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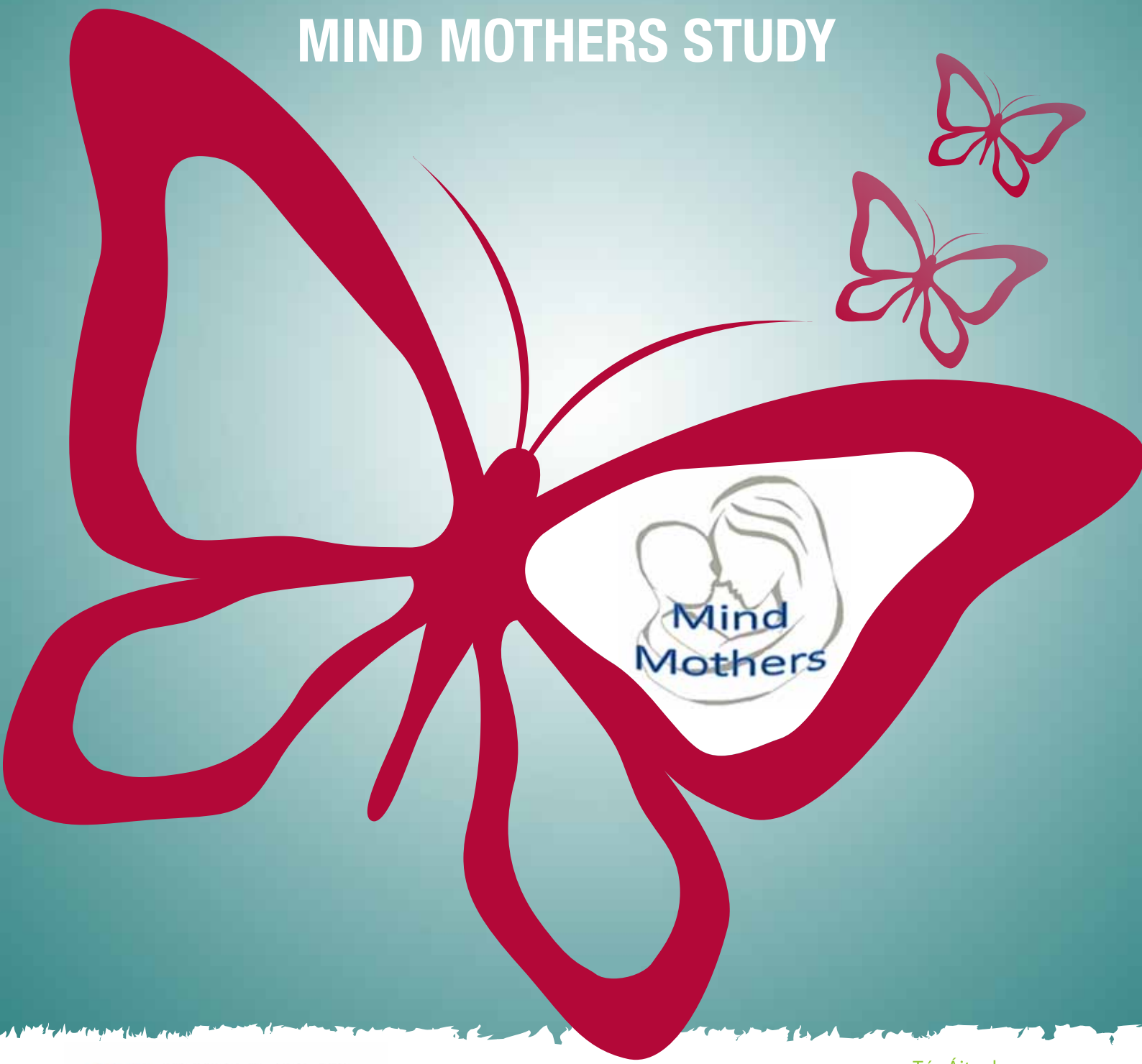
Services Director

Perinatal mental health: an exploration of practices, policies, processes and education needs of midwives and nurses within maternity and primary care services in Ireland

MIND MOTHERS STUDY



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The authors would like to thank all the participants who took time to complete surveys and give important information. We would also like to thank the Directors of Nursing, the Directors of Midwifery and Nursing, the Directors of Public Health Nursing and the Professional Development Coordinators for Practice Nurses in participating sites as well as key gatekeepers within these sites for facilitating the study. A special thanks to the steering committee for all their support (See appendix 1 for membership).

Perinatal mental health: an exploration of practices, policies, processes and education needs of midwives and nurses within maternity and primary care services in Ireland

MIND MOTHERS STUDY

Foreword

The Office of the Nursing and Midwifery Services Director is pleased to present this research report *"Perinatal Mental Health: An Exploration of the Practices, Policies, Processes and Education needs of Nurses and Midwives within Maternity and Primary Care services in Ireland" A Mind Mothers study.*

The central driver for this research came from Directors of Midwifery who articulated that although national policy stipulated the importance of supporting women at risk of developing or experiencing emotional or mental health difficulties in the perinatal period; this was an area of practice that required further development as between 15-25% of women will experience a mental health problem either during pregnancy or the first year post pregnancy.

The Office of the Nursing and Midwifery Services Director in partnership with Directors of Midwifery and Public Health Nursing, and the Professional Development Co-ordinators for Practice Nursing commissioned Professor Agnes Higgins and her team in the School of Nursing and Midwifery, Trinity College Dublin (TCD) to undertake research to explore the practices, policies, processes and the education needs of midwives, practice nurses and public health nurses in relation to perinatal mental health.

This report outlines the research methodology, it's findings and identifies recommendations in relation to policy, practice, education and further research in this area of practice. As part of the overall Mind Mothers project, this report informed the development of the *"Best Practice Principles for Midwives, Public Health Nurses and Practice Nurses"* and the *"Mind Mothers: An ELearning Programme in Perinatal Mental Health for Midwives, Public Health and Practice Nurses"* available on HSELanD.

Specific appreciation is extended to Professor Agnes Higgins and the research team in TCD for undertaking this research. Thanks are also extended to the chairpersons of the project steering group and finally appreciation is extended to all research participants who took the time to complete the survey; Midwives, Public Health Nurses and Practice Nurses. Your contribution is most valuable to the overall Mind Mothers project and to the improvement of care for women during the perinatal period.

