficulties. Other most commonly reported factors that were perceived as 'very important', across the whole sample, in identifying women's PNMH needs was: relying on gut instinct (83%); relying on prior experience (81%) and using an assessment tool (71%). In addition, the majority of respondents overall reported that perceived stigma associated with mental health was a 'major barrier' to women disclosing PNMH difficulties (83%) as was the reported fear of child removal (80%) (Figure 6.26 summarises the most commonly reported major barriers/facilitators to making decisions about referring women for PNMH care as perceived by MWs/HVs).

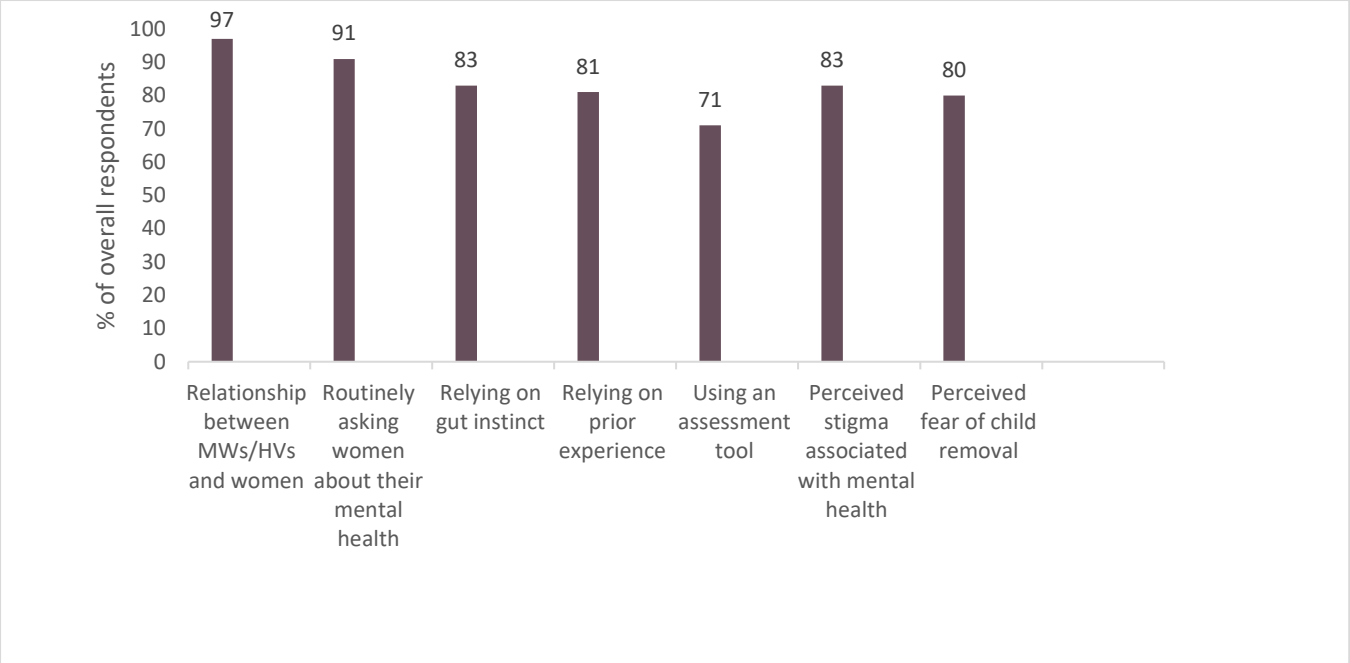


Figure 6.26: Most commonly reported factors by MWs and HVs overall perceived as major barriers/facilitators to making decisions about referring women for PNMH care

When asked if there were aspects of the job that could be reduced to allow MWs/HVs more time to manage women's mental health needs, half of all respondents answered 'yes'. A reduction in paperwork/documentation and IT/administration tasks were the most frequently reported open text comment related to this question where over half of all comments received related to paperwork/ documentation (25/41 comments).

All respondents agreed that PNMH training was needed. Approximately half of all respondents reported that they need PNMH training once a year. Over three quarters of MWs wanted training once a year compared to just over half of HVs ($p<0.010$). Significantly more HVs than MWs felt that their training had equipped

them ‘very well’ across a range of PNMH scenarios, e.g. women experiencing PNMH difficulties, women at high risk of developing PNMH difficulties and women requiring referral to secondary PNMH services. However, this was significantly related to having received PNMH training as part of professional training which could account for HVs reporting to be better equipped since significantly more HVs than MWs had received PNMH training as part of their professional training.

The least commonly reported factors that were perceived as a major barrier to the MWs and HVs overall were a lack of confidence in their ability to identify women experiencing PNMH difficulties (6%) and a lack of confidence in their ability to identify women at high risk of developing PNMH difficulties (7%). Other least commonly reported factors perceived as a major barrier were a lack of knowledge of referral pathways when: referring women with moderately severe mental health difficulties (15%); referring women who are currently well but at high risk of becoming unwell (16.5%) and referring women with severe mental ill-health who is suspected of requiring admission to hospital (16.5%). Figure 6.27 summarises the least frequently reported perceived barriers to MWs’ and HVs’ to making decisions about referring women for PNMH care.

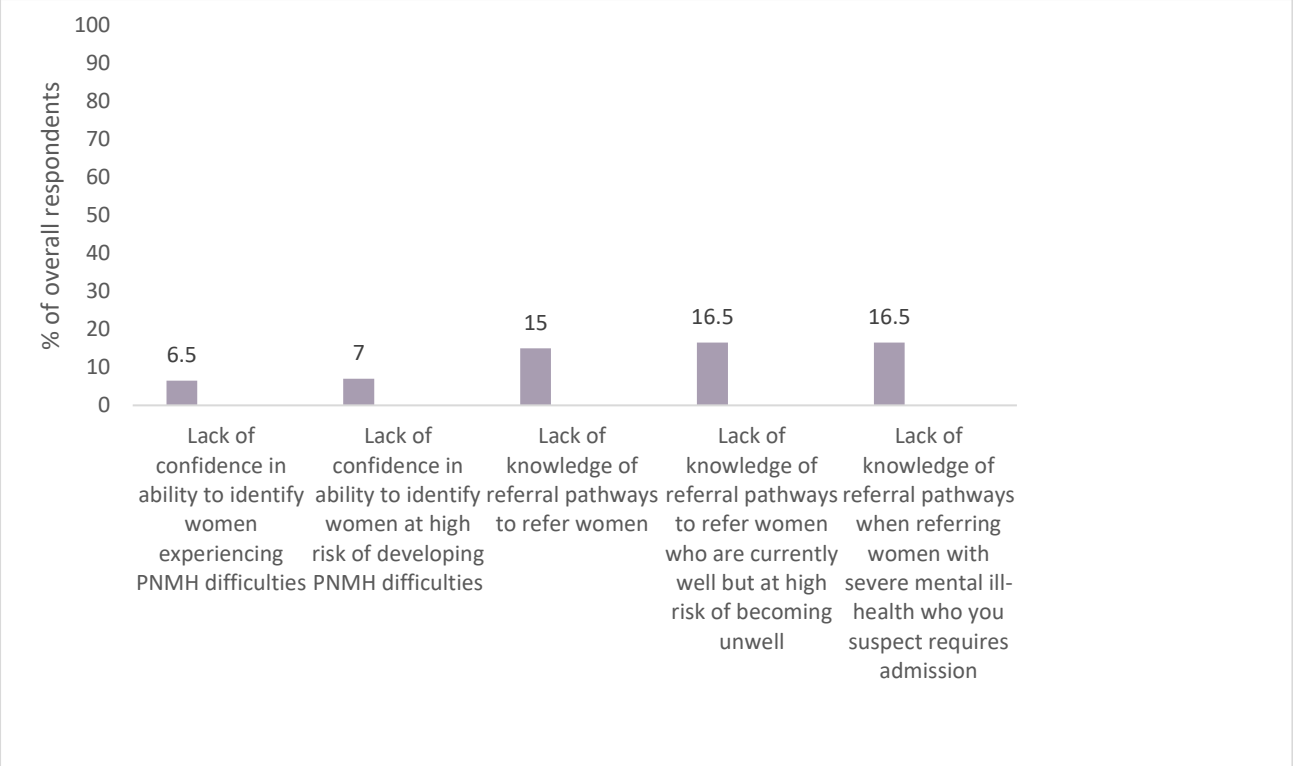


Figure 6.27: Least commonly reported factors by MWs and HVs overall perceived as a major barrier to making decisions about referring women for PNMH care

A number of significant differences were found in the frequency of responses between MWs and HVs overall (Refer to Figure. 6.28). Significantly more HVs than MWs reported reduced contacts with women, including in the home environment, as a 'major barrier' to identifying the PNMH needs of women. Most MWs were hospital-based which may explain why less than half of all MWs (48%) reported reduced contacts in the home environment as a major barrier compared to 72% of HVs. However, the difference between MWs and HVs did not appear to be related to base of work, having received PNMH training as part of professional training or length of qualification. Over half of all HVs (51.3%) reported delegating contacts to other staff was a 'major barrier' to identifying PNMH needs of women. A comment from a HV in Green Area illustrates this: *"The dilution of HV's role due to HV jobs being replaced*

by Nursery Nurses" and reinforces the notion that contacts were being delegated to other staff, e.g. Nursery Nurses. MWs were statistically significantly more likely than HVs to report that physical health checks left little or no time for mental health assessments as a 'major barrier' to identifying PNMH needs of women. However, reporting this was significantly associated with being qualified for fewer than 10 years, which could explain the difference between MWs and HVs given significantly more MWs than HVs had been qualified for ≤10 years.

Significantly more HVs than MWs reported using an assessment tool was 'very important' in identifying PNMH needs of women (p=0.006). All HVs reported using a tool all or some of the time, compared to less than three-quarters (65%) of MWs; over a third of MWs (35.0%) reported never using a screening tool. However, reporting that using an assessment tool was 'very important' was significantly related to length of time since qualification. Over three-quarters of respondents (76%) qualified for ≥11 years reported using an assessment tool was 'very important' and as more HVs had been qualified longer than the MWs, the difference could be explained by time since qualification.

MWs were more likely to report a lack of time to use a screening tool as a major barrier to referring women with PNMH difficulties than HVs. However, this was not associated with base of work, length of qualification or by having received various types of PNMH training, i.e. as part of their professional training, by a PNMH specialist and *not* by a PNMH specialist.

Fewer HVs than MWs were more likely to report a lack of knowledge of referral pathways across a range of referral scenarios as a ‘major barrier’ to them referring women. This result may be explained by the fact that more HVs had received PNMH training as part of their professional training than MWs (HVs: 95% vs MWs: 78%).

A number of significant differences were found in the frequency of responses between Blue and Green Areas respondents overall (Refer to Figure 6.29). Blue Area respondents were more likely to report using a screening tool compared to Green Area, and this may be explained by more respondents in Blue Area having received in-practice training by a PNMH specialist. Open text comments revealed that the most commonly used tools were the GAD, PHQ and Whooley Questions respectively. The least commonly reportedly used tool was the HAD, used by one HV in Blue Area.

Blue Area respondents were significantly more likely than Green Area respondents to report routinely enquiring about women’s mental health was perceived as ‘very important’ to women disclosing PNMH difficulties. Questions relating to how well PNMH training had equipped respondents across a range of scenarios such as: identifying women experiencing PNMH difficulties, identifying women at high risk of developing PNMH difficulties and with making decisions about whether or not women require a referral to secondary mental health services, revealed that Blue Area respondents were statistically significantly more likely than Green Area to report their training had equipped them very well across all scenarios. There was no

association between having received PNMH training *not* by a PNMH specialist and having received training by a PNMH specialist to explain these findings.

Furthermore, Green Area respondents were statistically significantly more likely than Blue Area to report a lack of secondary PNMH care as a major barrier to referring women with PNMH difficulties (p=0.011). Over a third of open text comments for this question highlighted that more PNMH services were needed. For all of the results in this section of the questionnaire on referral pathways, there was no association between time since qualification, base of work, having received PNMH training as part of in-practice training and reporting a lack of knowledge of referral pathways. This appears to suggest that the differences must, therefore, be related to outside factors not examined in this bespoke questionnaire. Figures 6.28 and 6.29 below summarises the significant differences in responses between MWs and HVs and Blue Area and Green Area found in this questionnaire that were perceived as major barriers/facilitators to decision-making about referring women for PNMH care.

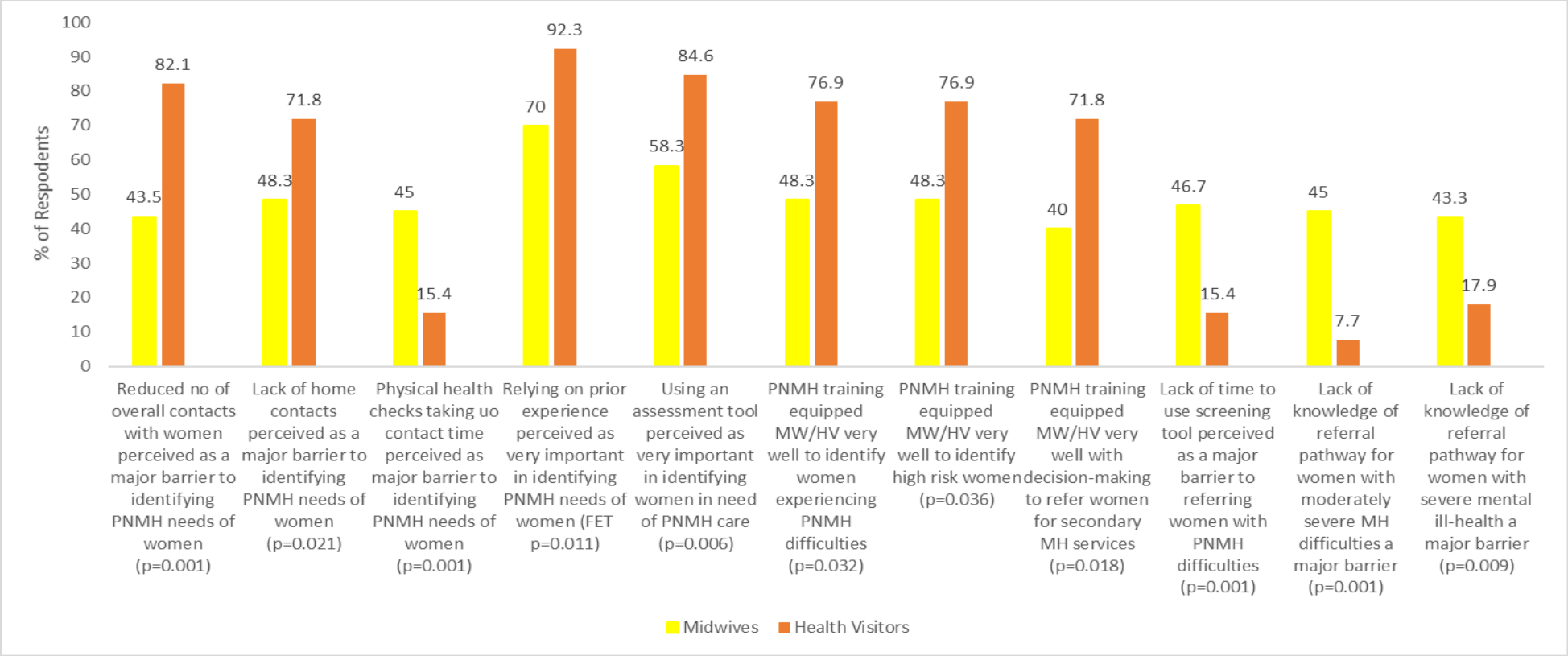


Figure 6.28: Summary of questionnaire items with significant differences in responses between midwives and health visitors perceived as major barriers/facilitators to making decisions about referring women for PNMH care

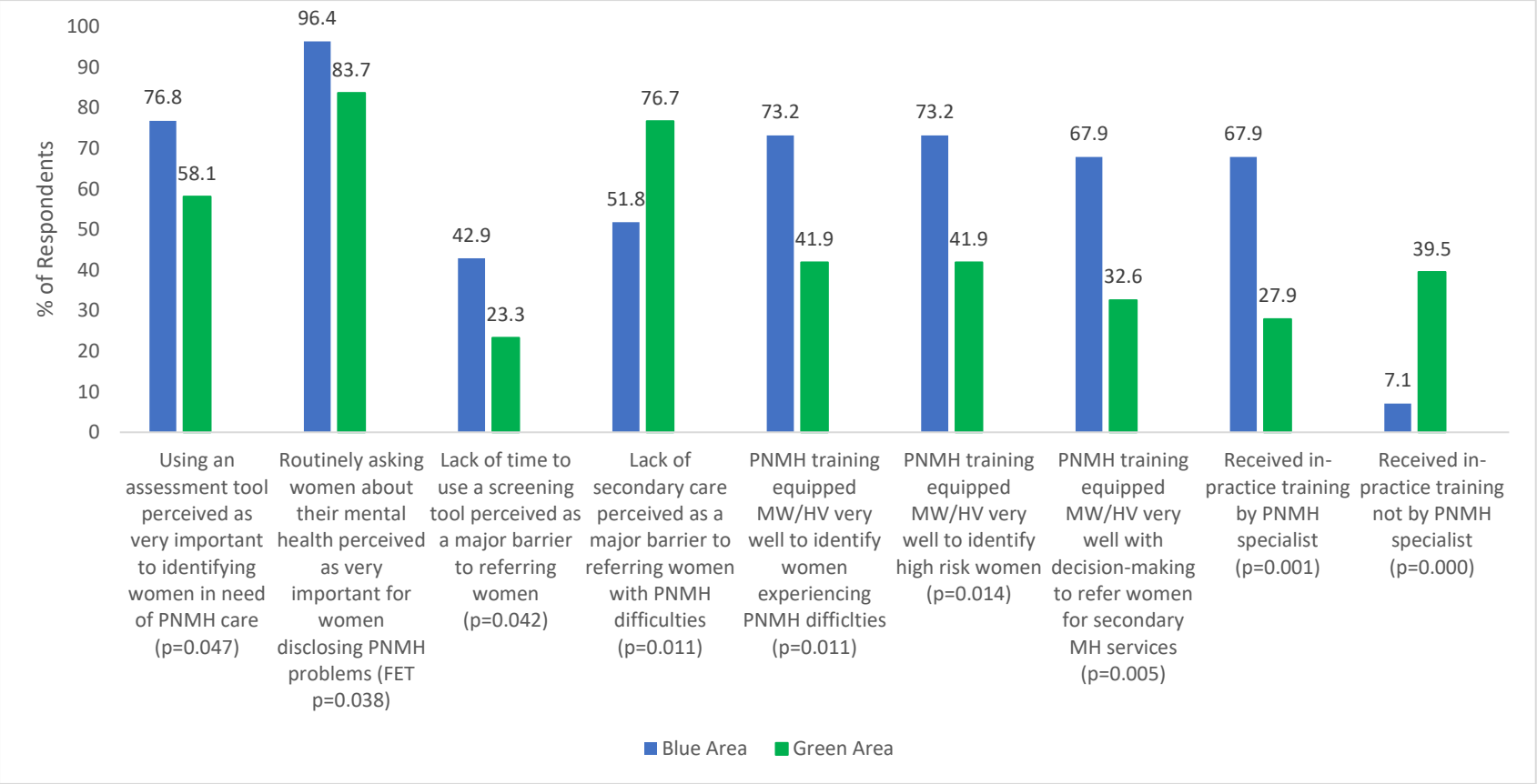


Figure 6.29: Summary of questionnaire items with significant differences in responses between Blue Area and Green Area that were perceived as major barriers/facilitators to making decisions about referring women for PNMH care

6.9 Discussion

This section will summarise the findings of the questionnaire study. Findings will be discussed in relation to the existing literature and how these findings impact on MWs'/HVs' clinical practice. The aim of this phase of the research was to build on the findings of Phase 2 and recruit a larger sample of MWs and HVs from across the population to elicit potential barriers and facilitators when making decisions about referring women for PNMH care, and to allow for statistical comparisons to be made between professional groups and geographical areas. Utilising the themes from the qualitative interviews, this study also sought to examine these themes with a view to producing findings with enhanced generalisability. This study is the first to explore the impact that PNMH service provision has on the reported practices of MWs and HVs specifically related to factors that influence PNMH referral decision-making. This section will consider the strengths and limitations of this study and suggestions for future research.

6.9.1 Main findings

6.9.1.1 Relationships

The most commonly reported aspect of clinical decision-making among MWs and HVs when deciding to refer women for PNMH care was the relationship between professionals and women. Almost all MWs (96.7%) and HVs (97.4%) in this study perceived that a trusted relationship between MWs/HVs and women was essential to facilitate women's disclosure of PNMH problems. Extensive literature has found that relationships between MWs/HVs and women are highly valued amongst professionals and women alike (Jack *et al*. 2005; Taylor *et al*. 2012; Cowley 2013; Hildingsson *et al.*

2019; Ménage *et al*. 2020). Extant research has found that a lack of trust between women and MWs is a key barrier to women disclosing PNMH difficulties where women are perceived by MWs to fear the involvement of social services (Baker *et al*. 2020). Baker *et al.* (2020) suggest that continuity of carer is central to the provider-patient relationship and to the development of a trusted relationship between women and MWs. In a study based in Ireland by Fawsitt *et al*. (2017), focus group discussions with pregnant women (n= 19) revealed that women valued continuity of carer as they felt it gave them a sense of safety as they would not have to repeat their medical history with each HCP, reducing the risk of important details about them being missed. Qualitative open text comments from the current study showed that respondents identified continuity of carer as a facilitator to women disclosing perinatal mental health difficulties. Continuity of carer and the subsequent relationships that develop as a result appear to play a key role in professional decision-making when identifying women with PNMH needs. Where a trusted relationship exists, women are perceived to feel safe to disclose PNMH difficulties and/or professionals are able to identify changes in mood/behaviour as discussed in the qualitative interviews and reiterated in the open text comments of the questionnaire.

Data from the qualitative open text comments stated that a number of factors impacted on the relationship between HCPs and women, one of which was a reduced number of contacts. The majority of HVs (82.1%) in this study perceived that a reduced number of contacts with women was a barrier to identifying PNMH difficulties as explained by a HV

from Green Area: *“Reduced contacts with women that have resulted in reduced ability to develop familiarity, confidence and trust for women with their HV, which I feel has a negative impact on developing therapeutic relationships with them and detracted from an opportunity to even identify that need in increasing cases now”.* Other open text comments suggested that some HVs were dissatisfied with the current number of contacts and would prefer to have more flexibility with contacts with women than the current recommended five mandated contacts. The literature highlights that in recent years changes to the health visiting services have resulted in a depleted workforce (Harris 2016; NHS Workforce Statistics 2018) which may explain why some HVs in this study were unable to carry out as many contacts as they would have liked. Reduction in contact numbers has the potential to impact on the capacity to build a relationship with women and also presents fewer opportunities for HCPs to identify new onset of a PNMH problem in women. A meta-analysis of seven randomised controlled trials involving more than 60,000 women to compare the effects of different antenatal care programmes for low-risk women across low and middle income countries (standard antenatal care versus women attending a reduced schedule of contacts) found reduced antenatal contacts were associated with maternal dissatisfaction (Dowswell *et al*. 2015) suggesting women and some professional groups, i.e. HVs, are dissatisfied with a reduction in the number of contacts. In contrast to HVs, the majority of MWs (56.7%) did not perceive reduced number of contacts as a barrier to identifying women’s PNMH needs. Nulliparous women with uncomplicated pregnancies are offered 10 contacts with a MW in the antenatal period plus locally agreed, individualised postnatal contacts (NICE 2006). Therefore, perhaps most MWs in this study were able to fulfil the

recommended number of contacts with women and were satisfied with the level of contact overall, which may explain why they did not feel that more contacts with women were necessary to be able to identify PNMH problems. Or more likely, most MWs were hospital-based and therefore were not responsible for conducting designated antenatal contacts. A further explanation why over half of the MWs in this study did not perceive reduced number of contacts as a major barrier may be related to the recommendations from Better Births (NHS England 2016a) which in particular promotes continuity of carer. Continuity of carer refers to the delivery of care based on a relationship of mutual trust and respect in accordance with the woman's decisions and ensures that women receive prompt referrals, and access to the correct care in the right place (NHS England 2016a). Consequently, MWs may perceive this to be more important/effective for facilitating disclosure of PNMH problems than simply an increased number of contacts that potentially could occur with a variety of different HCPs. It would be interesting for future research to explore women's satisfaction with current antenatal contacts and how this impacts on subsequent disclosure of PNMH difficulties.

Other open text comments reported to impact on the ability to form a trusted relationship between HCPs and women was a lack of contacts in the home as illustrated by a HV in Green Area: *"England has the lowest number of home visits in the UK. We need to see women in their home environment to build a trusting relationship"*. HVs were more likely to perceive lack of contacts in the home as a major barrier to identifying PNMH needs of women compared to MWs (71.8% v 48.3%). This was not an unexpected finding as all

HVs were community-based and the majority of MWs (78.3%) in this study were hospital-based therefore, did not conduct home visits. This concurs with previous research that found HVs perceived a reduction in home visits made it difficult for them to identify mothers with mental health difficulties (Alexandrou *et al*. 2018). Moreover, studies have shown that women themselves prefer home visits over contacts in a clinic environment (Flynn *et al*. 2010; Turner *et al*. 2010; Finlayson *et al*. 2020). Thus, home contacts appear to be the preferred environment for women and some professional groups, particularly HVs. The difference between HVs' and MWs' base of work was examined by comparing the responses of hospital-based MWs and CMWs in order to examine whether a lack of contacts in the home was perceived as a barrier to identifying women's PNMH needs. Though the responses of hospital-based and CMWs were compared, no significant difference was found between the two groups of MWs. Interestingly, the data did suggest a trend as 75% of CMWs reported this as a major barrier compared to 50% of hospital-based MWs. Given the small sample size (hospital-based MWs n=56; CMWs n=4) further research is needed in larger samples of CMWs to explore whether they perceive lack of home contacts to be a barrier to identifying womens' PNMH needs.

6.9.1.2 Physical health checks

One of the key findings from this study was that significantly more MWs (45.0%) than HVs (15.4%) perceived physical health checks took up contact time with women allowing them little or no time to conduct mental health assessments. A recent qualitative study found that women reported MWs focused on physical health during antenatal appointments with little enquiry about their mental health and well-being

(Nagel and Farrelly 2018). No research could be found on the overall recommended amount of time MWs should allocate for antenatal appointments. The literature states that routine antenatal appointments ranged from five minutes (Manithip *et al.* 2013) to an hour for an antenatal screening appointment (Waller *et al*. 2018). During antenatal contacts MWs are responsible for conducting checks on the mother and fetus; postnatal checks involve both the mother and baby, including screening tests which can be time consuming. Given the limited amount of time MWs have for appointments (findings from Phase 2 of this research suggested that, on average, MWs had 30 minutes allocated for an antenatal appointment), it is perhaps unsurprising that some aspects of care are not carried out, e.g. a mental health assessment. Many authors also concur that recent demands, such as dealing with women with complex medical conditions and social factors coupled with reductions in staffing, have led to capacity issues for MWs (Yelland *et al*. 2013; Dent 2018). Findings from an integrated review by Noonan *et al*. (2017a) found that some MWs focused on the physical aspects of their role and lacked a holistic approach to care. Conversely, for most HVs (84.6%) in this study, physical health checks was not perceived to take up contact time with women. This may be due to the fact that physical health checks of women are not part of the HVs role. Rather, the role of the HV is to take a history of health and social concerns and carry out a family health needs assessment (Baldwin and Kelly 2017). Irrespective of professional group, this study found that those respondents qualified for 10 years or fewer were statistically significantly more likely to report physical health checks taking up contact time with women as a major barrier. Possible explanations why the more experienced HCPs did not perceive physical health checks as a major barrier may be due to the fact that they

are more efficient at carrying out physical checks; or the more experienced HCPs may recognise the importance of PNMH. This result has important implications for the care of women with PNMH problems; if physical health checks are taking up contact time with HCPs then potentially women with previous and/or existing mental health problems may go undetected and ultimately untreated. Undetected/untreated problems in women may, in turn, negatively impact on their children (MMHA 2014) and impact on women's future mental health (Bonari *et al*. 2014). It would be interesting for future research to explore reasons why some MWs prioritise women's physical health over mental health.

6.9.1.3 Stigma and the fear of child removal

The majority of respondents (81%), irrespective of professional group or geographical area, felt that stigma around mental ill-health was a barrier to women disclosing PNMH problems. Furthermore, approximately 80% of overall respondents from both professional groups and geographical areas perceived that women fearing their child will be removed was a barrier to them disclosing PNMH difficulties. There is a wide evidence base to suggest that stigma associated with PNMH exists (Jomeen *et al*. 2013; Moore *et al*. 2016; Noonan *et al*. 2017a; Carroll *et al*. 2018) and women fear loss of custody of their child as a result of disclosure of PNMH (Megnin-Viggars *et al.* 2015; Baker *et al*. 2020).

Open text comments revealed that MWs and HVs perceived that women also feared being judged as a 'bad mother' if they disclosed PNMH difficulties. Two HVs (each from Blue and Green Areas) suggested this fear could be dispelled by professionals having

discussions with women about mental health and reassuring women that professionals will support women with PNMH problems.

6.9.1.4 Relying on gut instinct and prior experience to identify perinatal mental health needs

A high degree of consistency was found across both MWs and HVs who found relying on gut instinct was a major facilitator when identifying PNMH needs in women (MWs 85%; HVs 82%). Many authors support the notion that gut instinct plays a key role in clinical decision-making for MWs (Jefford *et al*. 2011; Barnfather 2013; Ménage 2016; Smith 2016; Baker *et al*. 2020) and HVs (Lemmer 1998; Almond 2001; Barker 2001; Chew-Graham *et al*. 2008). Similarly, the majority of respondents reported that they relied on their prior experience to facilitate the identification of women in need of PNMH care and significantly more HVs than MWs reported this (over 92% of HVs compared to 70% of MWs). Since significantly more HVs (82.1%) had been qualified for 11 years or more, it is perhaps reasonable to assume they would have more experience in which to draw upon. However, no statistical difference was found between time since qualification and the perception that relying on prior experience was a major facilitator to identifying PNMH needs of women as 70% of respondents who had been qualified for 10 years or fewer reported relying on prior experience compared to 84% of respondents qualified for 11 or more. It would have been useful to consider responses in the sample from MWs/HVs that were newly qualified / qualified for a short time (e.g. <2 years) to examine if they relied upon prior experience and/or gut instinct to aid clinical decision-making. However, since the number of respondents in this study that were qualified for <2 years was small, any results would not be meaningful.

6.9.1.5 Use of screening tools

HVs from both areas were significantly more likely to find using a screening tool as a facilitator to identifying PNMH needs of women compared to MWs. HVs were also significantly more likely to use a screening tool compared to MWs. More HVs than MWs may have reported using a screening tool due to the fact that more HVs (95%) had received PNMH training as part of their professional training than compared to MWs (78%). Another possible reason why more HVs used screening tools compared to MWs may be due to the fact that PNMH screening forms part of KPI data collected by HVs in this study at the mandated 6-8 week review, whereas MWs do not collect this data as confirmed in the Phase 1 interviews. Perhaps if MWs were required to collect this data as part of local KPIs then the use of screening tools would be commonplace.

A significant proportion of MWs (just over one third) in this study reported never using a screening tool. Previous research has shown the reported lack of using screening tools among MWs to be much higher at around 70% (Carroll *et al.* 2018; Noonan *et al*. 2018). The reported lack of using a tool by over a third of all MW in this study may be a possible reason why almost 42% of MWs did not perceive the use of a tool as very important in identifying women's PNMH needs. Or conversely, those MWs who do not perceive the use of tools as important do not use tools in practice. A further reason why over a third of MWs reported to never use a tool may be explained by six MWs from Blue Area stating in the open text comments that PNMH screening was not part of their role as they were in managerial positions and did not have direct patient contact. Almost half of all MWs (46.6%) reported lack of time to use a screening tool was a major barrier

to referring women with PNMH difficulties. A possible reason why MWs may not have time to use a screening tool may be due to the numerous physical checks/tasks they need to complete at routine contacts. Although not a significant difference, the present study also found there was a lack of confidence in the results of using a screening tool where over a quarter of MWs surveyed (27%) reported this as a barrier to referring women for PNMH care compared to 15% of HVs. Previous research supports the notion that some HCPs do not have confidence in the results of screening tools (Beauchamp 2014; Noonan *et al*. 2017a) and/or used screening tools as a supplementary tool, alongside intuition, as part of the broad decision-making process (Jomeen *et al*. 2013; McGlone *et al*. 2016; Myors *et al.* 2016; Noonan *et al*. 2017). While the number of respondents in the present study are small, when considered with findings of previous research, it could suggest that the use of screening tools to assess women's mental health are not consistently used in clinical practice by some HCPs. Possible reasons for not routinely using screening tools, other than the reason given in the open text comments, may be due to a lack of training in using screening tools (McCauley *et al.* 2011; Hauck *et al*. 2015; Myors *et al.* 2016; McGlone *et al.* 2016). Interview data from managers in Phase 1 confirmed that PNMH training for MWs was 'basic', suggesting a lack of specific training relating to PNMH such as how to accurately implement the use of screening tools. Perhaps the majority of respondents in this study preferred to rely on their intuition rather than use a screening tool to identify women in need of PNMH care.

Of the two areas, respondents in Blue Area were significantly more likely to perceive screening tools as important in identifying women's PNMH needs (Blue Area: 77% vs Green Area: 59%). Interestingly, though not statistically significant, almost half of respondents (48%) who had received PNMH training *not* by a PNMH specialist reported that using a screening tool was not important in identifying women's PNMH needs compared to over a quarter (27%) of respondents who had not received this type of training. Perhaps non-specialist PNMH trainers do not have knowledge of screening tools or the use of screening tools in practice is not highlighted as a priority. Or perhaps since the majority of respondents who received PNMH training *not* by a PNMH specialist were from Green Area, where there are limited referral options once a problem has been identified, it is possible that PNMH training does not include the use of screening tools. By comparison, 82% of respondents who received PNMH training by a PNMH specialist reported use of a screening tool as very important. Considering that 68% of Blue Area respondents received this type of training compared to 28% of Green Area respondents, it would suggest an association between working in an area with PNMH service provision and the type of PNMH training received resulting in the perception that screening tools are useful to identify PNMH needs of women. Interestingly, in this study, despite the different levels of PNMH services between areas, there was not a significant difference between areas in respondents who reported 'always' using screening tools (Blue Area: 45% compared to Green Area: 30%).

6.9.1.6 Routine questioning

Although routine questioning regarding women's mental health was the second most commonly reported perceived facilitator for MWs and HVs (91% of all respondents

reported this) to identify women in need of PNMH care, given the reported lack of use of a screening tool amongst MWs, it is unclear from the data what form of questioning took place by the MWs who reported never using a screening tool. Previous research has found that some MWs employ a selective use of screening (Higgins *et al*. 2018) which suggests that mental health screening ergo, routine questioning, is not carried out 'routinely'. In contrast, previous research has found that MWs routinely assess womens' mental health but in an informal manner through conversations and observing cues from women but beyond this approach, similar to the findings by Higgins *et al*. (2018), formal screening was not routinely carried out (Mellor *et al.* 2019). Respondents in Blue Area were significantly more likely to perceive routine questioning as very important compared to Green Area (Blue Area: 97% compared to Green Area: 84%). The difference between areas was not explained by having received PNMH training by a PNMH specialist nor by having received PNMH training *not* by a PNMH specialist. Perhaps routine questioning is perceived to be more important by respondents in Blue Area as this area has specialist PNMH services to refer women and therefore HCPs working in this area have the opportunity to refer women as early as possible in the perinatal period.

6.9.1.7 Aspects of job that could be reduced in order to manage women's mental health

Half of all respondents reported that there were aspects of their job role that could be reduced to enable them to manage the mental health needs of women. The majority of open text comments stated that MWs and HVs reported administration/IT and paperwork could be reduced to allow them more time to manage women's mental

health. Previous research has confirmed that in order to improve job satisfaction MWs and HVs want a reduction in non-clinical activities such as paperwork in order for them to devote more time to clients (Warmelink *et al*. 2015). In the current study, it is telling that over half of all HVs (52%) reported there were aspects of their job that could be reduced to allow them to better manage the mental health needs of women despite reporting that they routinely enquired about women's mental health (95%) and used an assessment tool to identify PNMH difficulties, all or some of the time (100%). Thus, the HVs response to this question suggests that PNMH assessments are being carried out, however, HVs would like more time to spend with women in other ways as demonstrated in an open text comment: *"Being known as a service to the wider population, e.g. ensuring partners are aware of HV's role in supporting them and their families"*, and it could be argued, view their role as exceeding beyond the assessment and referral stage and encompassing a supportive role too.

6.9.1.8 Frequency of perinatal mental health training

This study sought to determine the frequency to which respondents felt they needed to receive PNMH training and, to the researcher's knowledge, is the first study to compare the differences in the responses of MWs and HVs working in areas providing different levels of PNMH services. Significantly more MW respondents than HV respondents (77% of MWs and 52% of HVs) indicated they needed annual PNMH training and there was no statistically significant difference between areas. There was no association between frequency of training needed (annually or every two years) and having received PNMH training a part of professional training. It was not explored what form the training should take or how long it should be. However, qualitative open text

comments and interview findings from Phase 2, suggest face-to-face training is the preferred option and this concurs with previous studies (Ross-Davis *et al.* 2006b; Rothera and Oates 2011; Hauck *et al*. 2015; Noonan *et al*. 2018). The current research asked respondents how frequently they needed PNMH training and not how frequently they had received training. By establishing how frequently respondents had received training and by whom may have given an insight into the effectiveness of the training received which would have had an impact on answers to other parts of the questionnaire, for example how well such training had equipped them to identify and refer women with PNMH difficulties. Thus, although respondents were asked to provide information on where they had previously received PNMH training, the frequency of training was not known. This information could potentially provide recommendations for future PNMH training packages.

6.9.1.9 Lack of secondary care

It was anticipated that Green Area would report lack of secondary care as a barrier to referring women for PNMH care in view of the limited PNMH services in this area and it was not an unexpected finding to note that 77% of Green Area reported this. It is unclear why almost a quarter of respondents in Green Area did not perceive the lack of available secondary care as a barrier to referring women for PNMH care. It may be explained by the fact that less than a third of respondents in this area received training by a PNMH specialist and therefore are unaware of the importance of referring women for PNMH care. An unexpected finding was that over half of the professionals in Blue Area (52%) reported that a lack of secondary care available to women who require referral was a barrier when deciding to refer women. This was surprising given that this

geographical area had NICE (2014) recommended PNMH services as outlined in Chapter Four. A possible explanation of why Blue Area respondents would report this as a barrier is that although PNMH services are available in this area, according to open text responses and interview data, places are limited and therefore, some women have to wait to be seen by PNMH services due to capacity issues. Furthermore, qualitative comments in the open text responses revealed that some respondents reported that referral criteria for PNMH services were aimed at severe mental health difficulties and that services for women with “low-level” PNMH difficulties was lacking. Perhaps respondents from Blue Area were referring specifically to the lack of PNMH provision for milder PNMH problems.

6.9.1.10 Lack of knowledge of referral pathways

Overall, more MWs than HVs reported a lack of knowledge regarding secondary PNMH referral pathways as a barrier to PNMH referrals. This included referral pathways for women with severe mental health difficulties, women at high risk of developing mental health difficulties and women requiring admission to hospital. This was perhaps not an unexpected finding since the researcher also discovered areas of ambiguity and uncertainty when examining PNMH referral documentation in Phase 1 of this research. Over 40% MWs reported that lack of knowledge of referral pathways for high risk women and women with severe mental ill-health was a major barrier. However, when asked “how well has the training/education in PNMH helped you with your decision-making about whether or not a woman requires referral to secondary mental health services”, only 17% of MWs selected the response not at all. Considering the reported lack of knowledge by MWs in referring women with severe mental ill-health, this raises

the question why more MWs responded positively that their PNMH training had helped them with their decision-making regarding whether or not a woman requires referral. It is possible that some MWs were confident to decide that a woman should be referred, but less confident about where to refer women to or how to follow the referral pathways. Or perhaps as most of the MWs in this study were hospital-based, they would be less likely to refer women to PNMH services than CMWs. Alternatively, it may be that those MWs reporting to be confident are doing so in order to be seen as competent practitioners and given the topic of the research, wanting their practice to be viewed favourably, thus succumbing to social desirability bias. However, the anonymous nature of the questionnaire could mitigate against this. It is worthy of note that significantly more HVs in this study had received PNMH training as part of their professional training and significantly more HVs than MWs had been qualified for longer than 10 years which perhaps explains why they reported more knowledge of referral pathways compared to the MWs. Furthermore, this difference may be due to the fact that HVs also have a nursing and/or midwifery qualification (iHV 2020) and thus may have more accumulated clinical experience and potentially more PNMH referral experience in which to draw upon.

6.10 Strengths

This study has a number of strengths. A review of the literature revealed that little is known about PNMH referral decision-making among MWs and HVs. As such, this was the first questionnaire to explore factors that affected clinical decision-making among MWs and HVs about deciding whether or not to refer women for secondary mental health care; thus, it offers insight into an area of clinical practice not previously explored.

This was also the first study to explore the impact that PNMH service provision may have on MWs' and HVs' PNMH referral decision-making in clinical practice among professionals who worked across geographical areas that provided different levels of PNMH service provision. Thus, it represents an original contribution to the knowledge base regarding MWs' and HVs' professional decision-making.

A bespoke questionnaire was developed to ensure the content was informed by the literature and qualitative findings. Moreover, questions were based on verbatim quotes from Phase 2 which accurately reflected participant voices. The use of open text responses gave respondents the option to expand on questionnaire responses and added further depth to the quantitative data as these comments were collated and enabled frequency of themes to be noted. Furthermore, the creation and adherence of a coding scheme in content analysis are said to increase the trustworthiness and validity of the research (Hsieh and Shannon 2005).

When addressing quality issues within quantitative research it is vital to ensure validity (Denscombe 2017; Creswell 2015; Lacey 2010). Validity has been referred to as the accuracy, relevance and precision of the data (Denscombe 2017) or to put it more simply, does the research measure what it sets out to measure (Bowling 2014) without bias or misrepresentation (Lacey 2010). In accordance with the sequential design of this MMR study, the questionnaire was informed by the findings from the qualitative interviews. Development of the questionnaire utilised the main themes from the

interviews to compose and structure the questions. The three dimensions of validity are: content, construct and criterion validity (Curtis and Drennan 2013). Measures said to establish content validity, such as preliminary interviews, thematic analysis of interviews to inform questionnaire content, input from expert reviewers on the questionnaire content and structure (Curtis and Drennan 2013) and piloting (Denscombe 2017) were employed in this research. Construct validity relates to the extent to which a measure represents theoretically relevant concepts (Bowling 2014); thus, attention was given to ensure the questionnaire related to previous research findings and to the research question. Criterion validity refers to how well the questionnaire compares to other available and reliable instruments and how useful it is as a predictor of behaviours or experiences (Polit and Beck 2008). Criterion validity is often problematic and is most appropriate when there is concrete reliable criterion (Polit and Beck 2008). Unfortunately, no similar questionnaires were available; however, results were compared and considered with previous research detailed in the literature review (Chapter Two). Moreover, Creswell and Plano Clarke (2017) claim that measures and threats to validity in MMR must be specific to the type of design used. Thus, exploratory sequential MMR design strategies to minimise validity threats include explicitly describing how qualitative findings informed the development of quantitative features; the use of good psychometric instrument design and using a large sample of participants who are different from those in the qualitative sample, all of which were attempted to be implemented.

6.11 Limitations

The results reported in this chapter should be considered in light of some limitations. The survey response rate of 13.1% was disappointing and is acknowledged as a limitation as this may affect the generalisability of the findings. The poor response may affect the balance of views reported in the questionnaire as non-responders may have had different opinions to those reported by the respondents of the questionnaire. It may be that respondents of the questionnaire had an interest in PNMH or had specific experience in this area of practice and may not be representative of the MW and HV population as a whole.

There was an under representation of CMWs. Only 4 (6.67%) CMWs completed the questionnaire. The questionnaire was completed by a further 9 (15.0%) MWs on rotational posts who spent six months in each clinical area, e.g. antenatal, intrapartum, postnatal and community. On a rotational post these MWs would only spend a quarter of their time in the community. The low response rate from CMWs raises doubts as to whether this sub-group of MWs received the invite to participate. Alternatively, there may be a wide range of reasons why CMWs did not choose to participate, including lack of time, lack of motivation/interest in the study, and/or failure to receive the invitation to participate. It is acknowledged as a limitation as this sub-group of MWs may have generated further insight into referring women for PNMH care.

Despite employing various strategies that are said to increase response rates to questionnaires, such as ensuring: questionnaires are clearly designed with a simple layout; they have been thoroughly piloted; the aims of the study and instructions on completion are clearly explained; a stamped addressed envelope is provided for postal questionnaires; questionnaires are concise and questions are phrased in such a way to hold respondents attention (Boyton and Greenhalgh 2004), these had limited effect on the response rate. Possible reasons for the low response rate should be considered. Low response rates are compounded by factors such as bombardment of survey requests in healthcare (Bowling 2014) and respondents abandoning the survey part way through completion (Sue and Ritter 2012). It is also worthy of note that during the time of data collection for the questionnaire, one geographical area experienced major service changes which had resulted in the closure of some clinical areas. This may explain why Blue Area overall response rate was 9% compared to 38% in Green Area. Arguably, major service changes had the potential to impact on staff morale and engagement in other activities outside of their clinical role, such as participating in research and may offer some insight into the low response rate within that particular area.

Due to the anonymous nature of the questionnaire, the researcher was unable to personally distribute the questionnaire to respondents. Instead, the researcher relied upon the gatekeepers to distribute the email to participate to the MWs and HVs. The gatekeepers were busy professionals working in the NHS who inevitably had time and

workload pressures which may have made it difficult for them to distribute the email to participate in the given timeframe. Initial launch of the questionnaire produced only two online responses in the first two weeks which raised the question of whether the email had been distributed amongst all MWs and HVs. The researcher proactively followed this up by contacting all gatekeepers to gain confirmation that the email had been sent. Two of the gatekeepers advised that rather than personally sending out the email to the MWs/HVs working in the Trust, it was forwarded to numerous team leaders so that they could forward it onto their staff, and they were unable to confirm whether this had been done. However, they agreed to re-send the email to the team leaders and asked for it to be forwarded to MWs/HVs. This appeared to be marginally successful as more responses gradually filtered through. However, four weeks after launching the questionnaire, only 28 responses had been received. In an attempt to maximise the response rate several steps were taken. Firstly, a decision was made to extend the questionnaire closing date for a further four weeks. Secondly, whilst attending team meetings to personally hand out paper copies of the questionnaire was considered as another potential option, unfortunately this was not possible because of infrequency of the meetings which meant this was not feasible before the deadline.

As a final attempt to boost recruitment the researcher travelled to three out of the four Trust sites to hand out paper version questionnaires to staff on duty at the time of the visit which produced extra responses. One Trust did not reply to the researcher's request for permission to visit the research site. However, personally visiting the

research sites had some associated challenges. For example, some staff were too busy to complete the questionnaire on the day of the visit. On a visit to a HVs base, only a small number of staff were present in the office at the time of the researcher's visit. In an attempt to recruit CMWs, the researcher travelled to a community midwifery office. Regrettably, the CMWs were very busy at the time of the visit and unable to complete the questionnaire at that time; therefore, the researcher left 20 paper copies and a return envelope. Unfortunately, no responses were subsequently received from the CMWs following that visit. Nevertheless, personally visiting research sites was deemed a successful exercise as in one Trust 23 responses were collected in one day and also gave the researcher the opportunity to promote the research in person and encourage future online participation for the staff unable to complete the paper questionnaire.

In addition, there are shortcomings in using self-completed, cross-sectional questionnaires; findings rely on respondents' recall and access participants attitudes/views at a given time and thus are subject to recall bias and do not reflect the changing situations that may occur in healthcare practice. However, given the limited budget and expensive postage costs associated with postal questionnaires and/or costs involved in conducting face-to-face questionnaires, the use of a self-completed online questionnaire was the most feasible method for this research.

6.12 Conclusion

This chapter explored the opinions and experiences of MWs and HVs working in areas providing different levels of PNMH services, in order to understand the barriers and

facilitators to decision-making regarding referring women for PNMH care. It is understood to be the first study to consider referral decision-making in these circumstances among MWs and HVs. While this study has corroborated the barriers and facilitators to referring women for PNMH care that were identified in the qualitative, semi-structured interviews, it has highlighted some differences between the two professional groups and between the two geographical areas. Some of the findings from this study are consistent with previous research, for example, the relationship between MWs/HVs and women are key to women disclosing PNMH difficulties, and both professional groups rely on gut instinct to identify PNMH problems. New knowledge has been identified which has expanded on the findings of previous research. Whilst previous research has highlighted that HCPs lack knowledge and confidence about PNMH, this research has shown that specifically MWs working in an area without specialist PNMH provision perceive a lack of knowledge regarding referral pathways as a barrier to referring women with moderate and severe mental health difficulties. The next chapter will discuss the combined results from this MMR study in the context of the wider literature and its contribution to the existing knowledge base. It will discuss key implications for clinical practice and produce recommendations for practice with the ultimate aim of improving PNMH care for women. It will highlight the strengths and limitations of this MMR study and provide direction for future research.