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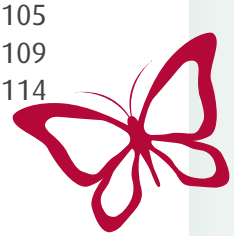

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Glossary and Acronyms

AMP	Advanced Midwife Practitioner
AN	Antenatal
CBT	Cognitive Behavioural Therapy
CPN	Community Psychiatric Nurse
DV	Domestic Violence
EPDS	Edinburg Postnatal Depression Scale
GP	General Practice/Practitioner
HSE	Health Service Executive
IPV	Intimate Partner Violence
MDT	Multidisciplinary Team
MH	Mental Health
MHS	Mental Health Services
MW	Midwife
NICE	The National Institute for Health and Care Excellence
NICU	Neonatal Intensive Care Unit
NMBI	Nursing and Midwifery Board of Ireland
OCD	Obsessive Compulsive Disorder
PHN	Public Health Nurse
PMH	Perinatal Mental Health
PMHP	Perinatal Mental Health Problem
PMHS	Perinatal Mental Health Service
PN	Practice Nurse
PND	Postnatal Depression
PPPG	Policies, procedures, protocols and guidelines
PTSD	Post-Traumatic Stress Disorder
RAMP	Registered Advanced Midwife Practitioner
RANP	Registered Advanced Nurse Practitioner
RGN	Registered General Nurse
RM	Registered Midwife
RMP	Registered Midwife Prescriber
RNID	Registered Nurse Intellectual Disability
RNP	Registered Nurse Prescriber
RPN	Registered Psychiatric Nurse
RSCN	Registered Sick Children's Nurse
SCBU	Special Care Baby Unit

Executive Summary

For most women, pregnancy and motherhood is a positive psychological process; however, for some women this life-changing event can be associated with psychological distress and mental health problems during pregnancy and up to one year following the birth of the baby. It is estimated that 15-25% of women will experience a mental health problem either during pregnancy or the first year post pregnancy, either as a new problem or as a reoccurrence of a pre-existing mental health problem. Though the focus of the literature is primarily on depression in the perinatal period, other mental health problems can and do occur, for example: prenatal depression, anxiety, postpartum psychosis and post-traumatic stress disorder. Despite the prevalence of perinatal mental health problems, they frequently go unrecognised by maternity and public healthcare practitioners. Providing psychological and mental health support to mothers, children and families in the perinatal period is now considered an important health issue, as early detection and intervention can improve maternal and infant outcomes, as well as reducing the potential risks of accidental or intentional harm to the mother, baby, other children and the family. The National Maternity Strategy (Department of Health 2016) identifies the need for better and more accessible mental health support pre, during and post pregnancy, and advocates for an integrated care model capable of responding to women with varying levels of support needs, including those requiring rapid access to specialist care.

Midwives, public health nurses and practice nurses, as part of the multidisciplinary healthcare team, are in an ideal position to address mental health and emotional well-being with women; however, studies into their role in the context of perinatal mental healthcare in Ireland are sparse. In line with the national maternity strategy which emphasises the need 'to analyse the training needs associated with the implementation of the new model of care to ensure that the current and future maternity workforce have the necessary skills and competencies to deliver safe high quality maternity care' (Department of Health 2016:7), this study explored practices, policies and processes around perinatal mental health from the perspectives of midwives, public health nurses and practice nurses.

Methodology

A mixed methods research design was employed to meet the overall aim of the study. The study comprised two components. Module one focused on an exploration of practitioners' (midwives, public health nurses and practice nurses) knowledge, confidence and education needs in relation to women who experience perinatal mental health problems, and their perceptions of barriers to discussing mental health issues with women. This aspect of the study involved an anonymous, self-completed survey of midwives, public health nurses and practice nurses. Module two comprised a documentary analysis of guidelines, policies and any other documentation in existence on perinatal mental health within maternity and primary care services. The objectives of the documentary analysis were to explore the policies, procedures and guidelines used to inform practice.

Ethical approval for the study was granted by the Research Ethics Committee of the Faculty of Health Sciences in Trinity College Dublin, and the ethics committee associated with each of the participating groups. The inclusion criteria for module one were that participants must be registered with the Nursing and Midwifery Board of Ireland (NMBI) and must be employed either full-time or part-time. Nominated gatekeepers distributed a study pack containing information about the study and either a hard copy of the survey or a link to the online survey. Data for module two were collected by contacting the Directors of Midwifery/Nursing within Ireland by letter or email, and requesting them to submit copies of perinatal mental health policies, procedures and guidelines used within their service.

Findings

In total 829 surveys were analysed, over half of which came from midwives (55.2%), with the remainder split evenly between public health nurses (22.4%) and practice nurses (22.3%). A total of 58 documents were submitted from 12 services.

- The findings show that although groups were involved in caring for women with perinatal mental health problems, the number of women they reported caring for in the previous six months appeared somewhat low given the estimated prevalence rates of perinatal mental health problems.
- The majority of public health nurses and midwives reported including mental health as a dimension of their assessment with women, asking women about their past mental health history/diagnosis and identifying women at risk of perinatal mental health problems compared to less than half of the practice nurses.
- The mental health screening practices by all three groups tended toward asking women (either all or those that have mental health risk factors) about their experience of mood disorders, anxiety, alcohol use, substance use and about past grief/loss experiences. In contrast much lower rates reported asking about issues which may be considered especially sensitive, including trauma history (intimate partner violence, sexual abuse/sexual violence), self-injury/suicidal thoughts, eating disorders and psychosis. This selective approach to assessment, whereby only some issues are explored with all women or with women who are considered to have risk factors, raises concerns that some women requiring support may be missed.
- Participant knowledge was greater in relation to depression, anxiety, risk factors, screening tools, and the impact of perinatal mental health problems on mother and baby compared to other areas where self-reported knowledge was lower (personality disorders, obsessive compulsive or ritualistic behaviour, eating disorders, self-injury/suicide in the perinatal period, bipolar affective disorder, drug use in pregnancy and breastfeeding, and legal aspects).
- Participants reported significant skill deficits in opening a discussion with women about eating behaviours, psychosis, intimate partner violence, sexual abuse/violence, and thoughts of harming themselves or their baby.
- Though the majority of participants discussed the nature of mental health issues with women and their concerns related to psychopharmacology in pregnancy and breastfeeding, their reported skill level in providing information and support to women around medication and breastfeeding, and to those concerned about the hereditary nature of mental health problems was relatively low.
- The findings also indicated that skills and practice in relation to providing information to women's partner and family could be improved, with high numbers of participants requesting training in communication and counselling skills to enable them to better engage with women and their partner/family.
- Care planning in relation to mental health problems was not routinely practised among participants in any group (public health nurses 55%; midwives 23%; practice nurses 9%), with low levels of skill being reported, particularly in developing a plan of care with women who were experiencing obsessive thinking, having thoughts of harming themselves or their baby, and hearing voices or having delusional thinking.
- The higher reported knowledge of, and willingness to discuss depression and anxiety may be a reflection of the emphasis within policy and practice guidelines on depression to the exclusion of other perinatal mental health problems, such as psychosis, bipolar disorders,

eating disorders, suicide, obsessive compulsive or ritualistic behaviour and the use of psychotropic medication.

- The documentary evidence also suggests that besides postnatal depression, information on perinatal mental health for women is scant, contains significant gaps and tends to conflate all mental health issues with depression. Though psychosis is a significant mental health risk in the puerperium, little information was available in terms of the risk factors or how to recognise its development.
- The lack of knowledge and skill undoubtedly also reflects the lack of education in perinatal mental health, with most practice nurses and 40% of public health nurses and midwives reporting never having received perinatal mental health education. Furthermore, as those who did receive education primarily gained it through their nursing/midwifery training, this is most likely outdated given the age profile of the sample.
- In addition to educational deficits, participants identified a number of organisational barriers (lack of care pathways/lack of perinatal mental health services/lack of time and heavy workload) that had a negative impact on their ability to address perinatal mental health issues with women. With the exception of midwives, just half of participants indicated that there was a specialist perinatal service within their organisation.
- Less than half of participants worked in services which had policies and guidelines, or care pathways on perinatal mental health, with participants identifying an urgent need for these aids to guide practice.
- Cultural issues around mental health also raised challenges and concerns in terms of knowledge of the impact of culture on mental health language and understanding, and the appropriateness of using models of 'illness' and screening tools that are not culturally sensitive. Interestingly, in the context of this study, the policy/guideline documentation reviewed made little or no reference to cultural competence in relation to perinatal mental healthcare. Neither did the information made available to women acknowledge variations in cultural interpretations of perinatal distress or indeed the language used to describe it.
- Other barriers identified included fears around women getting offended, misinterpreting questions as a judgement of their mothering capacity, and uncertainty about whether women wanted to be asked about mental health issues.
- Not surprisingly the participants identified a need for education in the area of perinatal mental healthcare as well as the development of perinatal mental health services, care pathways, guidelines and protocols to guide practice and address the barriers identified.