CHAPTER SEVEN

Integrated discussion and conclusions

7.1 Introduction

This chapter reviews and integrates the main findings of the research presented in this thesis and provides overall conclusions. An interpretation of the findings is drawn from the mixed methodological approach. The findings are also discussed in context with the existing literature. Strengths and limitations of this research are discussed and this chapter concludes with recommendations for clinical practice based on the findings presented in this thesis and suggestions for future research.

7.2 Background to research question and aims

Despite women having routine contact with HCPs in the perinatal period, evidence indicates that many UK women in need of PNMH care and/or secondary referral do not receive the care/referral they require in an accurate and timely manner and in some cases, not at all (Bauer *et al*. 2014; Redshaw and Henderson 2016). In addition, secondary PNMH care provision across the UK remains variable in both coverage and characteristics with some areas having no PNMH services, some areas providing services that meet NICE (2014) recommendations and others falling somewhere in between. MWs and HVs have been identified as key professionals in identifying and referring women with PNMH needs due to their skill set and the routine contact they have with women during this time (MMHA 2014; HEE 2016; NMC 2019). However,

previous research has shown that MWs and HVs lack knowledge and confidence in managing women's PNMH (Hauck *et al*. 2015), lack policy direction to aid referral decision-making (Rothera and Oates 2011; Carroll *et al*. 2018) and require and desire training and education across a variety of aspects related to PNMH, including but not limited to, the use of PNMH screening tools (Beauchamp 2014; Higgins *et al*. 2018), risk factors associated with perinatal mental ill-health and communication skills to broach PNMH with women (Milgrom *et al*. 2011; Myors *et al.* 2013; Hauck *et al*. 2015; Higgins *et al.* 2018; Carroll *et al*. 2018). In previous research there is a dearth of attention relating to MWs' and HVs' decision-making regarding whether or not to refer women for secondary PNMH care. Therefore, the overall question for this research was: What factors influence MWs' and HVs' decision-making in relation to referring women for secondary PNMH care? The aims of the research were to explore MWs' and HVs' decision-making in relation to referring women for secondary PNMH care to understand the barriers and facilitators to accurate and timely referrals, and in particular to examine any impact of having a local specialist PNMH service on MWs' and HVs' decision-making regarding referrals for secondary mental health care.

7.3 Discussion of main findings

The following section discusses the key findings related to the barriers and facilitators to referral decision-making among MWs and HVs, and the impact of available PNMH services on MWs' and HVs' decision-making regarding referring women for secondary PNMH care; findings were explored qualitatively through semi-structured interviews and measured quantitatively through a bespoke questionnaire.

7.3.1 Relationship between midwives/health visitors and women

The most important finding identified in this research was the importance of the relationship between MWs/HVs and women. This relationship was perceived by the MWs and HVs of this study to be important in two ways. Firstly, a trusted relationship was important for facilitating women's disclosure of PNMH problems. MWs and HVs valued the opportunity that a trusted relationship provided, reported to be enhanced by continuity of carer, whereby they perceived women felt safe to disclose pre-existing/existing PNMH problems. Many MWs and HVs taking part in the interviews, and from responses in the open text comments on the questionnaire, stated that repeated contacts with the same HCP were perceived to be necessary for women to develop a trusted relationship with their HCP which in turn enabled women to feel 'safe' to disclose PNMH problems. Secondly, a trusted relationship, again aided by continuity of carer, enabled MWs and HVs to get to know the women in their care and subsequently allowed them to observe changes in a woman's behaviour and/or presentation that may indicate emergence or worsening of PNMH problems. This in turn facilitated MWs'/HVs' in their decision-making about whether or not to refer a woman for secondary mental health care. The Maternal Mental Health Alliance and RCM (2018) reinforce the importance of a trusted relationship between MWs and women and echo that a trusted relationship increases the likelihood of MWs identifying any PNMH problem that may arise. A trusted relationship is central to the philosophy of midwifery and health visiting care and embedded in their respective codes of practice (NMC 2014; NMC 2015). Evidence by Baker *et al*. (2020) found that a trusted relationship that develops through continuity of carer between women and their HCP encourages women to be

forthcoming in disclosing mental health problems. This research builds on the findings of Baker *et al*. (2020) by specifically exploring the perceived importance of relationships between MWs/HVs and women in relation to women's disclosure of PNMH problems and thus, the impact on MWs'/HVs' decision-making regarding whether or not to refer women for PNMH care and contributes to the existing literature.

Although continuity of carer was valued by both MWs and HVs, several factors limited the provision of this and therefore acted as barriers to building relationships and consequently to referring women for secondary PNMH care. Across the sample, over 60% perceived reduced number of overall contacts were a barrier to identifying women with PNMH problems. Moreover, quantitative data showed that almost three quarters of the HVs in both areas perceived a lack of contacts in the home environment was a major barrier to identifying women's PNMH problems. Interview data suggested that HVs felt contacts with women in their own homes facilitated the building of one-to-one relationships with women, and that the home environment was perceived to engender feelings of security and confidence for women thereby facilitating disclosure of pre-existing/current PNMH problems which is reinforced in the literature (Cowley *et al*. 2013). Home visits were also perceived to be beneficial to HVs as they fostered a holistic approach to their assessment of women which enabled HVs to observe women in their own homes and assess how they were coping and/or observe women's parenting of their infants. This was felt to be important to some HVs and reinforced in the literature that has shown maternal depression can inhibit sensitive parenting

(Schechter *et al*. 2004; Muzik *et al*. 2015), as women may be less able to understand their baby's distress cues particularly around procedures such as the 'heel prick' test (Warnock *et al.* 2016), where less sensitive parenting may result in suboptimal infant emotional regulation (Muzik and Borovska 2010) and the development of a less secure mother-infant attachment (Brockington 1996). Being able to observe women's parenting in their own environments supported a holistic approach to care where HVs were not only able to observe women's parenting responses but also consider the long-term impact of mental ill-health on infants. This, in turn, facilitated MWs'/HVs' in the decision-making process. These findings are in line with a study by Doi *et al*. (2017) who conducted an evaluation of an enhanced health visiting programme in Scotland which included increased home visits. Mandated service in Scotland states that families receive a minimum of eleven contacts from their HV; the enhanced programme of care included additional home visits based on need (Doi *et al*. 2017). Doi *et al.* (2017) found that qualitative data from HVs (n=25) and parents (n=22) revealed that enhanced home visiting increased opportunities for early identification of health and wellbeing issues amongst women and their families which led to referral and engagement with other sources of help. Women in England have five mandatory contacts representing fewer than half of the contacts than their Scottish counterparts which arguably means fewer opportunities to build relationships between HCPs and women and fewer opportunities for subsequent disclosure. The findings of this study suggest that lack of contacts in the home environment are perceived as a barrier to MWs and HVs in their decision-making when deciding whether or not to refer women for PNMH care. Not only does this finding align with previous research, it provides new knowledge which highlights that changes

to how midwifery and health visiting services are delivered, i.e. reduced home visiting, could potentially have a negative impact on MWs' and HVs' decision-making in clinical practice.

The recent COVID-19 pandemic has resulted in a number of changes to working practices in both midwifery and health visiting services. For example, some face-to-face key contacts have been replaced by telephone, online or virtual consultations (Coxon *et al*. 2020; Conti and Dow 2020; iHV 2020a; Jardine *et al.* 2021; RCOG 2021); there has been a suspension in some mandated MW and HV contacts for women not deemed to be vulnerable (Conti and Dow 2020; Jardin *et al*. 2021; RCOG 2021); MWs and HVs have experienced increased caseload numbers (Coxon *et al*. 2020; Conti and Dow 2020; iHV 2020a) and redeployment of staff outside of their roles to various locations (i.e. COVID-19 wards, COVID-testing centres and community services such as district nursing) resulting in reduced number of overall contacts with women (iHV 2020a). Considering the perceived barrier that a lack of contacts in the home presents to some HCPs in relation to referring women for PNMH, this has implications for womens disclosure of PNMH problems where MWs'/HVs' contacts with women are likely to occur via telephone or virtually. Whilst some of these changes in practices may be temporary in response to the pandemic, nevertheless they have the potential to impact on the relationship between women and MWs/HVs. Furthermore, where face-to-face contacts continue, HCPs are required to wear personal protective equipment in the form

of face coverings (NICE 2020) which may also impact on communication between women and their HCP and potentially the development of their overall relationship.

In the current research, all data collection had been completed prior to the COVID-19 pandemic. Notably, the majority of MWs in this research were hospital-based and as such do not conduct home visits. Perhaps a larger sample of CMWs may have had different opinions about the lack of home contacts than their hospital-based colleagues. Or maybe CMWs may have had different opinions/views about the impact of a lack of home contacts from those expressed prior to the onset of the pandemic, which may have been similar to the opinions of the HVs, had data collection coincided with the pandemic. Although extant research has examined the impact that the COVID-19 pandemic has had on the mental health of expectant mothers and mothers of newborn infants (Papworth *et al*. 2021), an interesting area for future research would be to examine the impact that the COVID-19 pandemic has had on referral rates to secondary mental health care given that many face-to-face contacts/contacts in the home have been replaced by telephone or virtual contacts.

Another finding of this research was that some changes to the delivery of midwifery and health visiting services did not facilitate relationship building between HCPs and women. For example, across both geographical areas there had been a move away from individual MWs and HVs personally seeing women in their care/on their caseload, replaced by generic clinics for some contacts conducted by designated MWs/HVs. This

change in service delivery occurred in both Blue Area and Green Area, with a relatively similar response from participants across both areas reporting generic clinics were a barrier to identifying women with PNMH problems. Consequently, the relationships that develop between MWs/HVs and women were found to be impacted by these changes. In the case of generic clinics, designated MWs or HVs would conduct clinics for all women requiring, for example, a pregnancy booking appointment or a 6-8 week postnatal review. This meant that women attending these clinics may not see the MW and/or HV who conducted these clinics again during the perinatal period and vice versa. It could be argued that this barrier could undermine the potential of a specialist PNMH service if practitioners working in this area are firstly, unable to identify PNMH needs of women and secondly, make any subsequent referrals to specialist PNMH services.

Interview data revealed that some MWs/HVs disliked generic clinics as they prevented MWs/HVs from having the opportunity to personally see women on their caseload and build up a rapport with them, and generic clinics were not felt to be a conducive environment for women to disclose mental health problems. However, the introduction of generic clinics is not a novel approach to care, particularly in midwifery. Further to the opinions of over half of respondents in this research, Lewis (2009) conducted qualitative interviews with MWs (n=6) and women (n=8) on their experiences of generic postnatal clinics and found that clinics were reported to be beneficial in assisting women with the transition to motherhood by reducing isolation of being at home and encouraged a more confident approach to mothering. Since many postnatal clinics take place in health

centres or children centres, this encouraged the use of other support services in combination to the postnatal check (Lewis 2009). The study by Lewis (2009) supported the provision of some generic clinics after initial home visits by CMWs.

In the current research, over half of the sample perceived generic clinics were a barrier to identifying women's PNMH needs. Previous research has shown there are likely to be advantages of having generic clinics in addition to the drawbacks identified by the participants in this research around identifying women's PNMH needs. Therefore, further research is warranted related to perceived benefits/drawbacks of generic clinics in relation to decision-making when deciding whether or not to refer women for PNMH care. This is particularly relevant in the current climate where modifications have been made to perinatal care where clinics are becoming increasingly commonplace in midwifery and health visiting services in order to facilitate COVID-19 infection control procedures (RCOG 2020). It would also be useful to explore women's views of these clinics and how/if they impact on women's disclosure of PNMH problems where the findings could provide useful evidence to inform healthcare providers on how services should be delivered from women's (service users) perspective. It would be beneficial to obtain in-depth, qualitative data in addition to quantitatively driven data.

7.3.2 Stigma/fear of child removal

Stigma associated with perinatal mental ill-health has been extensively written about in the literature (Moore *et al*. 2016; Bayrampour *et al*. 2018; Nagel and Farrelly 2018; Smith *et al*. 2019). The findings from the qualitative and quantitative phases of this

study indicate that stigma related to PNMH problems was perceived and experienced to be a barrier to disclosure for MWs and HVs working in Blue and Green Areas. Many interview participants stated they perceived that stigma associated with mental ill-health and fear of child removal prevented women from disclosing PNMH problems. This finding was reinforced in the questionnaire results where approximately 80% of all MWs and HVs perceived this as a major barrier to disclosure. Participants discussed that they perceived women did not want to be viewed negatively as a mother if they disclosed PNMH problems and feared the consequences of disclosure where numerous participants gave examples where women had asked them *"You're not going to take my baby away are you?".* Authors such as Megnin-Viggars *et al.* (2015) and Baker *et al*. (2020) support the notion that fear of child removal is a barrier to women in disclosing PNMH problems. Arguably, stigma may deter some women from disclosing PNMH problems and perhaps may go some way to explain why a reported 50% of women do not receive the treatment they require (Bauer *et al.* 2014) as some women may choose not to disclose PNMH problems even when directly asked by their HCP.

Moreover, qualitative data revealed that some participants were reluctant to broach mental ill-health and/or lacked confidence to discuss it which is in line with previous research (Milgrom *et al*. 2011; Myors *et al.* 2013; Hauck *et al*. 2015; Higgins *et al.* 2018; Carroll *et al*. 2018). Whilst another participant felt some of their colleagues had a stigmatising attitude towards mental ill-health amongst fellow professionals. Previous research supports the notion that HCPs are reluctant to self-disclose mental health

conditions to colleagues for fear of a negative response (Lindsay *et al*. 2019). This has potential implications for women with current/pre-existing PNMH problems; if HCPs have a stigmatising attitude towards mental ill-health they may not screen women for PNMH problems or make any necessary referrals. An interesting area for future research could explore attitudes and opinions of MWs and HVs towards mental ill-health amongst fellow colleagues and whether a stigmatising attitude towards colleagues with mental health problems is widespread. This could be extended to explore attitudes towards mental health in general that may give an insight into how this impacts on their attitudes when caring for women with PNMH problems. This could be achieved both qualitatively using semi-structured interviews, and quantitatively using survey methods. However, semi-structured interviews may produce results where participants discuss favourable attitudes towards mental ill-health that may not accurately reflect their beliefs and attitudes. Thus, an anonymous survey method may represent a superior alternative to semi-structured interviews as this method could mitigate against social desirability bias.

Despite the differences between areas in terms of provision of specialist PNMH services, there was little difference between their respective responses regarding the perceived stigma associated with mental ill-health (Blue Area: 79% vs Green Area: 88% of respondents reporting stigma was perceived as a barrier to women disclosing PNMH difficulties). The reasons why both areas perceived the stigma associated with mental ill-health was a barrier to disclosure was unknown. It would perhaps be reasonable to

assume that Blue Area practitioners were less likely to perceive mental ill-health carried associated stigma since this area was more likely to receive PNMH training from PNMH specialist which arguably would promote a more tolerant and inclusive attitude towards mental ill-health. However, the MWs' and HVs' views were based on women's perceived stigma associated with mental health and not necessarily their own views about mental ill-health. Given that this research captured the views and opinions of MWs and HVs on their perceptions of women's views towards stigma and fear of disclosure, future research should seek to include the views of women. A particular area of interest would include women's views on strategies that MWs and HVs could employ in order to dispel/alleviate fear of disclosure/stigma associated with PNMH problems, and thereby potentially encourage women to disclose PNMH problems without the associated fears of disclosure. A qualitative approach is suggested for this research which encourages women to discuss their own views and opinions instead of predefined responses as set out in survey methods.

7.3.3 Lack of parity of esteem

A significant finding from the questionnaire revealed that almost half of all MWs in this study perceived physical health checks took up contact time with women allowing them little or no time to complete a mental health assessment and this finding has previously been evidenced in the literature (Noonan *et al*. 2017a; Nagel and Farrelly 2018). Interestingly, reporting in this study that physical checks took up contact time with women was associated with those MWs who had been qualified for fewer than 10 years. Perhaps less experienced MWs were less confident in assessing women's PNMH or took longer to complete physical checks during contact times leaving no time

to complete a mental health assessment. Notably, during interview discussions around barriers to deciding to refer women for PNMH care, many MWs recited the list of physical health checks they need to complete at each contact, often in a short amount of time. This list was considerable and included not only physical checks for mother and fetal/infant well-being, but encompassed lengthy documentation processes and subsequent checks based on the outcome of initial checks. For instance, an abnormal maternal physical check and/or neonatal check may necessitate a need for further investigations, e.g. in the form of blood tests, all of which have to be completed in the allotted appointment/contact time. The pervasive view was that these physical checks were more important than completing a mental health assessment in the limited time during a contact despite the evidence that suicide is a leading cause of maternal deaths (Knight *et al*. 2015) and that depression and anxiety disorders are the most prevalent health problems in the perinatal period (Howard *et al*. 2014). Very few HVs (15%) in this study reported physical health checks took up contact with women which reflects their role in general which is to complete a needs assessment of women and/or the family rather than carrying out physical checks. The lack of parity of esteem among some MWs was uncovered in the qualitative phase of this research and confirmed in the subsequent quantitative phase. According to Hughes (2016) sequential exploratory mixed methods approach is best for testing emergent theory as both types of data are interpreted during the integration of results suggesting this was an appropriate method for this research. Given that MWs provide care for women spanning the antenatal, intrapartum, and postnatal period, prioritising physical health assessments over mental health assessments could be potentially damaging for women. For future research it

would be interesting to explore why some HCPs, particularly MWs, prioritise physical health over mental health. Establishing potential beliefs and attitudes about the perceived importance/lack of importance of mental health in the perinatal period would be beneficial in informing midwifery educational programmes and challenge the notion that mental ill-health and its sequelae are less important than physical health.

7.3.4 Use of screening tools

A key finding of this research revealed differences and similarities between the professional groups and areas in terms of reported use, perceived value and confidence in using screening tools. However, there was consistency in the tools used where the majority of participants used the tools recommended by NICE (2014), i.e. GAD, PHQ, Whooley questions and EPDS. Interestingly, evidence presented in this thesis and in the literature suggests that MWs and HVs used validated screening tools inconsistently and incorrectly, where tools such as the Whooley questions and GAD-2 are applied in ways that may affect their psychometric properties, i.e. they are asked in a conversational manner and not verbatim as intended. It would be beneficial to explore the clinical practices of a larger sample of MWs and HVs regarding the use of and application of PNMH screening tools.

7.3.4.1. Training

PNMH training appeared to influence the use of screening tools and highlighted differences and similarities between MWs and HVs and between Blue Area and Green Area. This research showed that between the two professional groups, HVs were more likely to use screening tools in clinical practice compared to MWs and this finding is in

line with previous research (Ashford *et al*. 2017; Higgins *et al*. 2017a; Higgins *et al*. 2017b). Qualitative interviews revealed that HVs reported routinely using screening tools to assess women's mental health. Questionnaire data showed no HVs reported never using screening tools compared to 35% of MWs (p= 0.000). The fact that more HVs reported using screening tools may be due to the fact that HVs have prolonged contact with women following childbirth (i.e. up to five years) compared to MWs, they therefore have more opportunities to assess women for postnatal depression and are potentially more likely to use screening tools in clinical practice. Or it may be due to the fact that more HVs received PNMH training as part of their professional training compared to MWs. However, when the response to using screening tools between hospital-based and CMWs were compared, 75% of CMWs reported always using screening tools compared to only 18% of hospital-based MWs (p=0.022). Since the number of CMWs is small (n=4) these results are not generalisable.

A lack of PNMH training appeared to affect practitioners confidence in using screening tools and/or confidence in the results of screening tools in clinical practice for many MWs in this research. The reasons most stated by MWs in this research for not using screening tools was that they were unaware of the existence of such tools. This was surprising given that during the interviews some MWs reported that their electronic records prompted them to enquire about women's mental health using the Universal PNMH questions, i.e. the Whooley questions and the GAD-2. However, some MWs failed to recognise that these questions were screening tools which perhaps reinforces

a lack of training around PNMH and/or screening tools. Other reasons posited by MWs for not using tools was a lack of training in using screening tools which affected their confidence when implementing the tools in clinical practice, it was not in their role to assess women's mental health and/or a preference for relying on intuition/clinical judgement. Some MWs identified that they received inadequate training/education in PNMH; the training they received was described as minimal and predominately delivered online which was not felt to be sufficient. Previous research has shown that inadequate PNMH training is a barrier to HCPs in addressing perinatal depression (Byatt *et al*. 2012). The importance of PNMH training is reinforced by the RCM (2021) who recommends MWs receive training to equip them to identify, assess and refer women with PNMH problems. Research has shown that PNMH training supports MWs to develop knowledge and skills that enable them to support women with PNMH problems (Coates and Foureur 2019). Since this research examined how frequently MWs and HVs felt they needed PNMH training, further research is needed to establish the actual frequency of PNMH training received, who delivers this training, the quality and effectiveness of the PNMH training and how this impacts on MWs' and HVs' practice and confidence when deciding to refer women for PNMH care. This could be achieved by conducting large scale survey research amongst MWs and HVs and would provide useful data for educational and/or healthcare services when planning and delivering PNMH training.

Questionnaire data showed there was no difference between MWs' and HVs' preference for frequency of PNMH training for once a year (MWs: 55% vs HVs: 52%). The frequency of training is perhaps not as important as the content of the training. Perhaps if MWs received training in how to implement screening tools in practice, they may have more confidence to use the tools and more confidence in the results of tools. However, an important finding of this research revealed a difference between the two areas regarding PNMH training. Approximately three-quarters of Blue Area respondents reported that their training in PNMH had equipped them well to identify (Blue Area: n41/55 vs Green Area: n18/42; p=0.011) and refer (Blue Area: n38/55 vs Green Area: n14/42; p=0.005) women with PNMH problems compared to just over a third of Green Area respondents. Blue Area's training was more likely to be delivered by a PNMH specialist compared to Green Area (Blue Area: 68% vs Green Area: 28%; p=0.000). In essence, the data shows a significant association between perceiving that PNMH training equipped MWs/HVs to identify and refer women with PNMH problems and having received PNMH training by a PNMH specialist. Specialist PNMH MWs and HVs are reported to empower their colleagues, reduce demands on services, act as sources of expert clinical advice and support, co-ordinate and deliver evidence-based PNMH training and ensure women receive the best care (MMHA 2014; HEE 2016). Interview data from Blue Area participants reinforced the benefit of having a specialist PNMH practitioner in post where participants mentioned consulting with their specialist PNMH MW/HV for advice and support regarding PNMH referrals. Paradoxically, narrative accounts in the interviews from Blue Area participants also suggested a drawback of having a specialist PNMH MW; it could be argued that the presence of a specialist MW

was potentially deskilling for some MWs as, instead of personally assessing women's mental health, some MWs referred women directly to the specialist MW for assessment. Nevertheless, very few Green Area participants had the opportunity to receive PNMH training from a PNMH specialist, although many interviewees expressed how useful they perceived it would be to have such a practitioner in their area. Notwithstanding the provision and availability of a specialist PNMH MW/HV, many interview participants, particularly those from Green Area, expressed a desire for structured and focused PNMH training as they deemed the generic mental health online training insufficient and inadequate in addressing the shortfalls in their knowledge. Training/education was requested to cover topics such as using screening tools, PNMH disorders, managing women with PNMH problems, communication skills to broach PNMH, referral criteria/processes and new research in relation to PNMH. This is important knowledge that could be useful for Trusts/educational institutions when planning PNMH training for MWs and HVs and consequently has the potential to improve PNMH care for women.

7.3.4.2 Referral pathways

Research suggests that a positive screen with either the Whooley questions, PHQ-2 or GAD-2 should be followed by a further assessment to aid the diagnosis of major depressive disorder (Whooley, 2016; Kroenke *et al.* 2003; Milgrom *et al*. 2011; Bosanquet *et al.* 2018; Henshaw and Eriksen 2015). However, this did not appear to be common practice among the participants of this research as some participants did not screen women in the first instance, and where participants described using the Whooley questions/PHQ-2 and GAD-2, the majority of participants did not describe using further assessments when a positive result was received from the aforementioned tools.