Limitations

In establishing the implications of the results of the study, there are a number of limitations that must be acknowledged. Firstly, nurses' and midwives' practices and behaviours are self-reported, therefore it is impossible to determine whether the behaviour is the same and/or different in actual practice. Secondly, there is potential for a response bias with those more positively disposed to perinatal mental healthcare more likely to have completed the survey. Thirdly, in the absence of a national database there is no way of knowing how many participants received the surveys and how representative the sample is of the national numbers. Fourthly, there is also no way of knowing how representative the documentation received is of the overall documentation on perinatal mental health within services. Finally, the estimated response rate for midwives (27.7%), public health nurses (13.3%) and practice nurses (10.3%) could be considered low, although this is not unusual in survey research.

In light of the findings, the following recommendations are proposed:

Recommendations for policy

- National guidelines are required to inform the development of evidence-based policies and strategies for perinatal mental health at organisational and clinical practice levels.

Recommendations for practice

- A Health Service Executive wide approach is taken to the development of care pathways on perinatal mental health.
- Managers within local services need to review their policies on perinatal mental health to ensure that they address the full continuum of mental health issues experienced by women in the perinatal period, are recovery-oriented and culturally sensitive.
- A coherent approach to the development of documentation, including screening and other assessment documentation is required.
- The Health Service Executive needs to support the development of evidence-based information on perinatal mental health issues for women, their partners and families. This information needs to address the full continuum of perinatal mental health issues and be made available in both print and online media, and in different languages.
- Perinatal mental health education is incorporated into all programmes offered to pregnant women and addresses the full range of mental health issues.

Recommendations for education

- Education programmes in the area of perinatal mental health should be developed and delivered to all relevant health practitioners to enable them to develop skills to screen, assess and support women who are at risk of, or experience mental health problems in the perinatal period. This education needs to address the full range of mental health issues, with reference to cultural differences and with a specific focus on improving practitioners' skills in opening a discussion on sensitive subjects, responding to women's fears and anxieties, discussing referral pathways, and skills to communicate and support partners and family members.
- Existing education programmes should be reviewed to ensure that they are addressing the core knowledge and skills required to provide care to women and are addressing cultural competence in relation to perinatal mental health.
- In line with collaborative principles, women and family/carer input should be incorporated into such training.

Recommendations for research

- Further study be undertaken to explore the working patterns and relationships between practice nurses, PHNs and midwives in order to identify possible overlaps and gaps in service provision, and to support integration and ensure the most efficient use of nursing and midwifery resources.

Chapter 1:
BACKGROUND AND CONTEXT TO THE STUDY

Introduction

For most women, pregnancy and motherhood is a positive psychological process; however, for some women this life-changing event can be associated with psychological distress and mental health problems. Providing psychological and mental health support to mothers, children and families in the perinatal period is considered an important global (Beyond Blue 2008; World Health Organisation 2013) and national health issue (Department of Health and Children 2006; Department of Health 2016), as early detection of psychological distress and intervention can improve maternal and infant outcomes. In 2006, the report 'A Vision for Change', which set out a comprehensive framework for mental health services (MHS) in Ireland, identified the need for a joined-up approach between specialist mental health services and obstetric services (Department of Health and Children 2006). The recently published maternity strategy reiterates this desire and recognises that 'all pregnant women need a certain level of support, but some need more specialised care' and it 'proposes an integrated care model that encompasses all the necessary safety nets in line with patient safety principles, which delivers care at the lowest level of complexity, yet has the capacity and the ability to provide specialised and complex care, quickly, as required' (p.5). The strategy also states that 'Women at risk of developing or experiencing emotional or mental health difficulties in the perinatal period should be identified, and a multi-disciplinary approach to assessment and support adopted' (Department of Health 2016: 66). In addition, the National Institute for Health and Care Excellence (NICE 2014) recommends that a general discussion regarding mental health (MH) and well-being take place with all women at first point of contact in pregnancy and in the early postnatal period, and that questions about mental health and emotional well-being are asked at each encounter. Midwives (MW), public health nurses (PHNs) and practice nurses (PNs), as part of the multidisciplinary healthcare team, are in an ideal position to address mental health and emotional well-being with women in the perinatal period. The aims of the study were to explore perinatal mental health (PMH) practices, policies and processes within maternity and primary care services, and to identify confidence and competency of practitioners (MWs, PHNs and PNs) in the area of perinatal mental healthcare in order to inform future education and developments in the area.

To set the study in context, this chapter explores some of the literature on perinatal mental health problems and the role of the PHN, midwife and practice nurse.

Mental health problems in the perinatal period

Becoming a new mother is a time of transition and adjustment that is 'natural' and 'normal' (Aston 2015:12). For many women it is an intensely emotional experience, with at least half reporting changes in emotions and mood, at some point in their pregnancy or in the first weeks following the birth. Fluctuating emotions from excitement, joy and love to sadness, fear or anxiety are a normal part of adjusting to changed circumstances (Raynor & England 2010). For many women these emotions subside with support, empathy, rest and reassurance. However, for some women this life-changing event can result in women experiencing a range of perinatal mental health problems (PMHP) during pregnancy and up to one year following the birth of the baby. It is estimated that 15-25% of women will experience a mental health problem either during pregnancy or the first year post pregnancy (NICE 2014), either as a new problem or as a reoccurrence of a pre-existing mental health problem.

Despite the prevalence of perinatal mental health problems (PMHP), they frequently go unrecognised by maternity and public healthcare practitioners. It is estimated, for example, that between 7-15% of women will experience antenatal depression (depression during pregnancy), yet it is rarely screened for in pregnancy or included in prenatal literature or education offered to

women or indeed practitioners (Clark 2000). Similar to the rates of antenatal depression, reported rates for postnatal depression are around 15% (NICE 2014). In Ireland, however, prevalence rates of postnatal depression are reported to range from 11.4% to 28.6% (Department of Health 2016); differences in reported rates may be due to differences in screening instruments used and outcomes measured (Noonan *et al.* 2017b). Furthermore, women with a prior history of depression (Bennet 2004) or women who experience antenatal depression are at an increased risk of depression recurrence in the postnatal period (Glasser *et al.* 2016).