Importantly, only one out of the four Trusts' referral documentation (Trust 3) definitively advised practitioners to carry out further assessments using the GAD-7 and PHQ-9 when a positive response is received for the Whooley questions/PHQ-2 and GAD-2. Data from the open text boxes to the question: "Which tool(s) do you use?" revealed that only 22 out of the 63 comments received stated the PHQ-9 and GAD-7 were used in clinical practice and these responses were predominately from HVs in Blue Area. This further suggests that the PHQ-9 and GAD-7 were not routinely used by all MWs and HVs in this research despite being a recommendation in current NICE (2014) guidance. This may be due to a lack of policy direction in Trust referral pathways/documentation. Across both areas, many interview participants in this research voiced a desire for clearer referral pathways within their respective Trusts to inform and guide clinical decision-making regarding referring women for PNMH care. Moreover, quantitative data revealed that approximately a third of all respondents across both areas reported a lack of knowledge of referral pathways as a major barrier when making decisions about referring women for PNMH care across a range of scenarios, e.g. women at high risk of mental ill-health problems, women with moderately severe and severe mental ill-health problems. It could be argued that their reported lack of knowledge of referral pathways in these instances were a result of an unclear pathway in the first instance as indicated by many interview participants. This finding is in line with previous research that has found that MWs and HVs lack clear policies and guidelines to manage women's mental health needs (Bayrampour *et al*. 2018; Carroll *et al*. 2018; Alexandrou *et al*. 2018; Smith *et al*. 2019) and suggests that the lack of clarity

in policy direction regarding PNMH referrals is possibly widespread and not confined to the geographical areas covered in this research.

7.3.4.3 Availability of secondary perinatal mental health services

Overall, participants working in Blue Area were more likely to use screening tools compared to Green Area. Some specialist PNMH services in Blue Area (e.g. Parent and Baby Day Unit) stipulated that GAD-7 and PHQ-9 scores are completed prior to referral to this service which may explain why Blue Area participants were more likely to use screening tools since they had specialist services to refer to and some of these services requested screening results as part of the referral process. Or, as mentioned above, since more participants from Blue Area received PNMH training from a PNMH specialist, they were more likely to use screening tools in practice. This could suggest that having specialist PNMH services may have a positive influence for practitioners in terms of adhering to NICE (2014) guidance relating to screening womens' mental health using validated tools.

A possible reason why MWs and HVs from Green Area did not report using screening tools could be because they do not have comprehensive secondary PNMH services to refer women to. This finding was captured in the questionnaire data that highlighted differences between the two areas in terms of PNMH provision. Unsurprisingly, over three-quarters of Green Area participants perceived the lack of secondary specialist PNMH care as a major barrier to referring women with PNMH difficulties. Interview data from MWs and HVs in Green Area also demonstrated their frustration at the lack of

available PNMH services for women where they had limited referral options (pre-PNMH CMHT provision) such as, the GP, signposting/self-help strategies or 999 in an emergency. Some participants from Green Area likened identifying a woman's PNMH problems to 'opening Pandora's Box' where this led to further issues such as where to refer the woman once a problem had been identified. Interestingly, over half of Blue Area respondents also reported a lack of secondary care for women requiring a PNMH referral as a major barrier. This was an unexpected finding given that Blue Area provided PNMH services as recommended by NICE (2014). The lack of PNMH services may explain other differences across the two areas. Such as, why almost half of all respondents in Green Area (41.9%) perceived using a screening tool was not very important in identifying women with PNMH problems (compared to 23.2% of Blue Area participants; p=0.047) as, once identified, Green Area respondents had limited PNMH referral options for women. This provides new knowledge regarding the impact that PNMH services have on MWs and HVs decision-making when deciding whether or not to refer women for PNMH care as it suggests a link between adhering to NICE guidelines and having PNMH services.

7.3.4.4 Routine enquiry of womens' perinatal mental health

In accordance with current guidelines from the participating Trusts, which reflects the advice from NICE (2014), routine enquiry of women's mental health at designated times throughout the perinatal period was recommended practice. An important finding from the interview data, questionnaire results and open text comments revealed that routine enquiry of women's mental health was perceived as a major facilitator for disclosure and identifying PNMH problems. However, herein presents a contradiction with the data.

Whilst most respondents (91%) reported that routinely asking women about their mental health was perceived to be a facilitator for disclosure, almost half of all MWs and 15% of HVs reported that using a screening tool was not very important in facilitating identification of PNMH problems, and over a third of MWs completing the questionnaire reported never using a screening tool. This has significance for clinical practice where different methods/approaches are used by MWs and HVs to enquire about women's mental health instead of using validated screening tools. Inconsistent approaches may lead to ambiguity about whether or not a woman requires referral to PNMH services. Thus, it was not clear from the data what form of enquiry took place amongst participants who did not report screening tools as important and/or use screening tools in practice. Given that this research and previous research indicate inconsistent use of screening tools in practice, it would be useful for future research to explore with MWs and HVs what form of routine enquiry regarding women's mental health is carried out in practice and the overall use of screening tools in larger populations of MWs and HVs.

7.3.5 Intuition

A key finding of this research was that intuition was reported to be important to the MWs and HVs in their clinical practice when deciding whether or not to refer women for PNMH care. Intuitive practice is highly regarded in the literature amongst HCPs and is an important factor when making clinical decisions (Chew-Graham *et al*. 2008; Jefford *et al*. 2011; Ménage 2016; Smith 2016; Noonan *et al*. 2017b; Daemers *et al*. 2017; Fiddick *et al.* 2020). Authors such as Smith (2007) and Grant (1989) have highlighted the subjective nature of intuitive decision-making since it is both difficult to define and

quantify. Intuitive decisions were conveyed by the MWs and HVs in this study as ‘gut feelings’ and ‘common sense’ and not substantiated by any formal processes that provide evidence-based methods of assessment such as results from screening tools.

Data from the interviews revealed that intuition seemed to be closely linked to experience whereby clinicians were able to draw on previous experience and existing knowledge base to aid the decision-making process. However, this opinion was not reflected in the questionnaire data where there were no statistically significant difference in the responses from those participants qualified for 10 years or fewer than those qualified for 11 years or longer who reported that intuition was a major facilitator to identifying the PNMH needs in women (≤10 years: 37.3% vs ≥11 years: 62.7%, X^2=0.216; p=0.642). Where intuition was used to guide decision-making, participants utilised other measures to aid this process such as observation and in the case of HVs, assessing women’s behaviour in their homes and/or home conditions as signs of women’s ability to cope with their baby as potential indicators of low mood/mental health problems. Thus, in the current study, intuition often took precedence over formal methods of assessment such as using validated screening tools when making clinical decisions. Although the majority of MWs and HVs in this study relied on intuition, it is important to acknowledge potential pitfalls of relying solely on intuition in the absence of using evidence-based measures. This research has highlighted a number of factors that impact on decision-making for MWs’ and HVs’ when deciding whether or not to refer women for PNMH care. Namely, some women were perceived to be reluctant to

disclose mental health problems, MWs and HVs reported reduced overall contacts with women resulting in fewer opportunities to assess women's mental health and some participants (particularly HVs) reported reduced home contacts with women, all of which presented challenges to MWs and HVs when making PNMH referral decisions. Thus, if MWs and HVs rely exclusively on intuition to make clinical decisions, coupled with the aforementioned challenges, this may increase the risk of missing a PNMH problem in the absence of routinely using validated screening tools on all women. Although previous research has extensively explored the role intuition plays in clinical decision-making (Smith 2007; Pretz and Folse 2011; Hasani *et al*. 2016; Rosciano *et al*. 2016), there is a paucity of research examining intuition in relation to time since qualification among MWs and HVs when deciding to refer women for PNMH care. It would be interesting for future research to interrogate the role intuition plays in clinical decision-making according to time since qualification and/or length of time in job role when deciding whether or not to refer women for PNMH care e.g. inexperienced HCPs qualified for ≤2 years (Mizrachi *et al*. 2017) to explore whether they relied on intuition in order to facilitate clinical decisions. This may give further insight and understanding into the complex processes of clinical decision-making.

7.4 Conclusion

This chapter has presented an integration of the findings from this mixed methodological approach that set out to understand PNMH referral decisions among MWs and HVs. Central to gaining this understanding was to explore, what impact, if any, PNMH service provision had on MWs and HVs when deciding to refer women for PNMH care. The findings have revealed that in the main, participants from Blue Area

and Green Area (those with specialist secondary PNMH services and those without PNMH service provision respectively) reported similar barriers and facilitators to clinical decision-making regarding referring women for secondary PNMH care. This was an unexpected finding; the researcher anticipated that the provision of specialist secondary PNMH services would result in fewer barriers for the MWs and HVs working in that area. A key finding identified from both qualitative and quantitative analysis was that fundamental to MWs' and HVs' decision-making was the relationship between themselves and women. MWs and HVs from both areas perceived that where a trusted relationship existed, women were more likely disclose PNMH problems. However, the ability to build a relationship with women was influenced by the delivery of midwifery and health visiting services. Some changes to how services were delivered were perceived by participants to present a barrier to identifying women's PNMH problems and to developing relationships with women, such as, a reduction in overall contacts with women, a reduction in the number of home visits and the establishment of generic clinics, all of which occurred in both areas. It is worth mentioning that the period between conducting Phase 2 and Phase 3 revealed a 15.7% decrease in overall staff numbers (896 MWs/HVs employed at the time of Phase 2 compared to 755 MW/HVs employed at the time of Phase 3) which would undoubtably impact on the delivery of midwifery and health visiting services. Other similarities between the two areas and professional groups regarding the perceived barriers and facilitators to various aspects when deciding to refer women for PNMH care were the importance of relying on intuition to identify women with PNMH needs, the perception that stigma was a barrier to women disclosing mental health problems, preferences for frequency in PNMH

training, and perceived barriers to knowledge of referral pathways across various scenarios.

There were, however, notable differences between professionals groups and between Blue and Green Areas regarding perceived barriers and facilitators when deciding to refer women for secondary PNMH care. For example, HVs were more likely to perceive the use of screening tools as very important and more likely to use screening tools in clinical practice compared to MWs which concurs with the literature. MWs were more likely to perceive completing physical health checks took up contact time with women allowing little or no time to complete a mental health assessment compared to HVs. Blue Area participants were more likely to have received PNMH training from a PNMH specialist and more likely to perceive that their PNMH training had equipped them well to identify and refer women with PNMH problems than Green Area participants.

Thus, the findings from this research suggest that the provision of PNMH services within the participating Trusts does not have a fundamental influence on MWs and HVs when deciding whether or not to refer women for PNMH care. HV3 from Green Area stated "*We don't have a good service provision here for women with mental health problems. But that wouldn't stop me identifying it and offering health visitor support. And … obviously, if needed, I'd get it escalated up through the GP"*. The main difference is that once a problem has been identified, the referral options in Green Area are limited. Furthermore, the provision of PNMH services, whilst clearly important for women in

ensuring they receive appropriate and timely care appeared less important to MWs' and HVs' decision-making than the manner in which maternity and health visiting services were delivered. Comprehensive training in PNMH and clear referral pathways would also facilitate MWs and HVs when deciding to refer women for PNMH care.

7.5 Original contribution to knowledge

This research set out to understand PNMH referral decisions among MWs and HVs working across two geographical areas that each provided different levels of PNMH care provision. The Blue Area provided services in line with NICE (2014) recommendations and, at the inception of this research, the Green Area did not have any specialist PNMH services. This research was, to the researcher's knowledge, the first to explore PNMH referral-decisions among MWs and HVs, who are instrumental in identifying, assessing and referring women in need of PNMH care. As such, it provided novel findings into an area of clinical referral decision-making and provided new knowledge about the perceived barriers and facilitators to this process. Previous research has examined clinical decision-making among MWs and HVs but none have explicitly explored decision-making in relation to referring women for PNMH care. Furthermore, the provision of local PNMH services on clinical decision-making was explored which generated new findings into factors that have a potential impact on MWs' and HVs' decision-making in clinical practice.

This research found that MWs/HVs perceived that their relationships with women, and the ability to provide continuity of carer, was fundamental to facilitating referrals to

secondary PNMH care. The reason for this was that MWs and HVs perceived that a trusted relationship, aided by continuity of carer, not only encouraged women to disclose a history of and/or current PNMH problems but also allowed MWs/HVs to observe changes/deteriorations in womens' presentation that may indicate a mental health problem. This research has shown that there is inconsistent use of and application of the use of screening tools, particularly amongst MWs. This is an important finding since NICE (2014) recommend routine screening, using validated screening tools, of all women in the perinatal period. Interview and questionnaire data indicated that MWs and HVs expressed a desire for annual PNMH training updates via a face-to-face method. Finally, although the provision of PNMH services are fundamental to women receiving the specialist care they require, this research has shown that the level of local provision of specialist PNMH services does not have a dominant impact on MWs' and HVs' decision-making about referring women for secondary mental health care. More important factors to MWs and HVs are the way in which services are delivered. Particularly whether or not they are able to provide continuity of carer and thus build trusted relationships with women allowing them to be able to identify those women who would benefit from referral for specialist mental health care.

7.6 Strengths of this research

The use of a mixed method research approach afforded the exploration of referral decision-making in clinical practice through varied research lenses. The qualitative interviews provided rich, detailed data that explored the complex nature of referral decision-making in clinical practice. As interviews were participant led, MWs and HVs

were permitted to discuss, without restrictions from a structured interview, aspects of decision-making that were important to them and impacted on their decisions about referring women for secondary mental health care. The advantage of using the quantitative questionnaire enabled the views of a larger sample of MWs and HVs to be measured and revealed confirmatory evidence of the themes highlighted from the interview data, and also highlighted differences between the two professional groups and the areas with differing PNMH care provision. The combined data from the interviews and questionnaire captured knowledge of referral decision-making that had hitherto been unknown amongst these professional groups (i.e. MWs and HVs) and across different areas (i.e. areas with and without PNMH services). Whilst triangulation is not a guarantee of validity per se, it is a way of ensuring comprehensiveness of the data (Cassar and Kiger 2005). This research provides valuable insight into the complex nature of decision-making in clinical practice adding new knowledge to decision-making literature regarding referrals for PNMH care by MWs and HVs.

Furthermore, the MMR approach produced important findings related to clinical decision-making, e.g. some MWs in this research prioritised women's physical health needs over mental health needs. The chosen methodological approach produced findings that appear to suggest that a lack of parity of esteem existed amongst some MWs and might, therefore, be prevalent in MWs working in other areas across the UK. Thus, this finding suggests areas for future research that potentially could reproduce findings that could then be generalisable to the larger population of MWs offering an

insight into an aspect of clinical practice that could impact on women requiring PNMH care. Since an estimated 1 in 4 women experiences PNMH problems (NHS England 2021) the potential impact of this new knowledge is not insignificant.

Although there is a large body of research on clinical decision-making amongst HCPs, a review of the literature revealed there is little known empirically about whether PNMH service provision impacts on MWs' and HVs' decision-making in clinical practice when deciding to refer women for PNMH care. In order to address this aspect of referral decision-making, two geographical areas were selected for participation based on the fact that one area provided NICE recommended PNMH services and the other area did not provide any dedicated PNMH services (at the inception of the PhD). This research was the first to design, recruit and collect data from MWs and HVs across two geographical areas and has produced novel findings into areas of clinical practice which had hitherto not been studied and as such, presents an original contribution to the existing knowledge base.

Proactive measures were employed during both qualitative and quantitative phases of this research to encourage recruitment such as: personally visiting research sites, offering interviews at different times and venues to fit around the working patterns of the MWs and HVs, sending out reminder emails, displaying posters to encourage participation in the research and supplying each Trust with hard copies of the

questionnaire. These measures were employed to not only maximise recruitment numbers but for the convenience of the participants.

Since the researcher belongs to both professional groups and holds current registration as a MW and HV with the Nursing Midwifery Council she has the benefit of being an 'insider' researcher whereby she has the practical advantage of having a shared language, knowledge of professional practices and the related cultures of both professions. Not only is this thought to be an advantage in terms of access to participants and gaining a rapport with participants (Greene 2014), insider researcher's generate knowledge that is useful or relevant to their own practice (Fleming 2018).

7.7 Limitations of this research

Whilst this study has a number of strengths, it is important to consider the findings in the light of several limitations. Two areas were selected for participation based on the fact that one area provided NICE recommended PNMH services and the other area did not provide any dedicated PNMH services in order to explore whether PNMH service provision impacted on referral decision-making. However, following collection of the interview data (Phases 1 and 2) and prior to conducting the questionnaire study (Phase 3), Green Area obtained a PNMH CMHT. As a consequence, responses from Phase 3 did not provide comparisons between two areas that provided diametrically opposed PNMH services. Nevertheless, Green Area's PNMH provision did not meet the recommended services for women and was in its infancy when Phase 3 was conducted.

Therefore, Phase 3 was still able to examine the similarities and differences between the two areas. Clearly, aside from the differences in PNMH service provision, there were other differences between the two geographical areas which may have impacted on MWs' and HVs' decision-making when deciding to refer women for PNMH care which were not explored in this research. For example, the areas' demographics including cultural and ethnic diversity, socio-economic variations, urbanisation and rural differences.

The questionnaire response rate of 13.1% is acknowledged as a limitation. The response rate for this research may have been influenced by the use of gatekeepers and the associated potential for gatekeeper bias (Tuckett 2004). Bias can occur where gatekeepers control who the invitation to participate is sent to. Response rates for the questionnaire in particular could indicate that not all MWs and HVs that were eligible to take part in this research received the invite to participate. Nevertheless, the response rate gives rise to responder bias whereby non-responders may have had different opinions from those expressed by responders. As such this limits the generalisability of the findings. In an effort to combat gatekeeper bias it may be useful in future research to consider measures that would encourage gatekeepers to send out research invites to all those who are eligible to take part. This includes personally meeting with gatekeepers (instead of telephone and email communications) to discuss the research and the importance of inviting the chosen sample, prior to commencing data collection; and establish a convenient timeframe for gatekeepers, who are invariably busy, to send out

invites and co-ordinate launching the research to coincide with this. Undoubtedly, the low response rate could also have been due to other factors such as MWs and HVs workload/capacity issues, motivation to participate in research, internet accessibility/failure issues or a preference for handwritten questionnaires which may have been considered too time consuming. Or considering all of the participants were women and may have accessed maternity/health visiting services, and possibly experienced PNMH problems themselves, may not have wanted to answer questions on this topic as a HCP.

Despite efforts to recruit a whole population of MWs, only a small number of CMWs were recruited into this research during both the interview and questionnaire phases. Although recruitment was equally aimed at both hospital and community-based MWs, participation was unbalanced and favoured hospital-based MWs. An even spread of recruitment across both hospital and CMWs would have provided valuable data regarding referring women for PNMH care during the interviews and facilitated a more robust comparison between MWs and HVs of the questionnaire data; this in turn would have allowed comparisons to be made between the practices of both groups of MWs and HCPs based in the community. It would be useful to consider other methods of recruiting this sub-group of MWs that may be more successful than the methods employed in this research, e.g. via social media, personalised invitations to participate in research, via professional journals, attending CMWs team meetings, etc. The questionnaire response was also unbalanced in favour of Green Area MWs and HVs.

Thus, compared to Green Area, the sample in Blue Area was likely less representative of the population of MWs and HVs as the response rate in Blue Area was lower than Green Area (8.72% vs 38.0%).

The self-reporting nature of the questionnaire could have resulted in social desirability bias where respondents responses to questions may not reflect what they actually do in clinical practice. This is reinforced by some qualitative responses and in the literature that conflicted with questionnaire responses such as almost 60% of MWs stated using an assessment tool was very important to identifying PNMH needs of women but this does not correspond with interview data and/or the literature. However, the anonymous nature of the questionnaire was employed to mitigate against social desirability bias. Furthermore, due to the cross-sectional nature of the questionnaire, views of respondents were only captured at one time point. Future research may benefit from a follow-up longitudinal study to examine whether opinions and reported practices changed over time, particularly since Green Area's PNMH provision had improved during the course of conducting the research, and as the recent COVID-19 pandemic has changed working practices for MWs and HVs.

It has been highlighted that the Whooley questions and the PHQ-2 generate confusion in both clinical and research settings where one type of screening tool is used but the other tool is named and referenced due to their similarities (Whooley 2006). During the interviews, the tools used by participants were not confirmed by the researcher. For

future research purposes related to screening tools, it would be prudent to explicitly clarify which tools participants are referring to. This would avoid any confusion around which tools are being used and ensure rigour in the findings.

Finally, this research has explored PNMH referral decision-making from MWs' and HVs' perspective where these HCPs have shared their perceptions and experiences of the barriers and facilitators to this process. A limitation of this research is that it does not capture the voices of women with mental health problems and their role in the decision-making process when referring women for specialist PNMH care. It is acknowledged that womens' voices are underrepresented in the literature and thus it would be prudent redress this.

7.8 Recommendations for practice

Based on the research findings from this study, the following recommendations are offered for MWs/HVs and service providers to facilitate PNMH clinical referral decision-making.

MWs/HVs

- Where continuity of carer models are in place, MWs and HVs should continue to seek ways of working that facilitate and encourage the development of a trusted relationship between themselves and women, i.e. providing opportunities for continuity of carer where permissible.

- MWs and HVs are responsible for personal professional development; where shortfalls in knowledge are identified, MWs and HVs should seek to improve their learning, e.g. around PNMH/having difficult conversations/use of screening tools.

- Once trained in their use and administration, MWs and HVs should all use their employing Trusts chosen validated screening tool to support a consistent and more reliable assessment of women's mental health. Using such evidence-based screening tools may substantiate the more tacit and intuitive assessments made by MWs and HVs.

Service providers

- Service providers should ensure timely implementation and roll out of continuity of carer models in order to allow MWs and HVs to provide individualised care for women in order to facilitate the development of a trusted relationship.
- NHS Trusts and Academic Education Intuitions should provide comprehensive PNMH training (pre and post-registration) for MWs and HVs to ensure they have the necessary skills to equip them to identify, assess and refer women with PNMH problems. This research supports the delivery of annual PNMH training by a PNMH specialist MW/HV and via a face-to-face method.
- Service providers should ensure PNMH referral pathways/guidelines are available for HCPs that are clear, comprehensive and accessible. These pathways/guidelines should reflect current NICE guidance and up to date and reliable evidence based sources.

7.9 Recommendations for future research

Gaps in the literature and recommendations for future research have been identified in this chapter and previous chapters of this thesis. However, to further understand why approximately 50% of women who require PNMH care do not receive care in a timely and judicious manner, it is important to consider other issues that may contribute towards this. It is, therefore, prudent to ruminate on wider aspects of the current issues within midwifery and health visiting which may possibly offer insight into the complex factors that influence MWs and HVs when making decisions in clinical practice.

Recent evidence has shown that, even prior to the COVID-19 pandemic, health and care workforces were struggling to cope with workload demands due to staff shortages (Health Foundation *et al.* 2018). A survey of MWs (n=2000) by the RCM (2016) revealed that 66% had considered leaving the profession. The main reasons for wanting to leave the profession were a dissatisfaction with staffing levels, an inability to provide the quality of care required, high workload and poor working conditions (RCM 2016). More recent research has corroborated these findings where survey results indicated the most common reasons why MWs intended to quit midwifery were working conditions as a result of staff shortages and workload, and disillusionment with the quality of care provided to women (NMC 2017).

A similar picture is reflected in health visiting. A survey of HVs (n=1040) by the iHV (2020b) revealed increasing caseload numbers where 43% of HVs were responsible for caseloads of between 400 and 1000 children. The Community Practitioners and Health Visitors Association (CPHVA) (2016) recommend a caseload of 250 children for whole-

time equivalents, which should be reduced in areas of high deprivation. Moreover, the number of HVs has fallen by over 31% from 2015 (n=10,309) to 2019 (n=7,026) (iHV 2020b). Falling numbers of HVs make maintaining and building relationships with women difficult and weaken the prevention activities of primary care practice (Bryar and Cowley 2017). Thus, the evidence indicates that MWs and HVs are operating under increasing pressures which present challenges to them when attempting to fulfil all aspects of their job roles and arguably may impact on their decision-making in clinical practice. Data from interview participants and open text comments from the questionnaire confirmed that MWs and HVs are short staffed, feel their respective services are stretched and in some instances are dissatisfied with the level of care they provided. If, as evidenced in this thesis, relationships and continuity of carer are vital for MWs and HVs when making clinical decisions in practice, increasing workload, difficulties due to decreased staffing levels and the current pandemic will add further challenges to MWs and HVs. An area for future research would be to consider how any changes in service delivery are likely to impact on MWs and HVs relationships with women and the ability to provide continuity of carer as recent changes, such as reduced number of overall contacts, reduction in home visits and generic clinics, are perceived to have a negative impact on relationships between MWs/HVs and women and subsequent referral decision-making. For example, recently NHS England have pledged to open 26 ‘Maternal Mental Health Hubs’ across England where women will have access to maternity services, reproductive health and psychological therapies ‘under one roof’ (NHS England 2021). It would be interesting to explore if these hubs deliver care in a way that was found to be important to the participants of this research, i.e.

where HCPs can build relationships with women through continuity of carer. Of particular interest would be to explore if these hubs have an impact on women's disclosure of PNMH problems given that they will be community-based, since this research has found that delivering care in women's homes was important to identifying PNMH problems in women and their subsequent disclosure of PNMH problems.