Postpartum psychosis is considered the most severe mental health problem in the puerperium and is frequently categorised as a psychiatric emergency (Kohl 2004). It is estimated that, across all cultures, it affects one or two women per 1,000 births (National Institute for Health and Care Excellence 2007). The majority of symptoms develop within 2 weeks postpartum, but women may experience symptoms as early as 48 hours after giving birth or have a latent period of several weeks before symptoms develop (Higgins 2012). Women with a prior history of bipolar disorder, especially those who stop medication abruptly, are at risk of relapse and of developing postpartum psychosis, with the reported reoccurrence rates approaching 50% in the antenatal period and 70% in the postnatal period (Viguera *et al.* 2007; Wesseloo *et al.* 2016). Women with a diagnosis of schizophrenia, other types of psychosis or those that have experienced a previous postpartum psychosis are also at increased risk (Munk-Olsen *et al*. 2006; Munk-Olsen *et al.* 2009). Given the severity of psychosis and the timing of its onset in early motherhood, there can be significant risks to both the mother and the baby (Higgins 2012); therefore, early detection and rapid access to appropriate specialist services is essential to promote maternal recovery and reduce potential risks of accidental or intentional harm to the mother, baby, other children and family (Royal College of Psychiatrists 2002; Sit *et al*. 2006).

Similar to antenatal depression, perinatal anxiety is frequently underdiagnosed or misdiagnosed, yet it is a significant mental health issue in the perinatal period (Vesga-Lopez *et al.* 2008). The rate of anxiety disorders is estimated to be between 14-15% (SIGN 2012; NICE 2014) and approximately two-thirds of women who experience perinatal depression have co-morbid anxiety (Wisner *et al.* 2013). Pregnancy and early mothering can increase vulnerability to obsessive thinking and, whilst intrusive thoughts are common in the perinatal period, they may cause significant distress to women. The content of obsessive, intrusive thoughts is often influenced by the woman's context (Barber 2009), and therefore may be focused on the foetus, the birth, the woman herself or her partner. Obsessive and intrusive thoughts or images of harming the baby are not uncommon. In addition, the perinatal period may be a time of increased risk of developing obsessive compulsive disorder (OCD), with the prevalence rates for postnatal OCD ranging between 4-9% (Challacombe and Wroe 2013).

Research suggests that there are higher rates of Post-Traumatic Stress Disorder (PTSD) in perinatal women, particularly in those that have already been affected by childhood abuse or traumatic experiences, including childbirth (Seng *et al.* 2010; Hinton *et al.* 2015). Studies have also highlighted the potential for reoccurrence and/or the worsening of a pre-existing binge eating disorder (Watson *et al.* 2013). Evidence also suggests that substance misuse during pregnancy has increased over the last three decades (Barry *et al.* 2006; EMCDDA 2012; Hayes and Brown 2012; Patrick *et al.* 2012; Desai *et al.* 2014; Passey *et al.* 2014), which has physical and psychological consequences for both the mother and baby. Women with drug issues have also been found to be a particularly vulnerable group due to a lack of engagement with the maternity services (Department of Health 2016). The consequences of substance misuse may be further confounded by co-existing mental health difficulties and intimate partner violence (IPV) (Havens *et al.* 2009; Forray 2016). The potential for IPV to begin or escalate is understood to significantly increase during pregnancy (Jeanjot *et al.* 2008; Karmaliani *et al.* 2008; Talilleu and Brownridge 2010).

Some estimate that of women who experience domestic violence (DV) up to 30% are assaulted the first time during pregnancy (Health Service Executive (HSE) 2010; Taillieu and Brownridge 2010), with one in eight women in Ireland experiencing abuse during pregnancy (Kenny and ní Riain 2014). Hence, the importance of completing a mental health assessment and providing support to women throughout pregnancy, birth and early motherhood.

Implications of undiagnosed or untreated mental health problems for mother, foetus and baby

Mental health problems during and after pregnancy not only have implications for the psychological and physical welfare of the woman, but can also have implications for the foetus/baby and the whole family, if women are left without support and care (Oates and Cantwell 2011). Mental health problems can result in a decreased level of social and personal functioning for women, which in some circumstances can impact on their ability to care for themselves, their baby and family adequately (NICE 2014).

Maternal mental health problems can be associated with increased rate of pregnancy and birth complications, such as stillbirth, requirement for postnatal specialist care for the baby, growth retardation and low birth weight babies (Kim *et al.* 2013; Ding *et al.* 2014; NICE 2014). Women with a diagnosis of bipolar disorder, for example, are more likely to have small for gestational age babies (Özerdem and Akdeniz 2014), an induced labour or planned caesarean section, and have a 50% increased risk of preterm birth (Boden *et al.* 2012). The consequential risks of maternal distress to the foetus/baby also extend beyond the initial postnatal period. Emerging evidence indicates that untreated mental health problems in pregnancy and the postnatal period are associated with poorer long-term outcomes for children, including decreased emotional and cognitive development, difficulties developing and maintaining relationships, and poor attachment (Cox *et al.* 1987; Fendrich *et al.* 1990; Goodman and Brumley 1990; Hammen *et al.* 1990; Kelly *et al*. 1999; Mullick *et al*. 2001).

Whilst perinatal mental health problems can have a negative impact on the baby and infant, if unrecognised and untreated, perinatal mental health problems can also erode women's confidence to parent (Chew-Graham *et al.* 2008) and have been associated with partner relationship dissatisfaction (Røsand *et al.* 2011). In addition, suicide continues to be a significant cause of maternal mortality as indicated by the Confidential Maternal Death Enquiries Ireland (O'Hara et al 2016) and MBRRACE-UK report (Knight et al 2016). Whilst risk assessment is a critical component of mental healthcare, it can also have significant consequences for the woman and her baby. Challacombe and Wroe (2013) highlight how women experiencing intrusive and distressing thoughts of harming their baby, which is associated with OCD, were classified as 'high risk' and referred to child protection agencies, rather than receiving the necessary treatment for their OCD.

Whilst much of the research to-date focuses on the negative impact of mental health problems on mother, infant and family, some studies highlight how becoming a mother was a motivating factor for some women's recovery, increasing their motivation to attend mental health services for support and care (Nicholson et *al.* 1998; Diaz-Caneja and Johnson 2004; Edwards and Timmons 2005; Heron *et al.* 2012).

Women's experience of perinatal mental healthcare in Ireland

Regardless of whether a woman presents to a service with a pre-existing mental health problem, or develops one during the perinatal period, it is important that the maternity, public health, general practice and mental health services work together to provide the best care possible. Collaboration and information exchange across services and disciplines is critical for continuity of care (Myors *et al.* 2015). However, the current lack of specialist perinatal mental health services in most maternity services and the lack of integration and inter-disciplinary collaboration across maternity, public health and mental health services results in many women who experience mental health issues receiving fragmented care and 'falling through the cracks' of service delivery (Begley *et al.* 2010; Higgins *et al.* 2016b). Whilst research into the experience of women with mental health issues in Irish services is limited, there is some evidence that many women who experience mental health problems during pregnancy and in the postnatal period feel unsupported within Irish maternity (Begley *et al.* 2010; Higgins *et al.* 2016b), public health (Begley *et al.* 2010; Stewart-Moore *et al.* 2012) and mental health services (Tuohy 2014). Perinatal mental health was a recurring theme in the public consultation conducted as part of the Maternity Strategy, which identifies the need for better and more accessible mental health support pre, during and post pregnancy' (Department of Health 2016).

It is estimated that there are 1,400 public health nurses employed in Ireland, however, studies into the role of the PHN, and especially into the context of perinatal mental health are sparse. Whilst women in some studies valued the PHN as an important source of information in relation to the baby (Leahy-Warren 2005; Stewart-Moore *et al.* 2012), they also perceived the visits and telephone supports offered to be inadequate to support psychological well-being and expressed a desire for more frequent visits from PHNs (Stewart-Moore *et al.* 2012). Similarly, women with mental health problems in Begley et *al.*'s (2010) study reported that some PHNs lacked knowledge on mental health problems, and did not always prioritise women's mental health needs. These findings are not surprising, as research indicates that 'child health' accounts for 29.4% of all PHN work in Ireland (Begley *et al.* 2005), whilst postnatal mothers' care only forms 3% of the PHN caseload (Begley *et al.* 2004). In addition, a survey of PHN documentation revealed that there is no standard documentation used for recording the postnatal check or care, and some areas do not use any postnatal record (The Institute of Community Health Nursing 2013).

Similarly, studies into the role of the midwife in the context of perinatal mental healthcare in Ireland are also sparse. For many women the lack of continuity of service and care provision within the maternity services is a significant issue, as is their perception that prioritisation is given to the 'physicality and biomedical aspects of pregnancy' or the care of the baby over the mother's mental and emotional well-being (Begley *et al.* 2010; Higgins *et al.* 2016b). Whilst some women may be reluctant to disclose mental health problems for fear of stigma and loss of custody, even when women voluntarily disclosed their mental health history during their booking and maternity encounters, some midwives lack the knowledge and skills to respond sensitively and proactively, and tend to divert responsibility onto the woman to seek help if required (Higgins *et al.* 2016b). This lack of action not only leaves women without vital support, but has the potential to instil a sense of rejection and stigma in women, which can impact negatively on future disclosure, by perpetuating the belief that maternity care practitioners or services are not interested in their mental well-being. While women who experience mental health problems are critical of midwives for their failure to respond to their emotional needs in an informed, empathetic and timely manner, they also view them as important sources of information and support (Begley *et al.* 2010; Higgins *et al.* 2016b). Women that have accessed mental health support via maternity services in Ireland are very positive about the care provided by midwives, mental health nurses

and psychiatrists who provide specialist perinatal mental health services (Higgins *et al.* 2016b). Whilst PHNs and midwives are important providers of perinatal care, GPs are often the first and only port of call for those seeking help for mental distress and are also the primary gatekeepers to specialised mental health services (Tedstone-Doherty *et al.* 2007). Indeed, most women with perinatal mental health issues are treated in the primary care context by their GP, unless they have been assessed as requiring specialist mental health services. GPs also provide a continuum of care to women from pre-pregnancy through to the postpartum period and beyond. As part of that service, the practice nurse working in collaboration with the GP (McCarthy *et al.* 2011) comes in contact with a significant number of women either during pregnancy or in the postnatal period. Thus, they have the potential to be key people in the provision of information and support in relation to perinatal mental health. Whilst the evidence around their role is sparse, in an Irish study involving 451 practice nurses high rates of involvement in antenatal care (70%, n=317), postnatal care (71%, n=321), and pre-conceptual advice (71%, n=320) were recorded (McCarthy *et al.* 2012). Studies outside of Ireland also suggest that they are ideally placed to identify mental health problems, such as anxiety and depression (Crosland and Kai 1998), and are currently involved in the provision of information and advice to patients and their family on depression, and the use of antidepressant medication (Gray *et al.* 1999). Other studies indicate that approximately 82% of practice nurses in the UK have responsibility for aspects of mental health and well-being (Hardy 2014), with Gray *et al.* (1999) estimating that 10% of the practice nurses' caseload is people with psychological or mental health problems. In the context of perinatal mental health, nearly 80% of practice nurses in an Australian study saw women in the first eight weeks postpartum (Brodribb *et al.* 2016).

Understanding the education and training needs of midwives, public health nurses and practice nurses, together with the barriers they face in providing perinatal care, is critical if we are to better harness their potential to engage with women about their mental health and to empower practitioners to provide information and support to women, to make informed choices about care, and to refer women who are in need of specialist mental health assessment and intervention.

Chapter 2:
METHODS

Introduction

This chapter describes the aims and objectives of the study, which consisted of two separate modules using different methods to collect the data. Issues relating to recruitment, data analysis, validity and reliability, and ethics are also discussed.

Aims

The aims of the study were to explore perinatal mental health practices, policies and processes within maternity and primary care services, and to identify confidence and competency of practitioners (MWs, PHNs and PNs) in the area of perinatal mental healthcare.

Objectives of module one

The objectives of module one were to:

- Identify practitioners' (MWs, PHNs and PNs) current practices in perinatal mental healthcare, and level of knowledge and skill in responding to women who experience perinatal mental health problems
- Identify barriers encountered by practitioners (MWs, PHNs and PNs) in responding to the needs of women who experience perinatal mental health problems
- Identify practitioners' education and training needs in relation to screening, assessment and management of perinatal mental health problems

Objectives of module two

The objective of module two was to:

- Identify perinatal mental health policies, procedures, protocols and guidelines (PPPGs) used to inform practice within services

Research design and methods

Data for the study were collected using a mixed method design involving an anonymous, self-completed survey and documentary analysis.

Module 1: The anonymous, self-completion survey was used to meet the objectives of module one and focused on practitioners' practices, knowledge and skills in relation to perinatal mental health. In addition barriers to practitioners addressing perinatal mental health problems was included.

Survey design represents both a feasible and cost-effective method of obtaining information from the intended sample. Surveys facilitate the collection of detailed structured information from participants thus ensuring consistent information is collected across the sample. They are easy to administer and, in comparison to interviews, require less effort and time from participants, and are less expensive. Another advantage is that the likelihood of socially desirable responses is minimised through the anonymity which the survey offers (Parahoo 2006; de Vaus 2014). The survey was designed both as an online survey using the SurveyMonkey tool (SurveyMonkey Inc.) and as a hard copy postal survey, to enable participation by those without internet access.

The survey was developed by the research team based on research in the area and in consultation with practitioners and experts in the area. The survey consisted of four sections, using a combination of binary (yes/no), categorical and Likert scale responses. Three open-ended questions were included. See table 2.1 for a complete description. (The survey is available from the PI on request).

Table 2.1: Survey content

Topic:	Description:
Demographic data (Section 1)	Participants were asked 9 questions related to their gender, age, current role, length of time in role, area within the maternity and primary care services currently employed, midwifery/nursing qualifications, highest level of education, and contact with women with perinatal mental health problems.
Perinatal mental health education (Section 1)	Participants were asked 2 questions on education: had they received education in perinatal mental health and where they received their education.
Organisational perinatal mental health policies & procedures (Section 1)	Participants were asked about their knowledge of whether their organisation had perinatal mental health policies and procedures in place. The response category options were 'yes', 'no' and 'don't know'.
Perinatal mental health practices (Section 2)	Participants were asked to indicate (yes/no/not part of my role) if they carried out 11 perinatal mental health activities in their current clinical practice. Participants were also asked what their practice was in relation to asking women about 12 mental health issues (when completing a mental health assessment). The three response categories were: Never ask a woman; Ask women that have mental health risk factors; Ask all women.
Knowledge of perinatal mental health (Section 3)	Participants were asked to rate their knowledge on 19 aspects of perinatal mental health on a scale from 1 (not at all knowledgeable) to 5 (very knowledgeable).
Skill and confidence in perinatal mental health practice (Section 3)	Participants were asked to rate their skill in undertaking 35 aspects of perinatal mental health practices on a scale from 1 (not at all skilled) to 5 (very skilled). Participants were also asked to rate their overall confidence in relation to perinatal mental healthcare practice on a scale from 1 (not at all confident) to 10 (very confident).
Barriers to discussing mental health issues (Section 4)	Participants were asked to indicate the extent to which they regarded a range of factors as barriers to nurses and midwives discussing mental health issues with women. The response categories included: To no extent (1); To a little extent (2); To a moderate extent (3); and To a great extent (4). Higher scores indicated that the factor was perceived as being a greater barrier to discussion with women about mental health issues.
Open-ended questions (End of survey- 3qs)	Three open-ended questions were presented at the end of the survey. Two questions asked participants to list their top three educational priorities in relation to perinatal mental health and to list three changes they would like to see in the area of perinatal mental healthcare. The final question provided space for participants to comment if desired.