A final recommendation for future research would seek to explore women's views regarding PNMH referrals. Whilst this research has captured MWs' and HVs' views on women's perceived barriers and facilitators to disclosure, these views do not reflect the views of women themselves. Therefore, it is vital to capture women's opinions and viewpoints on their satisfaction on current antenatal and postnatal care practices (COVID-related working practices notwithstanding) and how this impacts on subsequent disclosure of PNMH problems. Furthermore, it would be interesting to investigate the impact that the COVID-19 pandemic had on PNMH referrals and women's satisfaction on the changes to care in response to the pandemic.

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Appendices

Appendix 1: Patient Health Questionnaire (PHQ-9)

Date_____ Patient Name:_____ Date of Birth: _____

***Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers*. a**

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all Somewhat difficult Very Difficult Extremely Difficult

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Appendix 2: General Anxiety Disorder (GAD-7)

***Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers*.**

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all Somewhat difficult Very Difficult Extremely Difficult

Appendix 3: Edinburgh Postnatal Depression Scale (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- ☐ Yes, all the time
- ☒ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

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Appendix 4: Email to managers/clinical leads to participate in Study 1

Institute of Health and Society
University of Worcester
Henwick Grove
Worcester
WR2 6AJ
joanne.johnson@worc.ac.uk

Dear (insert name of manager),

I am a PhD Student at the University of Worcester conducting a research project entitled *Understanding perinatal mental health care and referral decisions among midwives and health visitors.* Your Trust has agreed to participate in this study. As part of the research, I am interviewing Managers/Clinical Leads about local protocols for perinatal mental assessment and care, including referring women for secondary mental health care. I understand from your Trust R and D department that you are the Manager/Clinical Lead for midwives/health visitors and I am writing to invite you to take part in a research interview. Please see attached Participant Information Sheet for details of the study.

If you are willing to take part or have any questions about the research, please contact me on joanne.johnson@worc.ac.uk or 01905 542328. Thank you for considering taking part in this research and I look forward to hearing from you.

Yours sincerely,

Jo Johnson RN, RM, SCPHN HV, BSc (Hons), MSc
PhD Student

Appendix 5: Participant Information Sheet for Study 1 (Managers/Clinical Leads)

IRAS ID: 235568 Version 1: 26/02/18

Understanding perinatal mental health care referral decisions among midwives and health visitors.

You are being invited to take part in a research study which will be carried out by the researcher, Jo Johnson. Before you decide to take part in this study it is important for you to understand why the research is being carried out and what it will involve. Please take time to read the following information carefully. If there is anything you are unsure of, or unclear about, please do not hesitate to contact the researcher on 01905 542328 or alternatively, email the researcher joanne.johnson@worc.ac.uk This research is co-funded by Staffordshire and Shropshire NHS Foundation Trust and the University of Worcester. Thank you for taking the time to read this information.

Purpose of the study

The aim of this study is to explore midwives' and health visitors' approaches to mental health care in the perinatal period, including decision making around referring women for secondary mental health care. One element of the research is to explore local Trust protocols for perinatal mental health care by midwives/health visitors by conducting interviews with Managers/Clinical Leads (Study 1). Study 2 and 3 of the research will involve interviews and questionnaires with midwives/health visitors about perinatal mental health care and referral decisions.

Why have I been chosen?

You have been chosen to participate as you are a Manager/Clinical Lead of midwives/health visitors working in a Trust that has agreed to take part in this research.

Do I have to take part?

No. Your decision to take part in this study is entirely voluntary. If you do decide to participate please keep this information sheet and you will be asked to sign a consent form. If you do decide to take part, you are free to withdraw from the study up to two weeks following the interview and without giving a reason. To have your data withdrawn, contact the researcher via the email address at the end of this information sheet.

What will happen to me if I take part?

If you decide to take part, you will be invited to take part in a one-to-one interview conducted by Jo Johnson. This will be held in a private room in your place of work, at a given date and time that is convenient to you, or alternatively, via telephone. The interview should last no longer than 50-60 minutes. However, it must be noted that in the unlikely event of any declaration that suggests potential harm to yourself and/or a third party or conduct that directly contravenes the NMC

guidelines (2016), may result in the researcher divulging such information to your line manager in the first instance in accordance with NMC professional body guidelines, which you will be made aware of.

What do I have to do?

You will be asked to take part in a one-to-one interview to share your knowledge of local Trust protocols for perinatal mental health assessment and care by midwives/health visitors, including referrals to secondary mental health care. The information you provide during the interview will be confidential and will not be shared in a way that identifies you or the Trust you work in.

Are there any risks to taking part?

There are no risks anticipated in taking part in this research.

What are the possible benefits of taking part?

While there are no direct benefits to you of taking part, it is hoped the possible benefits of this research will be to gain an understanding of the complexities faced by midwives and health visitors when managing/referring women who have perinatal mental health problems. It is hoped that the findings from this research will inform training needs and produce recommendations for practice and healthcare services resulting in the potential to improve perinatal mental health care.

What will happen to the results of the research?

The results of this study will be presented in the form of a PhD thesis which should be completed by no later than January 2021. The researcher may submit all or part of this research for publication to academic and/or professional journal and present this research at conferences. Any quotes used for publication will be anonymised. Please be assured that the information you provide during the interview will not be shared in a way that identifies you, the participant, or the Trust you work in.

Who has reviewed the study?

This study has been reviewed by the University of Worcester Health and Science Research Ethics Committee (reference SH17180018-R) and Health Research Authority (reference 235568).

Contact for further information

Jo Johnson, PhD Student
University of Worcester
Henwick Grove
Worcester
WR26AJ
joanne.johnson@worc.ac.uk
Tel: 01905 542328

If you have any concerns or complaints about this research and you would like to speak to an independent person who is not the researcher, please contact: Michelle Jellis, Administrator, Health and Science Research Ethics Committee, University of Worcester, ethics@worc.ac.uk

References

Data Protection Act (1998) Available at: http://www.legislation.gov.uk/ukpga/29/contents

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South Staffordshire and Shropshire Healthcare NHS Foundation Trust

University of Worcester

Appendix 6: Consent Form for Study 1 (Managers/Clinical Leads)

IRAS ID: 235568 Understanding perinatal mental health care and referral decisions among midwives and health visitors.

Name of Researcher: Joanne Johnson. **Please initial boxes**

I confirm that I have read and understand the information sheet; version 1 dated 26/02/18, for the above study and have had the opportunity to ask questions and have them answered satisfactorily. ☐

I understand that my participation is voluntary. If I decide to participate, I am free to withdraw from the study up to two weeks following the interview and without giving any reason. ☐

I agree to take part in the above study. ☐

I agree for the interview to be audio recorded and for the data to be used for the purpose of this study. ☐

I understand that in the unlikely event of any declaration that suggests potential harm to myself and/or a third party or conduct that directly contravenes the NMC guidelines (2016), may result in the researcher divulging such information to my line manager in the first instance in accordance with NMC professional body guidelines, which I will be made aware of. ☐

.....	.....	.....
Name of participant	Date	Signature
.....	.....	.....
Researcher	Date	Signature

Reference: Nursing Midwifery Council (2016*) The Code: Professional standards of practice and behaviour for nurses and midwives.* London: NMC

Appendix 7: Interview guide for managers/clinical leads

ICE-BREAKER

Thank you and outline purpose of research.
Purpose of interview.
Overview of my professional background.
Potential benefits of this research.

Please tell me about your professional role/current role?

Prompts: post, how long you have held that post, professional background, etc.

Do you manage PNMH and other services?

Prompts: What are they?

ASSESSMENT AND SERVICE PROVISION

What guidelines do midwives/health visitors use when assessing women's perinatal mental health?

Prompts: Use of assessment tools such as EPDS, GAD, the use of referral pathways, local Trust policies/protocols for assessment and referrals, guidelines for women with mild PNMH problems and management of milder PNMH cases, etc.

Would you describe to me the services you provide to women experiencing perinatal mental health problems in your Trust?

Prompts: in-patient and out-patient services, community teams, services for women who don't need admission, options for women who don't need referrals to secondary care.

GAPS

How well do you think the services provided by your Trust meet the needs of women experiencing perinatal mental health problems?

Would you like to see any changes in service provision in your area? If so, what changes would you like to see.

Prompts: Gaps in service provision – what are they?

Talk me through the ideal service you would like to provide to women with PNMH problems.

Prompts: What does the service look like, particular staff roles specific to PNMH, e.g. specialist MW/HV, etc.

LOCAL POLICIES AND REFERRALS

What do you know about how your Trust records/collates data relating to the assessment and referral of women with perinatal mental health problems and other data relating to PNMH that is not referrals to secondary services?

Prompts: Does PNMH form part of local KPI's? How is this information recorded?

What do you do with the data relating to PNMH?

Prompts: Is it used for commissioning purposes?

TRAINING

Talk me through the staff training your Trust provides for midwives/health visitors specific to perinatal mental health?

Prompts: If so, who delivers the training - Local or out of area? Is it mandatory? How is it delivered – classroom, online, etc.?

Do you allow/encourage MW/HV to access specialist PNMH training provided out of area?

Prompts: Is this funded by the Trust, funded by practitioner?

CONCLUSION

Is there anything I haven't asked you that you thought I would?
Would you like to hear about the findings of my research on completion?
The key things I have learnt from this interview are: (Clarify back with manager key issues from the interview).
Thank-you for taking part. Reiterate assurances of confidentiality.

Appendix 8: Health & Sciences Research Ethics Committee (HSREC) Confirmation

19 February 2018

HSREC CODE: SH17180018-R

UNDERSTANDING PERINATAL MENTAL HEALTH CARE REFERRAL DECISIONS AMONG MIDWIVES AND HEALTH VISITORS

Dear Jo

Thank you for your application for full review ethical approval to the Health & Sciences Research Ethics Committee on the 8 January 2018.

Your application has been reviewed in accordance with the University of Worcester Ethics Policy and in compliance with the Standard Operating Procedures for full ethical review.

The Committee has now completed its peer review of the project work and is happy to grant this project ethical approval to proceed.

Your research must be undertaken as set out in the approved application for the approval to be valid. You must review your answers to the checklist on an ongoing basis and resubmit for approval where you intend to deviate from the approved research. Any major deviation from the approved application will require a new application for approval.

As part of the University Ethic Policy, the University Research Committees audit of a random sample of approved research. You may be required to complete a questionnaire about your research.

Yours sincerely

John-Paul

DR JOHN-PAUL WILSON

Deputy Pro Vice Chancellor Research

On behalf of Chair of the Health & Sciences Research Ethics Committee

Appendix 9: Approval letter from HRA

Mrs Joanne Johnson PhD Student
University of Worcester
Henwick Grove Worcester
WR26AJ

Health Research Authority

Email: hra.approval@nhs.net

10 April 2018 Dear Mrs Johnson

Study title: Understanding perinatal mental health care referral decisions among midwives and health visitors.

IRAS project ID: 235568

Protocol number: SH17180018-R

REC reference: 18/HRA/2081

Sponsor: University of Worcester

I am pleased to confirm that HRA Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further from the HRA.

How should I continue to work with participating NHS organisations in England?

You should now provide a copy of this letter to all participating NHS organisations in England, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should formally confirm their capacity and capability to undertake the study. How this will be confirmed is detailed in the "summary of HRA assessment" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

How should I work with participating NHS/HSC organisations in Northern Ireland, Scotland and Wales?

HRA Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland, Scotland and Wales.

If you indicated in your IRAS form that you do have participating organisations in one or more devolved administration, the HRA has sent the final document set and the study wide governance report (including this letter) to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see IRAS Help for information on working with Northern Ireland, Scotland and Wales.

How should I work with participating non-NHS organisations?

HRA Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The attached document "After HRA Approval – guidance for sponsors and investigators" gives detailed guidance on reporting expectations for studies with HRA Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England. What should I do once I receive this letter?

You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows: Name: Dr John-Paul Wilson

Email: j.wilson@worc.ac.uk

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below. Your IRAS project ID is 235568. Please quote this on all correspondence.

Yours sincerely

Thomas Fairman HRA Assessor
Email: hra.approval@nhs.net
Copy to: Dr John-Paul Wilson, University of Worcester, (Sponsor Contact); Mrs Ruth Langley-Burke, South Staffordshire and Shropshire Healthcare NHS Foundation Trust, (Lead NHS R&D Contact)

Appendix 10: Invite to MWs/HVs to participate in Study 2

Institute of Health and Society
University of Worcester
Henwick Grove
Worcester
WR2 6AJ
joanne.johnson@worc.ac.uk

Dear Health Professional,

I am writing to invite you to participate in a research project which I am conducting for a PhD at the University of Worcester. I enclose a Participant Information Sheet which states the title and explains the aims of the project. Your Trust has agreed to participate in this research and as part of the research, I am inviting all midwives/health visitors from your Trust to take part.

This phase of the research will involve a one-to-one interview about perinatal mental health care, including decision making about referrals to secondary care, which is expected to take no longer than 60 minutes and be held in a private room within the Trust at a time that is convenient to you. Alternatively, if a private room is not available, a telephone interview can be arranged. Anything you say would be totally confidential.

The number of interviews I need to conduct will be dictated by data saturation. Data saturation occurs when no new themes are identified during the interviews. Therefore, volunteering to take part in the research may not guarantee you will be interviewed and I will let you know if this is the case. However, the next phase of the research will involve completion of a questionnaire for which you will also be invited to take part. Participation in the interviews will not exclude you from completing the questionnaire. If you feel that you would like to take part in the research interview, please email me: joanne.johnson@worc.ac.uk . If you prefer not to participate, please dispose of this letter via recycling.

Thank you for considering taking part in this research and I look forward to hearing from you.

Yours faithfully,

Jo Johnson, RN, RM, SCPHN HV, BSc (Hons), MSc, PhD Student

Reply Slip: Please return to Jo Johnson at the above address or email joanne.johnson@worc.ac.uk

I am interested in taking part in the research interviews.

Name: …… Position: Midwife/Health Visitor (delete as appropriate).

Trust employed by: …… Contact details: ……..

Appendix 11: Participant Information Sheet for Study 2
Version 1: 09/04/18

Understanding perinatal mental health care referral decisions among midwives and health visitors

You are being invited to take part in a research study which will be carried out by the researcher, Jo Johnson. Before you decide to take part in this study it is important for you to understand why the research is being carried out and what it will involve. Please take time to read the following information carefully. If there is anything you are unsure of, or unclear about, please do not hesitate to contact the researcher on 01905 542328 or alternatively, email the researcher: joanne.johnson@worc.ac.uk This research is co-funded by South Staffordshire and Shropshire NHS Foundation Trust and the University of Worcester. Thank you for taking the time to read this information.

Purpose of the study

The aim of this study is to explore midwives' and health visitors' approaches to mental health care in the perinatal period, including decision making around referring women for secondary mental health care. The findings from the interviews will inform the development of a questionnaire for the next phase of the research.

Why have I been chosen?

You have been chosen as you are a practicing midwife/health visitor working in a Trust that has agreed to take part in this research.

Do I have to take part?

No. Your decision to take part in this study is entirely voluntary. If you do decide to participate please keep this information sheet and you will be asked to sign a consent form. If you do decide to take part, you are free to withdraw from the study up to two weeks following the interview and without giving a reason. To have your data withdrawn, contact the researcher via the email address at the end of this information sheet.

What will happen to me if I take part?

If you decide to take part, you will be invited to take part in a one-to-one interview which will be audio recorded, where you will be asked to share your opinions and experiences with the researcher about perinatal mental healthcare. This will be held in a private room within your place of work at a given date and time that is convenient for you or alternatively, via telephone. The interview is expected to last no longer than 60 minutes**.** Interview transcripts will be stored on a University of Worcester issued laptop for the purpose of thematic analysis and audio recordings will be deleted after transcription. The information you provide during the interview will be confidential and will not be shared in a way that identifies you or the Trust you work for. However, it must be noted

that in the unlikely event of any declaration that suggests potential harm to yourself and/or a third party or conduct that directly contravenes the NMC guidelines (2016), may result in the researcher divulging such information to your line manager in the first instance in accordance with NMC professional body guidelines, which you will be made aware of.

What are the possible benefits of taking part?

While there are no direct benefits to you of taking part, it is hoped the possible benefits of this research will be to gain an understanding of the complexities faced by midwives and health visitors when managing/referring women who have perinatal mental health problems. It is hoped that the findings from this research will inform training needs and produce recommendations for practice and healthcare services resulting in the potential to improve perinatal mental health care.

Are there any risks to taking part?

There are no risks anticipated in taking part in this research.

What will happen to the results of the research?

The results of this study will be presented in the form of a PhD thesis which should be completed by no later than January 2021. The researcher may submit all or part of this research for publication to an academic and/or professional journal and disseminate this research at conferences. Any quotes used for publication will be anonymised. Please be assured that the information you provide during the interview will not be shared in a way that identifies the participant or the Trust you work in. Data will be kept in accordance with the Data Protection Act (1998).

Who has reviewed the study?

This study has been reviewed by the University of Worcester Health and Science Research Ethics Committee (reference SH17180018-R) and the NHS Health Research Authority (reference 18/HRA/2081).

Contact for further information:

Jo Johnson, PhD Student
University of Worcester
Henwick Grove
Worcester
WR26AJ
Tel: 01905 542328
Email: joanne.johnson@worc.ac.uk

If you have any concerns or complaints about this research and would like to speak to an independent person, who is not the researcher, please contact:

Michelle Jellis
Administrator
Health and Sciences Research Ethics Committee
University of Worcester
ethics@worc.ac.uk

Reference

Data Protection Act (1998) Available at:
http://www.legislation.gov.yk/ukpga/29/contents
Nursing Midwifery Council (2016) *The Code. Professional standards of practice and behaviour for nurses and midwives.* London: NMC

South Staffordshire and Shropshire Healthcare NHS Foundation Trust

University of Worcester

Appendix 12: Poster for Study 2 recruitment

Please reply by 27th August 2018

Interested in taking part in research that seeks to make a difference? Are you a practicing midwife / health visitor?

If you answered 'Yes' to the above, I would be interested in talking to you about your experiences of perinatal mental health care. Can you spare an hour to be interviewed at your place of work?

Please contact: 01905 542328

joanne.johnson@worc.ac.uk for more information. I am a qualified midwife and health visitor with 26 years of clinical experience. Anything you say will be confidential.

Appendix 13: Reminder email to participate in Study 2

University of Worcester
Institute of Health and Society
Henwick Grove
Worcester
WR2 6AJ
joanne.johnson@worc.ac.uk

Dear Health Professional

I am a PhD student at the University of Worcester conducting research to better understand midwives' and health visitors' mental health care and decision making in the perinatal period.

Two weeks ago an email was sent to you inviting you to participate in a research study. **This follow-up email is being sent to remind you to respond if you would like to participate and have not already done so.**

If you choose to participate, you will be asked to participate in a one-to-one interview with me about perinatal mental health care. The interview should take no longer than one hour and can be held in a private room within your Trust. Alternatively, if a private room is not available, a telephone interview can be arranged. The information you provide at the interview will be completely confidential, and no identifying information about you or your Trust will be disclosed as a result of taking part in the interview.

A Participant Information Sheet which contains additional information about my research is attached.

To participate, contact me via email: joanne.johnson@worc.ac.uk to schedule an interview. Many thanks for considering taking part.

Yours faithfully,

Jo Johnson
PhD Student, RN, RM, SCPHN – HV, BSc (Hons), MSc

Appendix 14: Interview guide for Study 2

ICE-BREAKER

Thank you and outline purpose of research.
Purpose of interview.
Overview of my professional background.
Potential benefits of this research.

Please tell me about yourself in terms of your professional background and qualifications, etc.

Prompts: your post, how long you have practised as a MW/HV, professional qualifications, e.g. mental health qualifications.

How long have worked in this organisation? Do you have access to specialist PNMH services?

ASSESSMENT

How many women do you see with PNMH problems?

Talk me through when and how you start to think about how a woman has PNMH problems.

What assessment tools, if any, do you use when assessing womens PNMH?

Prompts: EPDS, GAD, etc.

How and when do you use tools in your assessment?

Prompts: Usefulness of tools, do they give you confidence in aiding your assessment of PNMH.

What would help you with your assessment of women's PNMH?

Prompts: Tools, service provision, education, staffing levels, previous experience, qualifications etc.

What guidelines influence your practice when assessing women for PNMH problems?

Prompts: NICE guidelines, local policies/protocols.

Do you think these guidelines/policies are 'fit for purpose' for the assessment of women with PNMH problems?

Prompts: Do they assist you in your assessment?

Is there anything that would assist you in your decision to refer women for secondary PNMH care?

Prompts: Having a referral pathway, education in PNMH care/disorders, availability of services, etc.

How do you manage mild PNMH problems?

Prompts: What strategies do you employ, e.g. signposting women to support groups, providing extra visits, etc.

What are the things that make it difficult when assessing women's PNMH?

Prompts: Confidence, experience, knowledge, workload, service provision, education, support – from colleagues, services, multidisciplinary team, etc.

Once you have assessed a woman you are concerned about, what happens next?

Prompts: Who do you refer, where to – MBU or not?

TRAINING

What training have you received in PNMH? Is it adequate in equipping you to assess women with PNMH problems?

Prompts: What was the training, who delivered it, is it mandatory?

Would you like further training/guidance on managing PNMH?

REFERRALS

What are the factors that influence your decision to refer women for secondary care?

Prompts: severity of woman's symptoms, assessment score, services available locally, woman's individual circumstances such as family support, your previous experience/confidence in PNMH.

When referring women for secondary care, do you experience any issues with the referrals?

Prompts: secondary services accepting referral e.g. meeting referral criteria/capacity to accept referral, lack of confidence, professional knowledge and experience, etc.

If you encounter problems with referrals to secondary services, what course of action do you take?

Prompts: Do you contact in-patients units out of your area for availability of beds? Is this problematic?

Do you feel confident dealing with PNMH care, in terms of referrals, management of care and follow up care.

Prompts: What has influenced your confidence – education, previous experience, qualifications, etc?

If you were unsure about how to manage a woman with PNMH problems, what action would you take?

Prompts: Where/who would you go to for advice/support? Do you rely on referral pathways or local policies to assist you in your management?

Conclusion

Is there anything I haven't asked you that you thought I would?
The key things I have learnt from this interview are: (Clarify back with MW/HV key issues from the interview).
Thank-you for taking part. Reiterate assurances of confidentiality.

Appendix 15: Revised interview guide for Study 2

ICEBREAKER

Thank you and outline purpose of research
Purpose of interview
Overview of my professional background
Potential benefits of this research

Ask demographic questions and complete table. Start recording.

ASSESSMENT

Talk me through when and how you start to think about how a woman has PNMH problems.
What facilitates your assessment and/or referral of women with PNMH problems?
Prompts: Continuity of carer, place of assessment.
What are the barriers to assessing/referring women for PNMH care?
How do you manage mild PNMH problems?
Prompts: Strategies, signposting, providing extra visits, etc.
Once you have assessed a woman you are concerned about, what happens next?
Prompts: Who do you refer to, where to – MBU, parent and baby unit, GP?

REFERRALS

What are the factors that influence your decision to refer women for secondary care?
Prompts: Severity of symptoms, assessment score, services available, woman's individual circumstances such as family support, your previous training/experience/confidence in PNMH.
When referring women for secondary care, do you experience any issues with the referrals?
Prompts: secondary services accepting referral e.g. meeting referral criteria/capacity to accept referral, lack of confidence, professional knowledge and experience, etc.
If you encounter problems with referrals to secondary services, what course of action do you take?
Do you feel confident dealing with PNMH care in terms of assessment, referrals, management of care and follow up care?
What has influenced your confidence?
Prompts: Education, previous experience, etc.
If you were unsure about how to manage a woman with PNMH problems, what action would you take?
Prompts: Where/who would you go to for advice/support? Do you rely on the referral pathways or local policies to assist you (if you have them)?

CONCLUSION

Is there anything I haven't asked you that you thought I would or should ask?
What are the key things you want me to take away from this interview?
(Clarify back with MW/HV key issues from the interview)
Thank you for taking part. Reiterate assurances of confidentiality.

Appendix 16: Consent Form for MWs/HVs taking part in Study 2

Title of Project: Understanding perinatal mental health care referral decisions among midwives and health visitors.

Name of Researcher: Joanne Johnson

Please initial boxes

1. I confirm that I have read and understand the Participant Information Sheet version 1 dated 09/04/18 for the above study and have had the opportunity to ask questions and had them answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw up to two weeks following the interview, without giving any reason. ☐

3. I agree to take part in the above study. ☐

4. I agree for the interview to be audio recorded and for the data to be used for the purpose of this study. ☐

5. I agree to the use of anonymised quotes in publications or presentations. ☐

6. I understand that in the unlikely event of any declaration that suggests potential harm to myself and/or a third party or conduct that directly contravenes the NMC guidelines (2016), may result in the researcher divulging such information to your my manager in the first instance in accordance with NMC professional body guidelines, which I will be made aware of. ☐

.....	.....	.....
Name of participant	Date	Signature

.....	.....	.....
Researcher	Date	Signature

Reference: Nursing Midwifery Council (2016) The Code. Professional standards of practice and behaviour for nurses and midwives. London: NMC

Appendix 17: Example of Thematic Analysis coding of interview transcript

JJ: Can you talk me through when and how you start to think a woman has PNMH problems?

Booking appt v. important. Accurate and up to date records facilitate assessment.

MW: From booking[1]. Erm, if there's already notes on her, erm on her records, if there's history, if she discloses it … Erm I must admit, I'm not very good at picking it up when there's no prior … erm but it takes me a while to get to that point where [she thinks] it's a bit odd, this woman needs support so I do find it a challenge to identify … when women might need some additional support. Erm … but as a midwife, its part of the whole picture when you book a woman, in the community anyway. And I work predominately in the community. So you are looking for a background in mental health as well as their general health so …

Lacks confidence in identifying PNMH.

Is this referring to relationship and continuity of carer?

Essential part of the assessment is the history taking.

Standardise use of the universal PNMH Qu's.

JJ: Would you use any assessment tools?

MW: Well part of the booking is the support questions. They're about your history of mental health and then there's the four questions about current anxiety levels, current mood levels, current worries and that sort of thing. So there is that, erm that sort of a formal part of the booking. Depending upon her answers to those questions you might delve further into how well otherwise she is emotionally feeling and it may just be she's low in mood but not clinically depressed. Erm, she may just be anxious coz she's a new mum or what have you. Erm its trying to decide her answers to those four key questions are as to whether there's something going on and you need to look at anything any further.

Depending on disclosure?

Unsure of herself/lack confidence.

JJ: So do you think those questions are adequate in getting that information?

MW: Erm, [sighs heavily] no, clearly coz you're then left thinking well is this serious, isn't this serious. But what we have on the [redacted] system is a series of other

Not confident in the PNMH Qu's

1Key for coding: Yellow = semantic; Blue = facilitator; Green = barrier; Purple = latent code

Appendix 18: Manually organised table of quotes from TA of interview transcripts		
Theme	Subthemes	Example quotation and Participant ID
Identifying Need	Continuity of carer	*"I think it's down to continuity of carer and the quality of care because it can be very difficult to pick it up. You know, you need that length of time sometimes, to actually be with someone and see them rather than you going into a house, flying in and flying back out again".* (Midwife 4) ****** *"I think, continuity if it works and they roll it out as they say, that would be amazing to have a midwife antenatally, intrapartum and postnatally. So if there's any birth trauma or mental health issues from that then that midwife's going to know and will be able to follow it through, and not have to ask those difficult questions coz she'll have witnessed it*" (Midwife 13) ****** *"We are very, very good, and I've only recently realized how good, we are very good at continuity of carer antenally and postnatally. So although we haven't cracked the intrapartum bit, our continuity of care is very, very, good. And so it does mean that women are under a very small team of midwives so they tend to get to know their team of midwives..."* (Midwife 4) ****** *"We used to have a model where you would generally book your women that were going to be on your GP service care.... A lot has been taken away, so that there might be a midwife who is just a booking midwife for example. She books women from all sorts of areas during her day. So she doesn't necessarily have that link with women and I think that some of that* [continuity of carer] *has been lost. So you don't get to see, you know, your booking midwife might identify it* [PNMH problem] *but then actually you then wouldn't see them until they're 16 weeks pregnant, and that's quite some time after their booking appointment. So you've not developed that relationship with them initially"* (Midwife 10) ******

Identifying Need	Continuity of Carer	*"I talk and erm … its one of the reasons why continuity of carer is good* [to have] *as well"* (Midwife 16) ****** *"I'm all about the relationship. All about it… How on earth can you expect someone to come to you* [and say] *'I feel rubbish.. or this is happening to me' without building up that relationship I will never know. So that is the big thing for me and its very difficult for health visitors to pick these initial concerns up erm ...without that"* (Health Visitor 6) ****** *"..you've seen that woman for seven, eight months antenatally, and then a couple of weeks postnatally, so you can see how their mood is and how they deteriorate, how they feel emotionally or whether they feel like they are getting support, and the ladies who do need support"* (Midwife 12) ****** *"Continuity of midwife. So building up that relationship for a woman wishing to disclose [PNMH problems] or/and a midwife being able to observe any changes in that woman's behaviour. If she's not seeing her every antenatal appointment or through to postnatally, if it's a different midwife, they're not going to notice those subtle changes potentially"* (Midwife 13) ****** *"At the moment with these key contacts that we're allowed to do …. a lot of the time it's the nursery nurses that do the nine-month and two-year check. We're moving from this service and its so upsetting. We can do home visits but only if there's a need. But I think the people that have the need, are not going to come to clinic. We're not going to pick up all these cues at home or be able to open a conversation"* (Health Visitor 3) ******

Identifying Need	Continuity of Carer	*"..the 12 month check, that was the health visitor and I believe the nursery nurses are going to be allowed to do that now and the 2 years* [check], *the nursery nurses do that"* (Health Visitor 7) ****** *"I know people don't like change and we don't like the fact that we're not visiting, and it isn't because we don't like change, but you can see the difference in your practice. And I've not been qualified very long, erm, you know, but four years ago when I qualified, it was a completely different role to what I am doing now. You pick up more, you were able to contain people, whereby now you're not able to. I did a 6 week review last week and you know, mum was crying on me and there was just lots of stuff that I did not expect because I'd been in and done the one visit and we were ok, erm so yeah, it throws you, it really upsets you".* (Health Visitor 6) ****** *"…with the more significant MH issues, I think its got to help to see somebody that you know, somebody you can build a relationship up with. Erm, because those women who have issues with anxiety or even, you know, depression, they've got to feel that they can trust you in order to be honest and tell you exactly how they feel"* (Health Visitor 6) ****** *"*[lack of] *Continuity and relationships is one of the biggest bug bears that I hear talked about with my colleagues"* (Health Visitor 5) ****** *"…but by changing into big teams like that, things are going to get even more missed than they do now. I don't think the continuity is going to be as good" (Midwife 14)* ****** *"..obviously there's loads of changes going on with maternity services isn't there…" (Midwife 10)* ******

Identifying Need	Continuity of carer	*"I suppose now we don't really build up that rapport with the woman coz we don't see them so often, so it's difficult to get a true picture of what's going on and maybe for her to be open and honest with us erm, because we haven't got the rapport that we used to" (Health Visitor 7)* ****** *"And what I feel we're lacking is that we don't have those contacts anymore to really get to know them [the women] so that they feel they can tell us [about their PNMH problems]" (Health Visitor 2)* ****** *"I think health visiting needed tightening up a bit to make it more … to sort of turn it around. You know a lot of it is now is putting the responsibility on the parent. You know, now its been over twelve months [since the change in service delivery] I can see how that works...the model is very much based on women, you know people, taking responsibility for their own health and the health of their family, so you know, not relying solely on the health visitor to do everything to, you know, take responsibility. You know, come and see us if you have a problem, you've got our numbers, you've got our clinics, come and see us… erm … asking for help is a sign of strength. You know it's that sort of responsibility. And you know not sort of sitting around waiting for someone to come and knock on your door for a visit and telling them things. You know take responsibility..." (Health Visitor 8)*
	Disclosure	*"I'm a firm believer that clients tell you want they want you to hear, no matter how open* [you are]*, how 'You can tell me anything' you are, you are going to get those who feel that they can't say that to you* [disclose PNMH problems]. Health Visitor 4 ****** *"There are ones that will* [disclose PNMH problems]. *But there are just as many out there who never will* [disclose]*…."* (Health Visitor 2) ****** *"It's difficult sometimes to say how many* [women with PNMH problems] *I see because sometimes women don't tell you..."* (Midwife 6) ******

Identifying Need	Disclosure	*"..because those women who have issues with anxiety or even, you know, depression, they've got to feel that they can trust you in order to be honest and tell you exactly how they feel" (Health Visitor 6)* ****** *"So it all depends whether the lady is willing to tell you the information isn't it?"* (Midwife 5) ****** *"I think women are now able to disclose and discuss openly with someone they perhaps trust a little bit more..."* (Midwife 11) ****** *"I think there is, erm there is still a stigma attached to it [mental health problems]"* (Midwife 10) ****** *"I believe there's a huge stigma with mental health. Huge, huge, huge stigma…"* (Health Visitor 4) ****** *"..people thinking mental health is still something to be ashamed of. I'd say that's the biggest barrier"* (Health Visitor 8) ****** *"So how can we expect women to you know, disclose it* [PNMH problems]*, if you can't even talk about it and get supported by your own that you work with? And it's supposed to be a caring profession …if we can't recognise, sympathise within ourselves and our colleagues, how can we* [sympathise] *with the women?"* (Midwife 14) ****** "'Oh Lisa's off sick' '*What's she off sick with?'* 'Stress' *'What do you mean stress? Why's she stressed?'* *It's that attitude you know? But if you said she's broken her leg, they'd be like 'Oh my God'"* (Midwife 14) ******

Identifying Need	Disclosure	*"You know, even the midwives are quite happy to share their own experiences. Many of them have had babies and suffered with their mental health so that makes it more normal and allows them [the women] to talk about it" (Midwife 3)* ****** *"And sometimes its about normalizing how she feels as well. Especially for the mild ones. And sometimes I say, actually look at the bigger picture, take a step back and look at what's actually happening here. And just saying to them, there's absolutely nothing wrong in feeling like this, its ok to feel this way, and what you actually need is to speak to somebody, to talk to people, erm…" (Health Visitor 6)* ****** *"Everybody has some degree of mental health/emotional impact on becoming a parent so I would say to all the families that we see and all the mothers and sometimes the fathers as well ... actually getting them to understand their emotional health as well" (Health Visitor 4)* ****** *"Having a baby in those first six weeks with sleep deprivation and everything like that. I know I wouldn't do it again and I've got one child and I thought I was going mad! And sometimes actually just saying to families and saying to mothers, actually you're okay to say I'm not enjoying this, you're okay to love your child and actually look at the child and go "what have we done?". Okay, it's okay to look and often that takes the anxiety to have the health visitor go "It is hard work and it's okay to not feel great and to fake it until you can make it happen and all the rest of it". (Health Visitor 4)* ****** *"Other than saying you need to go and see your GP, I would refer on [to the GP] but I wouldn't be able to go any further than that" (Midwife 8)* ****** *"Erm so the computer system we use has a series of questions that we ask anyway when prompted. So in the last four weeks have you felt little interest in doing things, anxious, on edge or depressed or tearful. So we have those standard questions but then obviously its down to the individual midwife to deviate away from that and get a conversation going that's a bit more meaningful"* (Midwife 13) ******

Identifying need	Disclosure	"*We use a system* [electronic records], *which gives you prompts so you're asking the lady about how they're feeling, are they feeling depressed or feeling low or need help with their mood. So we're having those conversations with their daily checks so that starts conversations* [about mental health]..." (Midwife 3) ****** *"I'll challenge her and say well you know it isn't always easy to live with because I know, 'coz I've had anxiety and I've driven my family nuts* [laughs] *I do bring myself into it in that respect"* (Midwife 9) ****** *" ..so now because we talk about it more and its much more of a national agenda, I would say that most women* [are] *reporting some element of either historic mental health conditions or current or altered state of mood in pregnancy… because we're asking the question, women are giving us the answers"* (Midwife 11) ****** *"I know I feel that it is increasing* [PNMH problems]. *And whether it is actually increasing or whether women are just more comfortable in talking about it I couldn't tell you"* (Midwife 15) ****** *"I think its* [disclosure] *getting better and I think we all talk to them* [the women] *about mental health and certainly PND is discussed fully at discharge…"* (Midwife 3 ******) *"There's not enough emphasis on mental health. We're always going on about diet and exercise and whatever, but we're never saying you know, well actually if you're feeling like this there might be something emotionally that we might need to talk about it and see what we can do to help you"* (Midwife16) ****** *"We talk about the normal physiological changes in pregnancy; you talk about the sickness, the backache and constipation, those sort of things… And that's the trouble isn't it? People could go to the end of their pregnancy 'Oh nobody asked me* [about my mental health]*'"* (Midwife 14) ******

Identifying need	Disclosure	*"I still think there's a certain attachment of, because the big fear for women is, will they take my baby off me? … sometimes they think that goes hand in hand and the thing we do is contact social services…* [if a woman discloses PNMH problems]" (Midwife 10) ****** *"People don't want to admit to their friends and family and also some appear less likely to admit* [PNMH problems] *to professionals as well. Erm, through fear of failure. I think we live in a society where everything is so fast paced and so many demands on parents to be working and to be parents and keep going erm… and fear of you know, what the referral pathway is. You know, the classic 'Oh are my children going to be taken off me?"* (Midwife 13) ****** *"A lot of adults recently, in the last few weeks have sort of admitted to me that they think, I've been scared to ask for help coz you'll get social services involved or you'd think I couldn't cope"* (Health Visitor 8) ****** *"I think mothers still feel we're going to take their baby way, it's that old fashioned view … that they're not good enough mothers and the children will be removed. And we've got the power to do that"* (Health Visitor 7) ****** *"Well I think that the other thing that contributes to that* [the stigma] *is that they are in the perinatal period and there's that perception that women don't want to be viewed negatively. And people will still, I can I tell you this without a shadow of a doubt, women will still say things to me like, 'You're not going to take my baby away are you?'. So a significant proportion of women, still have that fear that their child will be removed. But for all the work that we've done to have those discussions about parity of esteem, all that kind of stuff, there is still that belief that health visitors and the health visiting service are associated with that"* (Health Visitor 5)
	Time	*"Time. Time is the biggest killer for us really. We're limited … we haven't got sufficient staff to cope … so I can't honestly say, I know hand on heart these women get enough time"* (Midwife 3) ******

Identifying need	Time	*"Lack of time is the biggest thing* [barrier to assessing PNMH]*"* (Health Visitor 1) ****** *"How busy the ward area is, that's a major, major thing. And I do sometimes feel that you probably can't spend as much time with these ladies as what you'd ideally like. Just because there isn't … enough staff anyway"* (Midwife 8) ****** *"I think its allowing midwives and other professionals to have more time to be with the woman, with the family, to do home visits, to be able to follow up and carry through erm, proper assessment and interviews. Erm, I think that would actually stop women from deteriorating. If they felt that they had that support at the ground level" (Midwife 12)* ****** *"We're quite lucky when they're inpatients because we've got a supportive midwife in post and … she sees them antenatally and she's in touch with them so there's some continuity for those ladies. And obviously if we're concerned on the ward we get [specialist MW] to come and see them before they get discharged. So it's quite good and better for us. And as you know working on a busy postnatal ward with 16, 17 discharges every day. Our time is quite limited with the ladies..." (Midwife 3)* ****** *"If it is that we were concerned about a lady postnatally, [specialist MW] normally does just antenatal, but she would see a lady if we are concerned…" (Midwife 5)* ****** *"Well the busy one [clinic] is 30 [women] and that's in quite an affluent area and they all want to discuss something or other. Generally between 25 and 30 [women attending] is an average clinic. And that's in an hour and a half". (Health Visitor 7)* ****** *We just don't have the capacity really [to do an antenatal contact]. I sometimes think we should have, but we don't. We prioritize them, in our office, where we prioritize, we do*

Identifying need	Time	*prioritize primips and child protection, then multips might get a telephone call if we've got lots of capacity". (Health Visitor 3)* ****** *"So definitely, like being able to get all the post-natal checks done and all the antenatal care side of things done, make sure all the scans and everything like that. Yeah it does, it probably ends up taking away from the other parts of the job. And I think the turn over is so quick as well. Yeah. See you kind of can't sit and do that [assess mental health], which is a shame". (Midwife 8)* ****** *"Yeah, without a doubt [PNMH gets missed]. Coz you've got … let's just say, a 28 weeker comes in. You have to start measuring her tummy, make sure they've got a growth chart printed off, erm 28 week bloods, you're talking to her about whooping cough, flu vaccine, are they well in themselves, you know the health check, DV you know, you're asking about all those things. And going through those things, sometimes I think it's just easy to ask those things and just actually not listen to what they are saying. Because you're too caught up because you know that after 30 minutes when that lady's gone, you've got another one coming in". (Midwife 13)* ****** *"So you're doing blood pressure, wee, telling them about whooping cough and everything else that goes with it. Talking about breastfeeding and talking about everything else in your few minutes. And most ladies that come into clinic are consultant care so they've got problems. They're not bog standard, normal 'OK. How are you feeling' 'Oh fine'. You don't get those 'oh fine' ladies. You get the ones you know… so I think in clinic there's not enough time in just a general clinic [to discuss mental health]" (Midwife 14)* ****** *"You can't assess someone's mental health in that time… Oh, bloods, weights, heights, histories, everything, previous children, any problems, any concerns, yeah it's just incredible ...screening..." (Midwife 12)*

Education, Skills and Experience	Targeting Resources	*"..our services are very stretched. We've got a lot less health visitors. We can't provide the service that we could historically … we try to target the ones that are most vulnerable". (Health Visitor 1)* ****** *"…a woman I saw not so long ago, I had a referral from the midwife to say that she'd actually been sectioned earlier in the year erm, so I did manage to do a targeted antenatal which is unusual". (Health Visitor 7)* ****** *"..if I'd identified somebody who perhaps at that time had answered* [positive] *to the marker questions but really said 'I don't really want all of the extra services and I feel like I just need to work through things', I would just offer additional antenatal appointments, contact the health visitor about getting early access to the health visitor. But again, you know, that's all, you know resources…"* Midwife 10 ****** *"Well I think the most important thing is the decline in the service as erm, the health visiting service and the service provided to women with poor perinatal mental health. We used to provide a very good service with the listening visits. The tools we used worked well and since we've stopped using the EPDS and using the universal* [questions] *we don't capture as many women. Erm and then … so just being able to refer on and you know, a lot of women we're missing and … which will then have a knock on effect with children's health as well".* (Health Visitor 7) ****** *"And like I said, there aren't the specialist services out there. We're supposed to be early intervention aren't we? [Laughs]. I don't feel as though ….. there's a huge gap here. You know and if, if a woman were to be sectioned or admitted to hospital these are unlikely to be here in the local area and unlikely to be with her baby" Health Visitor 3* *You know what support I can safely offer and I mean really, we just need to have better mental health services in…. well, in the world [laughs] but certainly in* [redacted]*. Health Visitor 3*
	Intuition and Confidence	*"But in fact I had one lady just recently, who gave birth to a Down's baby. She didn't know she was having a Down's baby, she'd split up with her partner during the pregnancy and came across as really coping but she was always wide eyed and I thought you know,*

Education, Skills and Experience	Intuition and confidence	*you're not coping, you're not coping! And one day I went there and she just cried the whole visit. And she'd answered no to the Whooley questions" (Health Visitor 2)* ****** *"Erm I think I'd have more confidence if I knew there was somewhere to refer to. I think I would have more confidence if I knew that when I put in that referral it would happen timely, it would be quickly and well-focused and well-managed but I think dealing with mental health is like trying to knit fog sometimes. It's tricky to get it right"*.(Midwife 15) ****** *"yeah I do* [feel confident]. *I do, but I think that's because I've been nursing a long time. And erm, I worked at* [MBU] *Unit and so had a lot of support there. And I get a lot of support from the specialist perinatal mental health - health visitor. I talk to her now and again coz sometimes I have students with me and she'll have them with her for the day. Erm I do feel confident really..."* (Health Visitor 7) ****** *"I will have a lot of conversations with mums* [in the hub] *in tears because of this, that and the other. And a lot of it is sleep deprivation or struggling to deal with other children, that kind of thing. And all of it is significant to that mum so it is really useful to have in that situation, some guidance really* [of supervision from specialist PNMH HV]" (Health Visitor 6) ****** *"Sometimes you just think in your stomach that something is not quite right".* (Midwife 3) ****** *"… its difficult to quantify but you get a feeling that somethings not quite right".* (Midwife 1) ****** *"…I think I rely on my common sense … its your gut feeling at the end of the day that prompts you into doing whatever you do* [referring]*".* (Health Visitor 6)

Education, Skills and Experience	Intuition and confidence	****** *"I've often got a sense that something isn't right but it's knowing the right way to open it up a little bit without opening Pandora's Box and leaving her in a miserable mess…"* (Health Visitor 3) ****** *"So you know, it helps you know, just talking, and your gut feeling and how you notice things like, I can remember as a student health visitor, and being in clinic and seeing a family and thinking, that family makes me feel really uncomfortable. Or seeing a mom and a baby's interaction and thinking that makes me feel stressed, what is going on there?"* (Health Visitor 1) ****** *"Erm I think confidence is a difficult one to assess because we've identified the lack of training, you always feel you could and should be doing more. But you don't know what the more is or what it looks like"* (Midwife 11) ****** *"… I suppose I feel as confident as I can do without the extra training. Well additional training would give me more competence without a doubt, buts that's like anything isn't it, you know. So with the skills I have I feel confident to know my referral pathways and who can support me."* (Midwife 3) ****** *"I think it's useful to have some more training and some more, sort of scenarios of training where you know, what's worked well and what hasn't worked well and you know, where these services work together, you know, case studies..."* (Midwife 10) ****** *"We don't get much training on PNMH. I think training would help you recognize it and to see what is available to you service wise and you know what you do with that information because half of the time it's all very good saying I'm a bit worried about it and you don't really know what you've got to do with it".* (Midwife 7)

Education, Skills and Experience	Intuition and confidence	****** *"But it is down to education. And there's not really any education out there is there?"* (Midwife 14) ****** *"I think managing people with PNMH is more useful* [training needs]. *At the moment all we have is signpost knowledge, we know where to signpost to but we probably don't have enough understanding of long term implications unless you've been through it yourself… I think what we really need is a focused study day around perinatal mental health that refocuses on all aspects, so it needs to be broader so we have a better understanding and how we can help the ladies. But without the resources it's very difficult isn't it?"* (Midwife 3) ****** *"Erm we do get a perinatal mental health and maternal mental health erm, sort of in-house training which is quite good as a one off thing. Yeah it's a one off thing. And I think the mental health thing is so, it's so massive… I do think that, erm I know this sounds ridiculous, but sort of like a module for health visitors completely based on mental health that would be sort of something that you would have to do once you qualified or something or be part of your training"* (Health Visitor 2) ****** *"It would be good if there was some sort of compulsory study day or interaction I think, to make mental health education within the profession more tangible and meaningful. I don't think its good enough using e-learning personally".* (Midwife 13) ****** *"I don't think its* [PNMH] *talked about enough … I don't think student midwives are that aware of just how common it is and how vigilant they actually need to be"* (Midwife 16) ******

Education, Skills and Experience	Intuition and confidence	*"… mandatory updates* [on PNMH] *but its limited. We would always look to* [specialist midwife] *for support because we haven't got the knowledge really. We've got basic knowledge and signs to look for her but apart from that, that's it".* (Midwife 3) ****** *"It's* [de-briefing] *so important. But you know carrying stuff in your head and writing*…" (Health Visitor 3) ****** *"..its not even training. Its much more of a peer support thing because other people do things in different ways and sometimes you think, that's brilliant you know … I think sometimes just having perhaps even like a peer support group about certain things where you could have discussions about certain, erm bring up certain cases".* (Health Visitor 2) ****** *"So we've got a perinatal mental health lead and I'd go to her* [for advice]*. She's really lovely and she's the one that does our supervision. So I'd definitely go to her. I'd also use my colleagues".* (Health Visitor 6) ****** *"Its always good to have updates. So extended knowledge. So maybe new research, new thoughts, new processes, that really. The extra bits"* (Health Visitor 7) ****** *"We can identify all we like, we can have all the education we like but in the end we haven't got anywhere to refer people to who have the expertise who can help them*" (Health Visitor 2)