Module 2: Documentary analysis was selected to meet the objectives of module 2. Organisational documentation is valuable as it can provide researchers with an understanding of the context and culture therein, and its relationship to practice (Fitzgerald 2012). As documentary analysis had been used successfully in a previous study by the authors to identify practices not readily available through the self-reported survey method (Higgins *et al.* 2016a), it was deemed appropriate for this study. Documentary analysis is an expedient form of data collection that does not cause disruption to practitioners or patients, or give rise to any ethical considerations related to privacy, confidentiality or anonymity (Shaw *et al.* 2004). In addition, a distinct advantage of documentary analysis compared to other methods of data analysis, is that the data has been developed

independent of any research study, making it a 'non-reactive' methodology (Bryman 2012).

Inclusion and exclusion criteria

Module 1: The inclusion criterion for module 1 was that participants must be:

- registered midwives, public health nurses and primary care nurses with the Nursing and Midwifery Board of Ireland (NMBI)

The exclusion criteria included:

- agency midwives and nurses working in any of the areas
- student midwives and student nurses working in any of the areas

Module 2: The inclusion criterion for module 2 was that services must be:

- Public maternity and primary care services

Recruitment and data collection

Module 1: Because no national database of the three groups exists, the sample for the survey was recruited through separate gatekeepers for each group. The Directors of Public Health Nursing and the Professional Development Coordinator for Practice Nurses within Ireland granted approval for their respective areas and acted as gatekeepers for recruitment. The Directors of Midwifery and Nursing provided permission to the research team to access and recruit staff within their service and in some cases nominated others to act as gatekeepers for recruitment.

Within the midwifery sites, nominated gatekeepers received information packs containing a Letter of Invitation, Participant Information Leaflet, a Survey and a stamped envelope (addressed to a member of the research team). These gatekeepers were requested to distribute the surveys to potential participants who met the inclusion criteria. Participants were requested to return the survey to the researchers, gatekeepers, or return by placing in sealed boxes that were located in strategic areas within some of the hospitals.

Public health nurses and practice nurses completed the survey online. The Directors of Public Health Nursing and the Professional Development Coordinator for Practice Nurses within Ireland facilitated the research team by sending an email, containing a Letter of Invitation, Participant Information Leaflet and link to the online survey to all public health nurses and practice nurses that they had on their databases.

To increase the response rate, two follow-up letters/emails were sent to the nominated gatekeepers two weeks apart, which requested them to remind potential participants to complete and return the surveys.

Module 2: Access to documentation for module 2 was sought from the Directors of Midwifery and Nursing, Directors of Public Health Nursing and the Professional Development Coordinators for Practice Nurses within Ireland. Each stakeholder received a letter/email requesting them to submit copies of perinatal mental health PPPGs used within their service. Two follow-up reminders, either through email or phone calls, were made two weeks apart requesting documentation.

Sample and response rate

Module 1: In total 831 surveys were received (See table 2.2 for a more detailed breakdown). As two individuals didn't indicate their role, analysis was conducted on 829 responses. In the absence of a national database, there is no way of knowing how many potential participants received the hardcopy survey or the email with the link to the survey; therefore, it is not possible

to provide an accurate % response rate. However, it is possible to give a response rate based on estimated national figures for each of the three groups.

Table 2.2: Study sample as proportion of national sample

Participating group	Number of surveys returned	Approx. number of group employed nationally	% of national sample
Public health nurses	186	1,395[1]	13.6%
Midwives	458	1,653 WTE[2]	27.7%
Practice nurses	185	1,800[3]	10.3%

Module 2: 24 services responded to the request for documentation. In total 58 documents were received from 12 services (See table 2.3 for more detailed breakdown). A further 12 services contacted the research team to provide information but did not submit documentation.

Table 2.3: Response rate to request for documentation

Participating group	No. of services who sent documentation	No. of services who responded but did not send documentation
Public health nurses	3	7 PHNs responded to say they use the EPDS and the Whooley questions but did not send information. 1 PHN responded to say they attempted to introduce the EPDS into their practice area but were unable to get agreement with GPs
Midwives	8	4 responded to say they had no documentation
Practice nurses	1	0

Data analysis

Module 1: Statistical analysis of participants' responses to the survey was performed using the Statistical Package for the Social Sciences (SPSS), version 21 (IBM Corp 2012). Descriptive statistics including frequency distributions, means and standard deviations were generated to describe the data. The numbers in some analyses may differ due to missing data. Further analysis was conducted using inferential statistics to examine whether they were any statistically significant differences in participants' mean skill, confidence, knowledge and barrier scores based on factors, such as age, education, duration of time in role, education in perinatal mental health or dealing with women with perinatal mental health problems in clinical practice. The types of parametric or nonparametric inferential tests used were determined by level of measurement and assumptions of normality tests. Parametrical statistical tests conducted included independent sample t-tests and one-way ANOVAs while non-parametric statistical tests conducted included the Kruskal-Wallis tests. The qualitative comments made by participants were subjected to a thematic content analysis by a member of the research team, while the educational priorities and perinatal mental healthcare changes identified by participants were grouped into broader descriptive categories.
Module 2: Data for module two were analyzed using documentary analysis techniques. The Microsoft Excel 2011 software programme was used to code data and run descriptive statistics. Documents were initially assessed for their location of origin (Midwifery, PHN and Practice Nurse) and type of document (Screening tool/questions, educational materials, policy/guidelines or other/unspecified). Following this each document was examined in greater detail for the focus, underpinning principles, and target audience.

1 Office of the Nursing and Midwifery Services Director (2012) Report on Current Public Health Nursing Services; Report prepared by Patricia O'Dwyer, Project Officer to the Expert Advisory Group on Public Health Nursing Services
2 Source of information: Final Report of the HSE Midwifery Workforce Planning Project (2016)
3 Source of information: http://irishpracticenurses.ie/

Reliability and validity

The face validity of the survey for module one was established by asking experts and specialists in the field of perinatal mental healthcare to review the survey and provide feedback in relation to its relevance and appropriateness as well as to identify any gaps in the survey. Practitioners from midwifery, mental health nursing and psychiatry with expertise in perinatal mental healthcare reviewed the survey. In addition, feedback on the survey was also provided by midwifery, public health and practice nurse managers.

Ethical considerations

Ethical approval for the study was granted by the Research Ethics Committee of the Faculty of Health Sciences in Trinity College Dublin, the ethics committee associated with each of the participating midwifery sites, and the ethics committee that approves studies involving public health nurses. Participants for both module one and two were informed that their participation in the study was voluntary and anonymous. The surveys were distributed by gatekeepers on behalf of the research team and completed surveys were returned indirectly to the research team either in the pre-paid envelope supplied via the gatekeeper, through the gatekeepers or online. Therefore, the research team had no access to participants' details. As the survey was anonymous, no identifying information was requested and participants were assured that no study site would be identified in any study publications. Return of the survey was taken as evidence of implied consent.

Information received for the documentary analysis was treated confidentially and anonymously and all documents were handled and reviewed by the research team only.

The next four chapters present the findings. Chapters 3, 4 and 5 present the survey data from PHNs, Midwives and Practice Nurses respectively. Chapter 6 presents the findings of the documentary analysis.

Chapter 3:
FINDINGS FROM PUBLIC HEALTH NURSES

Introduction

This chapter presents the results of public health nurses' survey responses. The demographic background of the public health nurses is first profiled before their education on and experience in perinatal mental health is described. Next, an overview of the range of perinatal mental health activities which public health nurses perform is given, while their self-perceived knowledge of perinatal mental health, and their self-reported skills and confidence in undertaking perinatal mental health activities is presented. The availability of services, education and guidelines in the services in which public health nurses work is presented while their perceptions of barriers to discussing mental health issues is outlined. Lastly, an overview of the educational priorities identified by public health nurses and the perinatal mental healthcare changes that they would like to see implemented is presented.

Sample profile

In total 186 participants completed the surveys. All were female, with nearly two-thirds aged over 45 (63.9%). 175 were Registered General Nurses, 148 were Registered Midwives, 41 were Registered Psychiatric Nurses, with smaller numbers registered in other nursing divisions. Only one was a Registered Nurse Prescriber. The majority of the sample was educated to postgraduate diploma level (59.1%) and employed in public health nursing services (93%). 7% were working outside public health services, which included 3.2% working in community services and 3.8% working in a range of other positions, which included: education, management and specialist/ consultant[4]. See table 3.1 for a full profile.

[4] For ease of reporting, irrespective of where participants were working or their role, they are referred to as Public Health Nurses in the remainder of the report.

Table 3.1: Demographic profile

		N	%
Age	25-29 years	7	3.8
	30-34 years	13	7.0
	35-39 years	14	7.5
	40-44 years	33	17.7
	45-49 years	35	18.8
	50-54 years	43	23.1
	55+	41	22.0
Highest level of qualification	Certificate	4	2.2
	Diploma	26	14.0
	Degree	22	11.8
	Postgraduate diploma	110	59.1
	Masters	24	12.9
Midwifery/Nursing Qualification*	RGN	175	-
	RM	148	-
	RPN	41	-
	RSCN	17	-
	RNID	2	-
	RNP/RMP	1	-
Area employed	Public health nursing services	173	93.0
	Community services	6	3.2
	Other	7	3.8
Length of time in role	0-2	22	11.8
	3-5	16	8.6
	6-10	47	25.3
	11 years+	101	54.3

*Participants could select more than one answer

Education on perinatal mental health

Whilst 61.5% of PHNs indicated that they received education (110/179), nearly 40% indicated that they had never received education in perinatal mental health. The biggest source of learning was as part of their training (n=105) either as a student public health nurse (n=63), student midwife (n=35) or student nurse (n=7). This was followed by in-service education or study days (n=75), and by self-directed learning (n=28) (See table 3.2).

Table 3.2: Education on perinatal mental health

Source of Education	N*
As part of my student training -Student public health nurse (n=63) -Student midwife (n=35) -Student nurse (n=7)	105
In-service education / study day	75
Self-directed learning	28
Colleagues with expertise in perinatal mental health	14
Post-graduate educational programme	8
Other	8
Stand Alone Module delivered by third level institution	2

*Participants could select more than one answer

Caseload of women with perinatal mental health problems

71% (n=132) of PHNs reported caring for women with perinatal mental health problems in their current role. These PHNs were then asked how many women experiencing a mental health issue had they cared for in the previous six months, with the majority reporting caring for between 1-5 women (79.2%).

Table 3.3: No. of women experiencing perinatal mental health issues cared for in the past 6 months

No. of women	N=125	%
1-5	99	79.2
6-10	15	12.0
11-15	9	7.2
16-20	1	.8
21-25	0	0
25+	1	.8

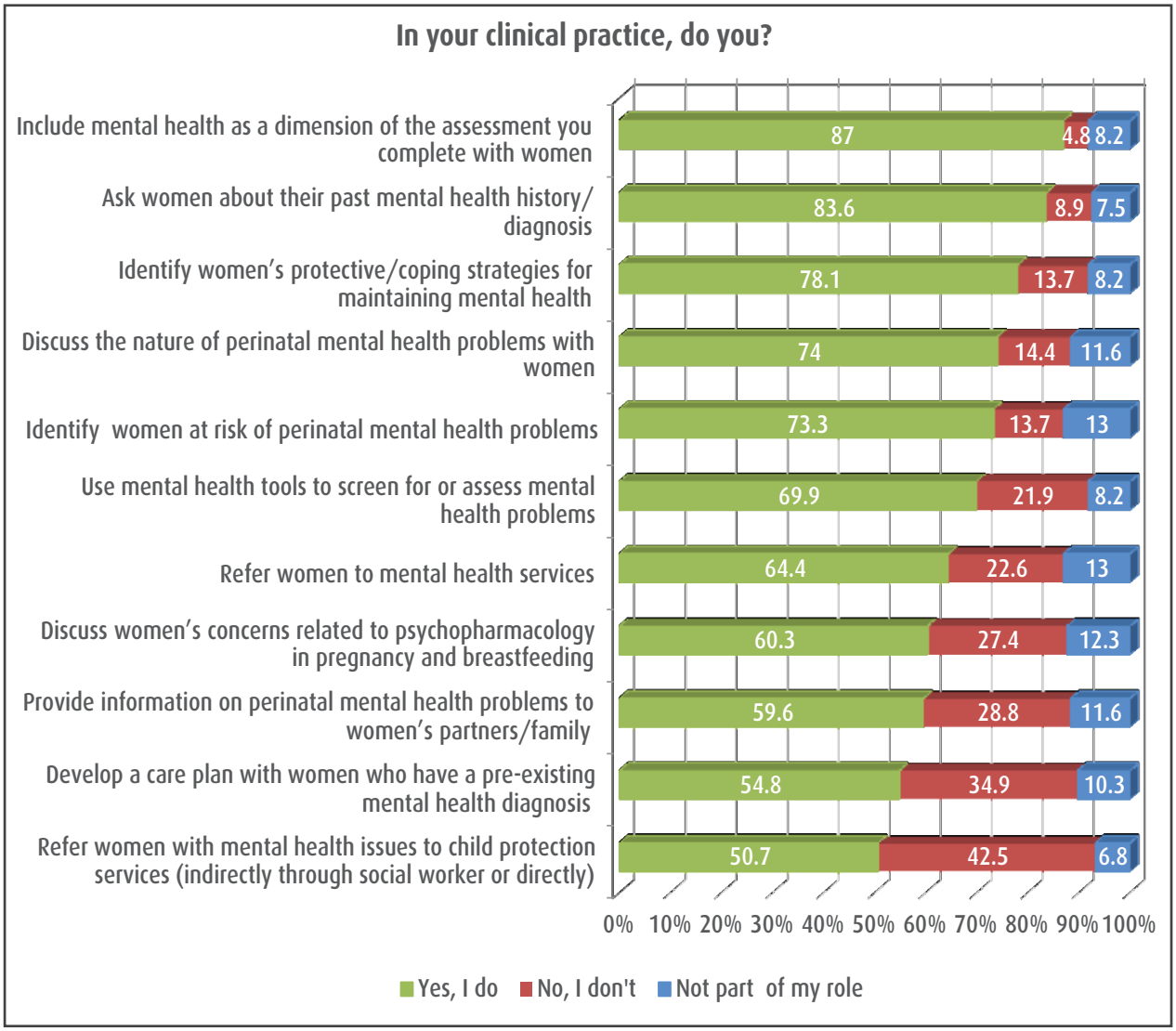
Current practice in relation to perinatal mental healthcare

PHNs were asked to indicate if they were currently undertaking as part of their role any of the eleven perinatal mental healthcare activities listed (Figure 3.1). Whilst less than 4% indicated that they were employed in positions that did not involve direct clinical contact, between 6 and 13% reported that the activities listed were currently not part of their role.