Referral Pathway	Use of Tools	"*Erm, structured tools? No, I don't think that there are* [that the midwives use]*".* Midwife 11 ****** *"I know there used to be the Edinburgh scale didn't there for postnatal* [depression] *but I don't know of any antenatal one [tool]. I've not seen any"* (Midwife 14) ****** *"We just normally ask the questions about how they're feeling and normally just sort of, what we normally do in the routine postnatal checklist when we've just examined them, erm and its sort of just asking them how they're feeling or whether they feel like they're coping well, if they've got support."* (Midwife 8) ****** *"We use the universal PNMH scoring system"* (Health Visitor 7) ****** *"Yes so if it's someone that actually is very low, I will use the GAD or the PHQ".* (Health Visitor 2) ****** *"Erm, … well I ask the appropriate questions, the universal questions at the designated times, the universal times"* (Health Visitor 8) ****** *"We have our own Trust policy [for PNMH assessment tools] that's quite clear cut really. You know we have an antenatal and postnatal mental health policy that obviously follows the Trust format. It is evidenced based and erm … is based upon the NICE guidance. And the locally commissioned service"* (Health Visitor 5) ****** *" We ask them … using your universal PNMH tools"* (Health Visitor 6) ******

Referral Pathways	Use of Tools	*"the promotional guide is very much my tool* [I use for assessing PNMH]*"* (Health Visitor 1) ****** *"I might use the EPDS but the Edinburgh isn't really recognised anymore I think. I've used the GAD as well"* (Health Visitor 3) ****** *"So that is very much my tool* [promotional interviewing guide], *as it encompasses everything so there's that, and the Solihull [Approach], the Solihull is riddled through me, you know containment, reciprocity and behavior management, you know the reflective tool as well as a teaching tool. So those two would be my two underpinning things [tools] I use"* (Health Visitor 1) ****** *"The GAD and things like that, that I would use if I had got positive answers to the Whooley questions, what professionally I was of the opinion, there's something here, I would go a bit further and put the GAD in there and actually explore it a bit deeper"* (Health Visitor 4) ****** *"No I don't [think the universal questions are useful]. I feel giving the mother a bit of paper actually allows her to express how she's feeling…. the questions are quite general… the EPDS was more specific and we had a lot more positive results from that than we do from the universal* [questions]*"* (Health Visitor 7) ****** *"The other thing I use a lot when talking about tools, is the GAD and the PHQ… and I found that was really, really good in helping mums understand why they're feeling [anxious/low]"* (Health Visitor 1) ******

Referral pathways	Use of Tools	*"Yeah I would say the tools do help me make a decision and help the woman make a decision to be honest, and help her realise I'm not where I want to be"* (Health Visitor 8) ****** *"..I think, the universal PNMH questions would be more effective if we visited more because we would get to know the women"* (Health Visitor 6) ****** *"it's not just about asking those four questions, it's about how they* [the HVs] *set their stall out. So it's the conversation they have about mental health and well-being before they ever ask those questions. It's about being very clear about what it is you are asking….. For me, you know, the biggest component for that universal assessment is the discussion you have about mental health and well-being and it's about setting your stall out"* (Health Visitor 5) ****** *"Yeah. I'm not a fan of the Whooley questions at all. Is it something you'd like help with?'. No. Okay! [laughs] so no, I don't think across* [redacted] *they are used, they're not encouraged [to be used]"* Health Visitor 3 *"Well I wouldn't say I was a fan of a tool [laughs]. I suppose I would start, … I would bear in mind the tools that are out there and I would use a tool to help a woman understand her progress. There was a lady that I was visiting quite regularly and she, she thought she was, she was comparing herself to a lot of other people and thought that things were much, much worse and that I was much more concerned than I was. So I kind of used the tool to give her a score in her mind, and then we did it again six weeks later and there was progress but she straightaway was "oh okay this is okay for me". So I kind of used the tool in normalising her feelings. But I don't routinely use a tool" Health Visitor 3*
	Knowledge of Referral Pathways	*"… I'm sure there's a pathway. There used to be but you don't ever see it being* [used].." Midwife 14 ****** *"I think a more straightforward referral pathway would be better"* (Midwife 8)

Referral Pathways	Knowledge of referral pathways	****** *".. the trouble is, we are in a process of change at the moment and the guidelines need updating and they need to be easier to read..."* (Midwife 9) ****** *"..there needs to be a clear pathway of referral and follow up that's fed back to the midwife"* (Midwife12) ****** *"I just think the referral system could be a little bit more streamlined"* (Midwife 13) ****** *"I think … I think the main barriers are … erm … a difficult care pathway to negotiate"* (Midwife 15) ****** *"No I don't think I would* [use an assessment tool]…*we've got a very open and easy access to erm* [specialist MW] *and I can just ring her up and say, I've got this lady…."*. (Midwife 1)

Key: Blue = Area with PNMH services; Green = Area without PNMH services

Appendix 19: Questionnaire for midwives and health visitors taking part in Study 3

A questionnaire to help understand perinatal mental healthcare referral decisions among midwives and health visitors

Thank you very much for taking the time out of your busy day to complete this questionnaire. Your views and experience are very important to helping understand your role in perinatal mental health referral decisions.

Before you begin, here are some helpful tips to completing the questionnaire.

- To enter your answer just type or click in the space provided.
- Once you have entered your answer, simply scroll down to the next question.
- You can skip any questions you do not wish to answer by simply scrolling down to the next question.
- You can withdraw from the study by closing the browser page down without submitting your responses and your data will not be saved.
- When you have completed the last question, please select the blue 'Finish' button to submit all your answers.

This questionnaire is anonymous so please do not include your name or any other identifiable details.

1. I have read Participant Information Sheet version 2, Date 06/11/19 and agree to complete this questionnaire. *Required*

- Yes

Demographic information

2. Are you working as a:

- ○ Midwife
- ○ Health Visitor

2a. Are you based in:

- ○ Hospital
- ○ Community
- ○ Both

2b. What is the name of your employing Trust?

3. How long have you been working in your current role?

	years
0-5 years	☐
6-10 years	☐
11-15 years	☐
16-20 years	☐
21+ years	☐

3a. How long have you been a qualified professional in total (years)?

4. Do you have a mental health qualification?

☐ Yes ☐ No

4a. If yes, please specify.

Identifying Need

5. How much of a potential **barrier** do you consider the following **to you being able to identify** perinatal mental health needs of women in your care/on your caseload? Please rate your response using this scale from 1 (not a barrier at all) to 5 (a major barrier).

Please do not select more than 1 answer(s) per row.

	1 Not a barrier at all	2	3	4	5 A major barrier	Unsure/Not applicable
Reduced number of overall contacts with women	☐	☐	☐	☐	☐	☐
Lack of contacts with women in the home environment	☐	☐	☐	☐	☐	☐
Delegating contacts with women to other staff, e.g. Community Nursery Nurse, Maternity Support Worker, etc.	☐	☐	☐	☐	☐	☐
Having generic clinics, e.g. booking clinic, postnatal clinics, 6-8 week clinics, etc. instead of personally seeing women in your care/on your caseload	☐	☐	☐	☐	☐	☐
Physical health checks/tasks taking up contact time with women allowing little or no time to conduct a mental health assessment	☐	☐	☐	☐	☐	☐
Lack of confidence in your ability to identify key risk factors for women at high risk of developing perinatal mental difficulties	☐	☐	☐	☐	☐	☐
Lack of confidence in your ability to identify women who are experiencing perinatal mental health difficulties	☐	☐	☐	☐	☐	☐

5a. If there are other **barriers** to your ability to **identify** perinatal mental health difficulties, please specify here and please include any other comments you would like to make about the **barriers** to **identifying** women's perinatal mental health needs.

6. How important do you consider the following potential **facilitators** to **identifying** perinatal mental health needs in women in your care/on your caseload? Please rate your response using this scale from 1 (not at all important) to 5 (very important).

Please do not select more than 1 answer(s) per row.

	1 Not at all important	2	3	4	5 Very important	Unsure/Not applicable
Relying on your gut instinct/intuition to identify women who are experiencing perinatal mental health difficulties	☐	☐	☐	☐	☐	☐
Relying on your prior experience of perinatal mental health issues/difficulties/needs	☐	☐	☐	☐	☐	☐
Using an assessment tool to identify perinatal mental health difficulties	☐	☐	☐	☐	☐	☐

6a. If you think there are other **facilitators** to **identifying** perinatal mental health needs, please specify here and please include any other comments you would like to make about **facilitators** to **identifying** women's perinatal mental health needs.

7. How important do you consider each of the following potential **facilitators** to women **disclosing** perinatal mental health difficulties? Please rate your response using this scale from 1 (not at all important) to 5 (very important).

Please do not select more than 1 answer(s) per row.

	1 Not at all important	2	3	4	5 Very important	Unsure
A trusted relationship between the woman and midwife/health visitor	☐	☐	☐	☐	☐	☐
Midwife/health visitor routinely asking women about their mental health	☐	☐	☐	☐	☐	☐

7a. If you think there are other **facilitators** to women **disclosing** perinatal mental health difficulties please specify here and please include any other comments you would like to make about the **facilitators** to women **disclosing** perinatal mental health difficulties.

8. How much of a **barrier** do you consider the following are to women **disclosing** perinatal mental health difficulties? Please rate your response using this scale from 1 (not a barrier at all) to 5 (a major barrier).

Please do not select more than 1 answer(s) per row.

	1 Not a barrier at all	2	3	4	5 A major barrier	Unsure
Women fearing their child will be removed from them/their care	☐	☐	☐	☐	☐	☐
Perceived stigma associated with mental health difficulties	☐	☐	☐	☐	☐	☐

8a. If you think there are other **barriers** to women **disclosing** perinatal mental health difficulties please specify here, and please include any other comments you would like to make about the **barriers** to women **disclosing** perinatal mental health difficulties.

9. Previous research suggests that lack of time impacts on professionals' capacity to manage the mental health needs of women. Are there aspects of your job role/workload that you consider could be reduced to enable you to have more time to manage women's mental health needs?

☐ Yes ☐ No

9a. If yes, please specify here.

Education, Skills and Experience

10. Have you received training/education in **perinatal mental health** in the following contexts? Please tick all that apply. If you have not received training/education in perinatal mental health, go to Qu 11.

☐ During nurse training
☐ During midwifery training
☐ During health visitor training
☐ Self-directed learning
☐ In-service training by specialist midwife or health visitor in perinatal mental health
☐ In-service training by perinatal psychiatrist/other expert in perinatal mental health
☐ In-service training NOT by a specialist in perinatal mental health
☐ Stand-alone module at college/university
☐ Externally delivered training at your Trust
☐ Other

10a. If you selected Other, please specify.

11. Please rate your response to the following questions using the scale from 1 (not at all) to 5 (very well). **How well has the training/education in perinatal mental health...**

Please do not select more than 1 answer(s) per row.

	1 Not at all	2	3	4	5 Very well	Unsure/Not applicable
...equipped you to identify women who are experiencing perinatal mental health difficulties?	☐	☐	☐	☐	☐	☐
...equipped you to identify women who are at high risk of developing perinatal mental health difficulties?	☐	☐	☐	☐	☐	☐
...helped you with your decision-making about whether or not a woman requires referral to secondary mental health services?	☐	☐	☐	☐	☐	☐

11a. How **frequently** do you feel you need to receive **perinatal mental health training/education**? Please tick one option.

☐ As a one off training session
☐ Once a year
☐ Once every two years
☐ Perinatal mental health training/education not needed
☐ Other

11a.i. If you selected Other, please specify.

11a.ii. If you have any comments/suggestions about perinatal mental health training/education, please comment here.

Referral Pathway

12. Do you use a screening tool to assess a woman's perinatal mental health?

☐ Yes, always ☐ Yes, sometimes ☐ No, never

12a. If you answered Yes, always/Yes, sometimes, which tool(s) do you use? Please specify here.

12b. If you answered Yes, sometimes/No, never, what is/are the reason(s) why you **don't** always/ever use a tool to assess a woman's perinatal mental health?

13. How much of a potential **barrier** do you consider the following to **referring** women with perinatal mental health difficulties? Please rate your response using this scale from 1 (not a barrier at all) to 5 (a major barrier).

Please do not select more than 1 answer(s) per row.

	1 Not a barrier at all	2	3	4	5 A major barrier	Unsure/Not applicable
Lack of confidence in the results of a screening tool	☐	☐	☐	☐	☐	☐
Lack of time to use a screening tool	☐	☐	☐	☐	☐	☐
Lack of secondary care available for women who require referral	☐	☐	☐	☐	☐	☐
Lack of knowledge of referral pathway when referring women with moderately severe mental health difficulties e.g. moderate depressive illness or anxiety states	☐	☐	☐	☐	☐	☐
Lack of knowledge of referral pathway to refer women who are currently well but at high risk of becoming unwell e.g. 'Red Flags' such as women with previous history of postpartum psychosis/bipolar disorder	☐	☐	☐	☐	☐	☐
Lack of knowledge of referral pathway when referring women with severe mental ill-health who you suspect requires admission	☐	☐	☐	☐	☐	☐

13a. If you think there are other **barriers** to **referring** women with perinatal mental health needs please specify here and please include any other comments you would like to make regarding your decision to **refer** women with perinatal mental health needs.

14. If there are any other comments you wish to make regarding **perinatal mental health referral pathways**, please specify here.

Please click the blue 'Finish' button to submit your answers.

FINISH

You have now completed the questionnaire. Thank you very much for your help.

Appendix 20: UW and HRA amendment approval

HEALTH, LIFE & ENVIRONMENTAL SCIENCES RESEARCH ETHICS PANEL (CHLESREP)

AMENDMENT OUTCOME

12 November 2019

REP CODE: SH17180018-R

UNDERSTANDING PERINATAL MENTAL HEALTH CARE AND REFERRAL DECISIONS AMONG MIDWIVES' AND HEALTH VISITORS'

Dear Joanne

Thank you for your amendment submitted for ethical approval to the Health, Life & Environmental Sciences (CHLES REP) Research Ethics Panel on the 6 November 2019.

Your amendment application has been reviewed in accordance with the University of Worcester Ethics Policy and in compliance with the Standard Operating Procedures for ethical review.

The outcome of the review is that I am happy to grant the amendment to this project ethical approval to proceed.

Please note your research must be undertaken as set out in the approved documents for the approval to be valid. Please ensure you review your answers to the checklist on an ongoing basis and contact the Research Ethics Panel again if you intend to make any further amendments to the approved research.

Yours sincerely

KG-Smith

KATHERINE GORDON-SMITH, PhD
Chair – Health, Life and Environmental Sciences Research Ethics Panel ethics@worc.ac.uk

NHS
Health Research Authority

IRAS Project ID 235568. HRA Approval for the Amendment

Dear Mrs Johnson,

IRAS Project ID:	235568
Short Study Title:	Understanding perinatal mental health care referral decisions.
Amendment No./Sponsor Ref:	Amendment number 1
Amendment Date:	November 2019
Amendment Type:	Non Substantial Non-CTIMP

I am pleased to confirm **HRA and HCRW Approval** for the above referenced amendment.

You should implement this amendment at NHS organisations in England and Wales, in line with the conditions outlined in your categorisation email.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

Please contact [hra.amendments@nhs.net]hra.amendments@nhs.net for any queries relating to the assessment of this amendment.

Kind regards

Dr Ashley Totenhofer
Technical Assurance Officer/Interim Amendments Specialist
Health Research Authority
Ground Floor | Skipton House | 80 London Road | London | SE1 6LH
E.hra.amendments@nhs.net
W. www.hra.nhs.uk

Appendix 21: Invite email to MWs/HVs to participate in Study 3 including PIS
IRAS ID: 235568 Version 1: 06/11/19

School of Allied Health and Community
University of Worcester
Henwick Grove
Worcester
WR2 6AJ
joanne.johnson@worc.ac.uk

Understanding perinatal mental healthcare referral decisions among midwives and health visitors.

Dear Health Professional,

I am writing to invite you to participate in a research project which I am conducting for a PhD at the University of Worcester. Your Trust has agreed to participate in this research and as part of the research, I am inviting all midwives/health visitors from your Trust to take part.

This phase of the research will involve completion of an anonymous questionnaire. I am inviting you to complete a questionnaire (either online or hard copy) about perinatal mental healthcare referral decisions among midwives and health visitors. There is a web link to the online version of the questionnaire below, but if you prefer to complete a hard copy, I have attached an email copy for you to print off and complete. Please do not email the completed copy to me in order to protect your anonymity; instead, return it via the return box/envelope in your Trust. In addition, I may attend team meetings where I can hand out hard copy questionnaires for you to complete. The questionnaire should take no longer than 15 minutes to complete. Your valuable participation will contribute towards understanding the complexities faced by midwives and health visitors when deciding whether to refer women for perinatal mental healthcare. It is hoped the findings from this research will inform training needs and produce recommendations for practice and healthcare services resulting in improved care.

It is important that you understand why this research is being carried out, therefore at the end of this letter there is a Participant Information Sheet (PIS) which details the reasons why this research is being carried out, the potential benefits and what it will involve for you if you decide to participate. Please read the PIS and click/tick the statement: 'I have read Participant Information Sheet version 2, date 06/11/19 and agree to complete this questionnaire' at the start of the online/paper questionnaire.

Completion of the questionnaire is anonymous. Please click on the web link to begin the questionnaire https://ucw.onlinesurveys.ac.uk/questionnaire-for-midwives-healthvisitors The questionnaire closing date is **07/03/20** so please ensure you complete the questionnaire before/on this date. Thank you very much for giving your time to help with this research.
Yours faithfully,

Jo Johnson RN, RM, SCPHN HV, BSc (Hons), MSc, PhD Student

IRAS ID: 235568 Version 2. Date: 06/11/19

PARTICIPANT INFORMATION SHEET

Understanding perinatal mental healthcare referral decisions among midwives and health visitors.

Invitation

My name is Jo Johnson; I am a registered midwife and health visitor currently undertaking a PhD in the School of Allied Health and Community at the University of Worcester. I would like to invite you to take part in a research project which involves completing an anonymous questionnaire. Before you decide whether to take part, it is important that you understand why the research is being carried out and what it will involve for you. Please take time to read this document carefully, and contact me if you have any questions on 01905 542328 or email: joanne.johnson@worc.ac.uk

Purpose of the study

The aim of this study is to understand perinatal mental healthcare referral decisions among midwives and health visitors.

Who is funding the research?

This research is co-funded by Midlands Partnership NHS Foundation Trust and the University of Worcester.

Why have I been invited to take part?

You have received this invitation because you are a practising midwife/health visitor working in a Trust that has agreed to take part in this research.

What will happen if I agree to take part?

If you agree to take part you will be asked to complete an anonymous questionnaire (either printed or electronic-online). The questionnaire consists of 14 questions and will take you approximately 15 minutes to complete. The questionnaire includes some questions about your role and training and questions about your opinions and experiences of deciding whether or not to refer women for secondary perinatal mental health care. It consists of mainly tick box questions and some optional open questions to allow you to write/type more detail about your answer if you wish. Please ensure you only complete **one** version of the questionnaire. If you wish to complete the electronic questionnaire, you will have received a short email inviting you to take part in the research that includes a link to complete the electronic (online) version of the questionnaire. Printed questionnaires are attached to the short invite email for you to print off and complete if you wish. If you complete a printed questionnaire, it should be

placed into the collection box/envelope at your place of work. The questionnaires will then be sent to me at University of Worcester. Please do not write your name or any other identifiable information on the questionnaire, and please do not email your completed questionnaire to me, because it is important that completion is anonymous.

Do I have to take part?

No. Your decision to take part in this research is entirely voluntary. If you decide to take part then the data you submit will be anonymous so once submitted you cannot remove your data from the study. If you do decide to take part you will be asked to agree to the statement: "I have read and understood Participant Information Sheet version 2, Date 06/11/19 and agree to complete this questionnaire". By completing the questionnaire you are providing consent for the data you have given to be used in the study.

What are the benefits for me of taking part?

While there are no direct benefits to you of taking part, it is hoped the possible benefits of this research will be to gain an understanding of the complexities faced by midwives and health visitors when deciding whether or not to refer women for secondary perinatal mental health care. It is hoped that the findings from this research will inform training needs and produce recommendations for practice and healthcare services resulting in the potential to improve perinatal mental health care.

Are there any risks for me if I take part?

There are no risks anticipated in taking part in this research.

What will you do with my information?

The results of this study will be presented in the form of a PhD thesis which should be completed by no later than January 2021. I may submit all or part of this research for publication to academic and/or professional journals and present this research at conferences. During the project, all data will be kept securely in line with the University's Policy for the Effective Management of Research Data and its Information Security Policy. Electronic data will be stored on the University of Worcester secure sever. Data from printed questionnaires will be stored at the University of Worcester in a locked cabinet in a restricted-access office. The data will be accessible to my Director of Studies, Professor Lisa Jones, in addition to me.

How long will you keep my data for?

At the completion of the project, your data will be retained in the anonymised form that it was collected for 10 years, after which all data relating to the project will be destroyed.

If you have any questions or would like further information, please contact me: Jo Johnson on 01905 542328 or email: joanne.johnson@worc.ac.uk If you have any concerns about the project you may contact me using my contact details above or my Director of Studies, Professor Lisa Jones email: lisa.jones@worc.ac.uk

Who has oversight of the research?

The research has been approved by the Research Ethics Panel for the College of Health, Life & Environmental Sciences in line with the University's Research Ethics Policy (ref SH17180018-R) and the NHS Health Research Authority (ref 235568).The University of Worcester is registered with the Information Commissioner's Office and the Data Protection Officer is Helen Johnstone (infoassurance@worc.ac.uk). For more on the University of Worcester's approach to Information Assurance and Security visit: https://www.worcester.ac.uk/informationassurance/index.html

If you would like to speak to an independent person who is not a member of the research team, please contact Michelle Jellis at the University of Worcester, using the following details:

Michelle Jellis
Secretary to Research Ethics Panel for College of Health, Life and Environmental Sciences
University of Worcester
Henwick Grove
Worcester WR2 6AJ
ethics@worc.ac.uk

Thank you for taking the time to read this information

Appendix 22: Hardcopy version of consent statement for questionnaire
Questionnaire for midwives and health visitors Version 1, Date: 06/11/19

A questionnaire to help understand perinatal mental healthcare referral decisions among midwives and health visitors

Thank you very much for taking the time out of your busy day to complete this questionnaire. Your views and experience are very important to helping understand your role in perinatal mental health referral decisions.

Before you begin, here are some helpful tips to completing the questionnaire.

- To enter your answer just write or tick in the space provided.
- You can skip any questions you do not wish to answer.
- Once completed, please place the questionnaire in the return box/envelope provided.

This questionnaire is anonymous so please do not include your name or any other identifiable details.

1. I have read Participant Information Sheet version 2, Date 06/11/19 and agree to complete this questionnaire. * *Required*

- ○ Yes

NHS
Midlands Partnership
NHS Foundation Trust
A Keele University Teaching Trust

University of Worcester

Appendix 23: Poster for Study 3

Understanding perinatal mental healthcare referral decisions among midwives and health visitors

Research

- **Do you want to share your opinions and experiences of referring women with perinatal mental health problems?**
- **Are you a midwife / health visitor?**
- **Can you spare 15 minutes to complete an anonymous questionnaire?**

If so, please take a paper copy below. Once completed, place in the envelope provided. Please DO NOT put your name or other identifiable details on the questionnaire.

Questionnaire closing date: 7th March 2020

For further information about this research, please contact Jo Johnson, the researcher: joanne.johnson@worc.ac.uk

Your participation in this research is very much appreciated.
Thank you!

Thank you

Appendix 24: Reminder invitation letter

University of Worcester
Institute of Health and Society
Henwick Grove
Worcester
WR2 6AJ
joanne.johnson@worc.ac.uk

Reminder – Understanding perinatal mental health care referral decisions among midwives and health visitors.

Dear Health Professional,

Two weeks ago you received an e-mail inviting you to participate in the above research. If you have already completed and returned the questionnaire, please accept my thanks and delete this e-mail as no further involvement is required. **If you have not completed the questionnaire I would be very grateful if you would consider participating in this research.**

I am inviting you to complete a questionnaire (either hard copy or online) about perinatal mental healthcare referral decisions among midwives and health visitors (please see web link below). If you need a copy of the questionnaire, I have attached an email copy for you to print off and complete. Please do not email the completed copy to me in order to protect your anonymity; instead, return it via the return box/envelope in your Trust. The questionnaire should take no longer than 15 minutes to complete. Your valuable participation will contribute towards understanding the complexities faced by midwives and health visitors when referring women who have perinatal mental health problems. It is hoped the findings from this research will inform training needs and produce recommendations for practice and healthcare services resulting in improved care.

Completion of the questionnaire is anonymous. Please click on the web link to begin the questionnaire

https://ucw.onlinesurveys.ac.uk/questionnaire-for-midwives-healthvisitors

The questionnaire **closing date is 07/03/20** so please ensure you complete the questionnaire before/on this date. Thank you very much for giving your time to help with this research.

Yours faithfully,

Jo Johnson RN, RM, SCPHN HV, BSc (Hons), MSc
PhD Student

Appendix 25: Open text comments from questionnaire

Question	Participant ID by profession/Area	Open Text Box Quote
5h (Other barriers to identifying PNMH difficulties)	HV1	I work in a small rural town where I am predominately the main HV so it is easy to develop and sustain my relationships with mum, even in a clinic environment. This is not so easy for my colleagues working in the city who are likely to score higher for barriers.
	HV1	Stigma of mental health and women not disclosing their challenges.
	HV1	We have flexibility to follow women up on our caseload and flexibility in clinics e.g. I can see a lady for emotional support in my 6 week/antenatal clinic. More contacts can increase the likelihood of disclosure of poor mental health.
	MW1	Language barrier.
	HV2	England has the lowest number of home visits in the UK. We need to see women in their home environment to build a trusting relationship. England = 5 core contacts. Wales = 8 core contacts and Scotland = 11 core contacts.
	MW1	Needing 2 or 3 contacts with the same person to have a good level of conversation.
	HV2	Reduced contacts with women that have resulted in reduced ability to develop familiarity, confidence and trust for women with their HV, which I feel has a negative impact on developing therapeutic relationships with them and had detracted from an opportunity to even identify that need in increasing cases now.
	MW1	Workload, staffing, time, lack of continuity.
	MW1	Where and who to refer to at what point.
	MW1	Being able to ask the right questions so women are more likely to open up to you. Not booking your own women.
	MW1	I do not have a clinical role.
	MW1	Lack of time spent with women (NB. I'm a delivery suite co-ordinator).
	MW1	Working as a hospital based MW, I feel time constraints are our biggest barrier, having time to spend with women to talk to them about how they are feeling.
	HV2	The dilution of HV's role due to HV jobs being replaced by Nursery Nurses.
	HV2	Lack of time to spend with clients, build a relationship and support them.
	HV2	Less contacts.

	HV2	The times we routinely see families, especially at 6 weeks as GP see them at that time as well and then nothing mandated until 9-12 months. I think a contact around 4-5 months to discuss solids and MH would be much better and definitely more valuable than at 6-8 weeks.
	HV2	Reduced contacts is the biggest factor. I personally feel confident in identifying MH issues in the PN period but as newly qualifies HVs have less contact with new mums this may become an issue for them.
	MW2	Not enough time at each contact with women due to heavy workload.
	MW1	Partners – if they make it difficult for women to discuss/disclose how they are feeling or speak on behalf of the women.
	MW1	Lack of continuity of carer currently.
6d (Other facilitators to identifying PNMH difficulties)	MW1	Having the confidence and skills to ask the right questions.
	HV1	Asking appropriate questions during discussion which give you a picture of what life is like for this mum.
	HV1	Family circumstances including their relationship with their partner+ support networks can impact a lot on clients. This includes partners mental health.
	MW1	Continuity of caseloads and care. Specialist midwives to be the key link for women with perinatal MH needs.
	HV1	Having more contacts at home rather than clinic.
	HV1	• Good communication and discharge planning with midwifery colleagues. • Good communication and discharge planning with GP colleagues. • Awareness of family history through familiarity of caseload. • Being known as a service to wider population e.g. Ensuring partners are aware of HVs role in supporting them & their families in this circumstance. • Clarity regarding perinatal services and referral processes.
	MW1	Speaking to family members of the woman.
	HV1	Developing a respectful relationship, continuity of carer.
	MW1	Access to our specialist MW for advice. Good team (multidisciplinary) communication and advice. Labour ward link MW liaising with specialist MW.

	MW2	Communication, time, relationships.
	MW1	continuity of carer - identify changes in mood.
	MW1	PNMH available for the trust up from 2yrs of age
	MW1	Parents and relatives
	HV2	Continuity of HV, same person building relationship and trust.
	HV2	Considering the woman's general appearance, engagement in conversation, interaction with her baby and the state of the home environment.
	HV2	Antenatal contact facilitates relationship building.
	HV2	A/N contacts and liaison with CMW's are essential as these can highlight any history and enable early identification and support.
	MW2	Contact with partners and family members.
	MW2	Need to use all 3 in conjunction with each other.
	MW2	Knowledge of womens previous mental health history. Other issues going on for that woman at the time.
	MW2	Open, honest discussion between a woman and a known, trusted midwife is essential along with transparent MDT working.
	MW2	Knowledge of personal issues which may predispose women to suffering a MH issue.
	HV2	Sharing of information from GPs - we do not always receive a full history from the GPs, and the women/clients are sometimes reluctant to disclose a history of depression/self-harm, etc.
7c (Other facilitators to women disclosing PNMH difficulties)	HV1	Women having prior knowledge of the possibility of a change to emotional wellbeing and feeling confident to talk about it.
	HV1	The woman feeling like the HV is interested in her emotional wellbeing and has time to listen/wants to listen.
	HV1	environment, preparing women to be asked about PNMH.
	HV1	Consistency of HV increases identification of mental health needs.
	MW2	Midwife being able to offer real help not just referral
	HV1	• A safe, confidential environment. • Ready access to professionals. • Familiar professionals. • Open, effective and clear communication between practitioners and client with clear outcomes. • Need to encourage women to disclose, so they feel safe and not judged. • SG concerns following disclosure
	MW1	Continuity

	MW1	Confidential and private space to have the discussions without other family members present.
	MW1	One midwife providing majority of care to build a strong relationship.
	MW1	Continuity of carer to be able to detect any changes in the woman.
	MW2	Time. Knowledge. Midwifes attitude on MH.
	MW1	Fear of repercussions so women may not answer questions accurately/honestly.
	MW1	Number of opportunities available to the woman e.g. number of appointments with health professional.
	MW1	Making it the norm to discuss feelings and emotions and valuing positive mental health equally to physical.
	MW2	Environment – home.
	MW2	Continuity of carer.
	HV2	Routine questions don't always illicit honest response.
	HV2	Some women even when asked won't disclose.
	MW2	If asking at every visit it becomes a tick box. If you mean it as you notice something about a lady, they are more likely to disclose.
	MW2	Supporting information.
	MW2	One on one discussion with MW or other HCP so that the woman can express her feelings without worrying about upsetting family members.
	MW1	More they are asked the more it is normalised.
8c (Other barriers to women disclosing PNMH difficulties)	HV1	Time to build relationships and establish trust is key. Definitely there remains a huge stigma surrounding mental health and the fear that children are easily removed from parental care
	HV1	I think that if the HV speaks about the first question when discussing PND, etc antenatally, and that we don't remove children and just want to provide support for the mum to get better then it would remove that fear.
	MW1	Past experiences of working with professionals. Misleading information given to the women by other women.
	HV1	Opinion of partner and friends and family. GP assessment and time allowed at 6 week check. I have asked a couple of ladies to return to the GP or I have followed up GP assessment with the client and referred on. Clients state they

		sometimes feel not listened to or not allowed time by other professionals.
	MW1	Not enough time during apt times for women to speak freely about MH and feel comfortable to do this.
	MW1	How far they have managed to have conversations with significant others about their mental health and the fact they are pregnant again.
	HV1	May fear it will have a long term effect on their personal relationships. May fear it will have a long term effect on career prospects.
	MW1	Thinking that women do not want to 'waste' any time of HCP
	MW1	Women may feel it is not in the MWs role to deal with MH. May feel low mood is normal/expected in pregnancy.
	MW1	Partners and family members present at appointment. Time allocated for appointments. Environment and appointments.
	MW1	Relationship with midwife. Always seeing different MWs therefore not building a trusting relationship with a MW.
	MW1	Relationship with MW Family influences Cultural stigma
	HV1	Partners of non-English speaking women often do not disclose issues.
	MW2	Midwife attitude, knowledge, empowerment. Lack of family support.
	MW1	Fear of being labelled a failure.
	MW1	Busy appointments - lack of time.
	MW1	Mental health problems are less often stigmatised, I feel they fear separation from their children more often than the associated stigma.
	MW2	I think these pre-conceived ideas about mental health are improving but there remains the notion that woman are frowned upon for not coping/admitting to feeling mentally unwell.
	MW1	Lack of contact and continuity with the same health professional.
	MW1	Making it the norm to discuss feelings and emotions and valuing positive mental health equally to physical.
	MW1	Fear of being perceived as a bad mother for not having bonded with their baby.
	MW2	Stigma. Fear of family/friends judging.

	HV2	Stigma is massive, ladies always say sorry or it takes me asking 3-4 times before they will open up and be honest and I think that comes from knowing your case load and families.
	MW2	Fear of being judged.
	MW2	They think an element of “baby blues” is normal and therefore don’t always think there’s anything abnormal.
	MW2	The professional giving woman permission
	MW2	Especially in strengthening family role.
	MW2	Worried what family and friends will say.
	MW2	Lack of continuity. Seeing different MWs at every appointment.
	MW2	Trying to have discussions with women on their own without partners/family members present.
	MW2	Lack of continuity of carer. Feeling like they don't know the MW well enough to be honest.
	MW2	Attending with family members.
	HV2	There is a stigma and fear, but it is easily dispelled if you talk to a woman about her MH or children’s services.
	HV2	Lack of information about treatment option. Women think of medication before talking therapy
	MW2	With limited training it is difficult to address mental health difficulties - worries about appropriate response, concerns about length of time before qualified mental health professionals can assess
9b (Aspects of job role that could be reduced)	MW2	But it’s the same for all women, different needs for each woman. Never enough time.
	HV1	Routine assessments on Emis - often duplicating information but time consuming
	HV1	Simple admin duties which can be delegated to other staff.
	HV1	Admin time. Computer systems not functioning quickly and effectively
	HV1	Numbers of caseloads can have an impact on planning diary.
	HV1	IT issues/connectivity problems.
	MW1	Documentation which is predominantly facilitated using a desktop computer means Midwives spend more time at a computer than they do with women.
	MW1	Repeat referrals for health when clients have been discharged. Paperwork for referrals repetitive. Data collecting takes up a lot of time.

	MW1	The referral process is paper based and while I appreciate that the information is required for lots of different reasons there needs to be an easier way of initially referring.
	MW1	Support with admin.
	HV2	A better/more joined up working relationship with midwives and GP's and more community resources to signpost women to.
	MW1	Poor staffing levels in hospital and in the community lead to lack of time spent with the ladies, gaining their confidence and building a relationship with them.
	HV1	More staff are needed & investment back into the service; government led.
	MW1	Teamwork Addressing staff issues
	MW1	Documentation, in this trust there is often duplication/triplication of documentation when more time could be spent building rapport with women.
	MW1	Help with admin tasks.
	MW1	Not my workload but continuity of carer would help.
	MW1	Office work and meetings!
	MW1	Paperwork Complicated computer systems
	MW1	Admin tasks that could be done by different groups
	MW1	More efficient IT system.
	MW1	Documentation, especially repetitive documentation
	MW2	I don't feel any aspect of my role could be reduced as every aspect is equally important however if there were more midwives available then the workload as a whole could be reduced for individual midwives allowing them more time to spend with the women they are caring for.
	MW2	Repetition in paperwork.
	HV2	Less repetition in paperwork.
	HV2	I feel the antenatal contact for Health Visitors should be stopped as the midwife is involved and our time could be better used by reinstating the 3-4 month contact as this would allow us to identify more women with mental health needs that may develop after the 6 week review. I feel not seeing women after 6 weeks until their baby is 9-12 months is too long and prevents us from building those trusting relationships and does not make us accessible to clients

	HV2	Paper/computer work
	HV2	Less time on the computer
	MW2	Post-natal ward is task heavy and limited time available to talk and build relationships. Need more midwives on shift to reduce heavy workload.
	HV2	Amount of paperwork.
	HV2	Limited time in appointments.
	MW2	Documentation, duplicates, being able to spend more time with women.
	MW2	Paperwork, staff shortages, lack of continuity.
	HV1	Being able to book own appointments and be more efficient rather than booked by the hub.
	HV2	Increased admin support to input and/or register mums and babies on our new EMIS system would be more cost effective than HVs doing it - this would allow more time with clients.
	MW2	Increased staffing.
	MW2	Having admin help.
	MW1	Unnecessary referrals to ANC for USS due to lack of C of C in the community.
	MW1	Unnecessary scan reviews sent by CMWs that wouldn't happen if women had continuity of carer.
	MW1	I am a specialist MW and I receive inappropriate referrals that could be dealt with by GPs or CMW for low level problems. None of our electronic systems are compatible with each dept. e.g. hospital uses different system to the GP, or PBDU, etc.
	HV2	Duplicating documentation - although this is an important part of the role.
	MW2	Smaller caseloads. Easier referral processes. More allocated time, improved training.
10b (Other contexts where PNMH training received)	HV2	Minimal training surrounding maternal mental health - My feeling is that there should be on-going learning opportunities in-house
	MW1	Discussion with mental health workers.
	HV2	During baby massage and baby yoga course. Enriched knowledge on supporting women in a nurturing way.
	MW1	e-learning General MH training not directly related to pregnancy.
	MW1	Visited a specialist PNMH midwifery service in a different trust.
	MW1	Church sermon on MH issues.
	HV2	Discussing issues with the perinatal team also helps, I have learnt so much from them.

	MW2	In 1996, 2000, 2011, 2019!
	MW1	I attended a learning event organised by HIPP organic with a talk about paternal perinatal mental health.
	MW1	Did module at on PNMH own cost and now I'm in specialist role I get funded for MH training. Currently doing birth trauma resolution training.
11e (Other options for frequency of training)	HV1	A initial training session followed by an annual update/refresher would be beneficial.
	MW2	One off then ad hoc sessions when new findings research interesting cases etc to learn from.
	HV1	Although there are supervision sessions to drop into, I would find it useful if a refresher was offered - either face-to-face or online.
	MW1	If referral process/guidelines etc change then training needed ASAP.
11f (Suggestions for PNMH training)	HV1	Clinical staff would benefit from mandatory training and updates.
	HV2	The issue of training regarding mental health is raised at SDRs but availability has been lacking
	MW1	Updates required with regards to current research. If interest is shown - practitioners to be able to become Champions – e.g. - Train the Trainer.
	MW1	An update regarding the referral process for acute services to use would be a beneficial update.
	MW2	We have just had a service for severe mental health provided, but there are so many women who are moderate in their needs and there is nothing to offer.
	MW1	e-learning General MH training not directly related to pregnancy.
	MW1	More information or who, when and where we need to contact.
	MW1	Need a full day per year - at least.
	MW1	Appropriate training for caring for women with various mental health illnesses.
	MW1	Feel it should be all staff as often women, when in-patient develop/have contact with women and may show how they feel with them rather than midwives/obstetricians.
	MW1	Online training would be useful.
	HV2	Experience and clinical supervision around mental health issues vital... networking also important and regular training and sharing of real life cases.

	HV2	In house training from my employers perinatal mental health team would be useful to establish referral criteria.
	HV2	It would be beneficial for HV's to receive specific training from the perinatal team.
	MW2	Current training insufficient, this year was the first update I have received in over 10 years. I use my years of experience when dealing with mental health issues and when deciding who to refer.
	MW1	I think it's important for all HCP to be trained in mental health.
	MW1	It's essential and helps identify their own needs. Needs to be an everyday part of care package we offer. Training increases confidence. Needs communication training too around having difficult conversations and around risk.
	MW2	Sometimes being a MW, you can feel like a 'jack of all trades' - it is very frustrating when someone you have referred sees a MH professional and a letter comes back stating how important it is that this lady needs more time with their midwife or extra appointments - we have a 15 minute allocated slot.
12b (What screening tool do you use?)	HV1	PHQ-9 or GAD-7
	MW2	[redacted] questions generic antenatal questions.
	HV2	Let's Talk assessment paperwork.
	HV1	PHQ-9 and GAD
	HV1	PHQ-9, GAD-7, EPDS
	MW1	No answer despite indicating Yes, always.
	HV1	GAD-7, PHQ
	HV1	Universal perinatal mental health questions and depending on answers will lead to use of GAD7 & PHQ9.
	MW1	No answer despite indicating Yes, sometimes.
	HV1	GAD-7 and PHQ-9.
	HV1	HADS, PHQ-9, GAD
	HV1	GAD7, PHQ9
	HV1	PHQ 9 and GAD 7 universal depression and anxiety identification questions.
	HV1	Whooley questions, GAD, PHQ-7, Perinatal Mental Health referral form screening.
	HV1	PHQ9 and GAD7 and depression and anxiety identification questions.
	HV1	NICE marker questions.
	HV1	PHQ9, GAD7
	HV2	Whooley questions. Promotional questions Antenatal and postnatal PHQ9 & GAD 7

	MW2	Previously Edinburgh score, or mood gym questions. access to tool not always possible due to electronic notes and better to have a printed copy whilst talking.
	HV1	Whooley and GAD-7
	MW1	Whooley
	HV1	PHQ, GAD and Whooley
	MW1	Guidelines for PNMH
	MW1	Whooley questions and if needed, EDPS
	MW1	Whooley questions
	MW1	GAD
	MW1	Use our assessment, GAD screen and record on electronic records.
	MW1	Hospital guideline Referral form
	MW1	Mood marker questions on [redacted]
	MW1	Whooley questions Medway
	MW1	Whooley questions, not a full assessment
	MW1	Marker questions
	MW1	GAD
	MW1	EPDS and Whooley
	MW2	Universal and EPDS
	HV2	Whooley and EPDS
	HV2	EPDS and Whooley
	HV2	Edinburgh postnatal depression score used following positive answers to Whooley questions
	HV2	Whooley
	HV2	We use the Whooley questions or EPDS tool, but I find my gut instinct is usually there first
	MW2	WQ, EPDS
	HV2	WQ, EPDS
	MW2	Inside green ante natal handheld notes.
	MW2	Maternity information systems.
	HV1	GAD7 and PHQ9
	MW2	We ask at booking and again at 36 weeks on maternity notes system.
	MW1	As per policy guidelines.
	HV2	GAD
	HV2	Universal tool, GAD7 and PHQ9.
	HV2	GAD7, PHQ9.
	HV2	Universal PNMH questions, GAD7, PHQ9.
	HV2	Universal PNMH questions then GAD7 and PHQ9.
	MW2	Whooley Questions.
	HV2	Whooley Questions, GAD7, PHQ9.
	MW2	Whooley Questions.

	MW2	Universal perinatal mental health assessment tool GAD
	MW2	GAD
	MW1	PHQ9, GAD7. Sometimes you ask these questions without actually following the tool.
	MW2	As part of the booking history on the electronic patient maternity records.
	MW1	GAD and PHQ then depending on answers leads to a comprehensive assessment.
	MW2	Questions on electronic records.
	MW2	GAD 7 and [redacted] tool.
	MW2	If a lady answers yes to the booking questions then we have a series of questions to ask them.
12c (Why don't you use a screening tool?)	HV1	I have had no training in using an appropriate tool.
	HV1	Very prescriptive. Sometimes ask similar questions within our conversation.
	HV1	I don't always feel the need to use the tools.
	MW1	Not available
	HV1	We have not been advised to use it routinely with women.
	HV1	Only on 1 occasion where it was evident the women was so distressed and threats of harm to herself and baby, I felt it inappropriate to ask her to fill in an assessment tool. Referral to appropriate agencies sent without the tool.
	MW1	To my knowledge there is not a tool available.
	HV1	Language barrier.
	MW1	Have not been required to assess a woman's perinatal mental health as a delivery suite midwife.
	MW1	Not always having guideline with template to hand in home setting.
	MW1	Not always applicable to situation or symptoms presented. Not always appropriate as some women may not respond well or be truthful using regimented questions.
	MW1	I do not screen for PNMH in my current role.
	MW1	Manager so not in current role.
	MW1	Not in my role.
	MW1	Depends on situation.
	MW1	Not in clinical role.
	MW1	Not mandatory to ask. Not always appropriate / no time.
	MW1	It is not a mandatory piece of data on our computer system.

	MW2	As far as I'm aware we don't have a screening tool.
	HV2	I feel these assessments can sometimes hinder relationship building and the general flow of the conversation so feel open questions are sometimes better.
	MW2	There's not one that I'm aware of.
	MW2	There isn't a tool.
	MW2	Don't know of one.
	MW2	Don't know what we have in way of a tool.
	MW2	Confidence in using tools.
	HV2	Depends on situation.
	MW2	Don't have access to one.
	MW2	Didn't know we had one.
	HV2	Professional judgement made over course of visits/contacts via promotional interviewing - if no history of mental health and if no evidence from face-to-face discussion then I would not routinely use a tool.
	MW2	Unsure whether I should – unclear guidance from employer.
	MW1	We refer directly to our specialist perinatal mental health team.
	MW1	Limited value - not personalised. Shouldn't detract from the clinical judgement.
	MW2	Don't know any.
	MW2	Don't tend to use tool in the work environments.
	MW2	I work on delivery suite therefore have never needed a screening tool.
13g (Other barriers to referring women with PNMH difficulties) 25	HV2	Women presenting later with problems can be seen by Psychiatric services but then become ineligible for therapy which is contrary to NICE guidance.
	HV1	Changes in services and meeting their thresholds.
	HV1	Assessment vitally important - role to identify and refer with relevant information (gain consent from women) - Specialist service may not be agreed.
	HV1	I often speak to the PNMHS team or crisis team for advice.
	MW1	No specific mental health midwife (although we do have a normal midwife for vulnerable women)
	MW1	Capacity issues. How women need to fulfil certain criteria to be able to access PNMH - I feel some women need 'low level' support - not available.
	MW1	Partner knowledge / attitudes of family. Lack of referral pathways. Highly experienced and qualified staff.

	MW1	Not having the PNMH team based in the department is a barrier which could help improve things if they were. Lack of time.
	MW1	Lack of specific support. X1 MBU with limited spaces.
	HV2	Being taken seriously by GP's always act as advocate for women with mental health issues, send copy to GP speak to them before appointment etc.
	HV2	Many referrals rejected.
	HV2	They have to self-refer and there is a big wait.
	MW2	There are strict guidelines regarding who we can and can't refer. Feels like women have to be really poorly to get referral accepted.
	MW2	We need training for ALL MWs and more services for women with low level PNMH problems. We need a specialist MW in PNMH.
	MW2	The new PNMH team is really good to have. There's a lack of knowledge in PNMH.
	HV1	It's good we are talking about it and its being researched.
	MW2	There's not enough services for women. The pathways need to be clearer.
	HV2	There's no service for bereaved parents.
	HV2	We need more services here.
	HV2	It's an up and coming area for interest and we need more training.
	HV2	Woman herself not wanting a referral. Obviously, this would be explored such as, are they afraid it will lead to child protection issues, etc.
	MW2	Mental Health team has tight criteria.
	MW1	For the quantity of women that have MH issues which are exacerbated in pregnancy the services are not big enough to support these women or staff are not adequately trained to support these women.
	MW1	Social services have high criteria and they won't see women who are well but high risk. As in-patients we can get MH team to see women, but we still have to wait for women to be seen!
	MW2	Limited resources i.e. clinic appointments for assessment. Women referred who are unable to get transport to appointments.
14	HV2	Service only takes women with a younger child (under 1) - There are occasions when a crisis

(Other general comments on PNMH referral pathways)		manifests later on and difficult to know what service is suitable.
	HV2	A brilliant service for [redacted] mothers and babies. It would be really useful if it could broaden to accept fathers as this has a major impact on family relationships and babies and are a hard to reach group who find it difficult to access the GP.
	MW1	GP support when women are pregnant is almost non-existent - this means no care is combined/seamless + continuous. Too much 'silo' working.
	MW1	Love it! Wish there was more opportunity for knowledge.
	HV2	Often long waiting lists after initial assessment by Perinatal mental health services e.g. for CBT.
	MW2	Improving but much to do and put in place.
	HV2	They are clear if you know about them. Need more services locally like a MBU.

4b. MW1 - Have PNMH master's degree module and a BSc in psychology.