In relation to assessment activities, over 80% of PHNs reported that they include mental health as a dimension of their assessment with women (87%, n=127), with a similar number asking women about their past mental health history/diagnosis (83.6%, n=122). Whilst over 80% asked questions about mental health, the number who reported identifying women at risk of perinatal mental health problems was less than 75% (73.3%, n= 107), with a smaller number reporting using mental health tools to screen for mental health problems (69.9%, n=102).

In relation to planning care and discussing issues with women, approximately three quarters of the sample reported identifying protective/coping strategies for maintaining mental health (78.1%, n=114), discussing the nature of perinatal mental health problems with women (74%, n=108), with just 60% discussing women's concerns related to psychopharmacology in pregnancy and breastfeeding (60.3%, n=88). Despite 73% reporting identifying women at risk perinatal mental health problems, approximately 55% (n=80) reported developing a care plan with women who had a pre-existing mental health diagnosis, with under 65% reported referring women to mental health services (64.4%, n=94). In relation to provision of information to partners/families less than 60% reported providing information on perinatal mental health problems to women's partners/family (59.6%, n=87), with just over half referring women with mental health issues to child protection services either indirectly through a social worker or directly (51%, n=74). Figure 3.1 shows these activities ranked in order of highest to lowest participation.

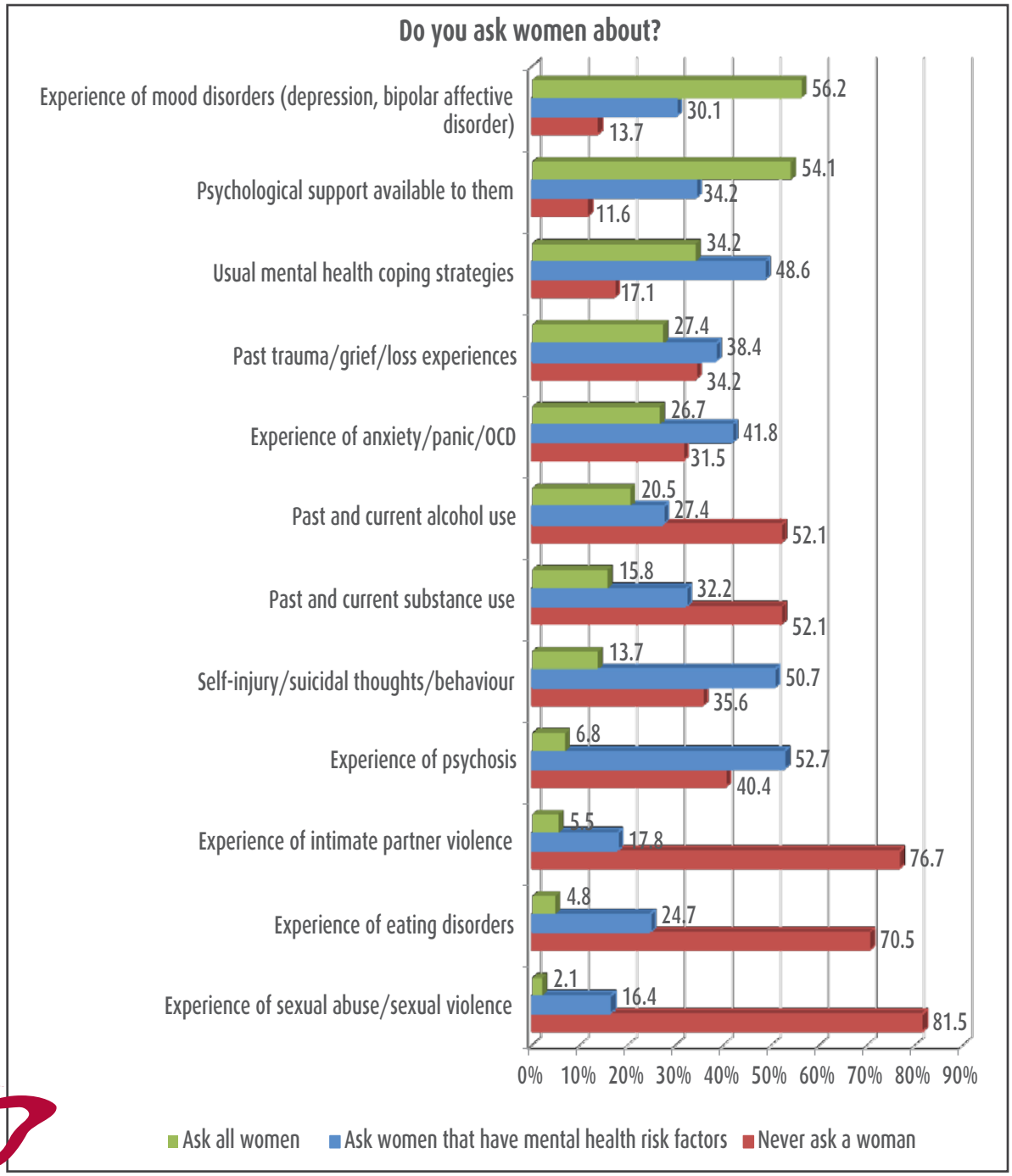
Figure 3.1: Current perinatal mental health activities



Current practice in relation to perinatal mental health assessment

To get a greater understanding of what PHNs included in their mental health assessment and with what group of women, PHNs were asked to indicate if they asked all women, or just women who have mental health risk indicators, about 12 mental health issues listed (See figure 3.2). Findings from this question suggest that whilst over 80% ask women about mood disorder (all women: 56.2%, n=82; women identified at risk: 30.1%, n=44), psychological support available to them (all women: 54.1%, n=79; women identified at risk: 34.2%, n=50) and coping strategies (all women: 34.2%, n=50; women identified at risk: 48.6%, n=71), between 70-80% of PHNs never ask any woman about sexual abuse/sexual violence (81.5 %, n=119), IPV (77%, n=112) or experience of eating disorders (70.5%, n=103). Half of the PHNs reported never asking women about past and current alcohol use abuse (52.1%, n=76) or substance abuse (52.1%, n=76), with between 30-40% never asking any women about psychosis (40.4%, n=59), self-injury/suicide thoughts (35%, n=52), past trauma/grief (34%, n=50) or anxiety/panic/OCD (31%, n=46).

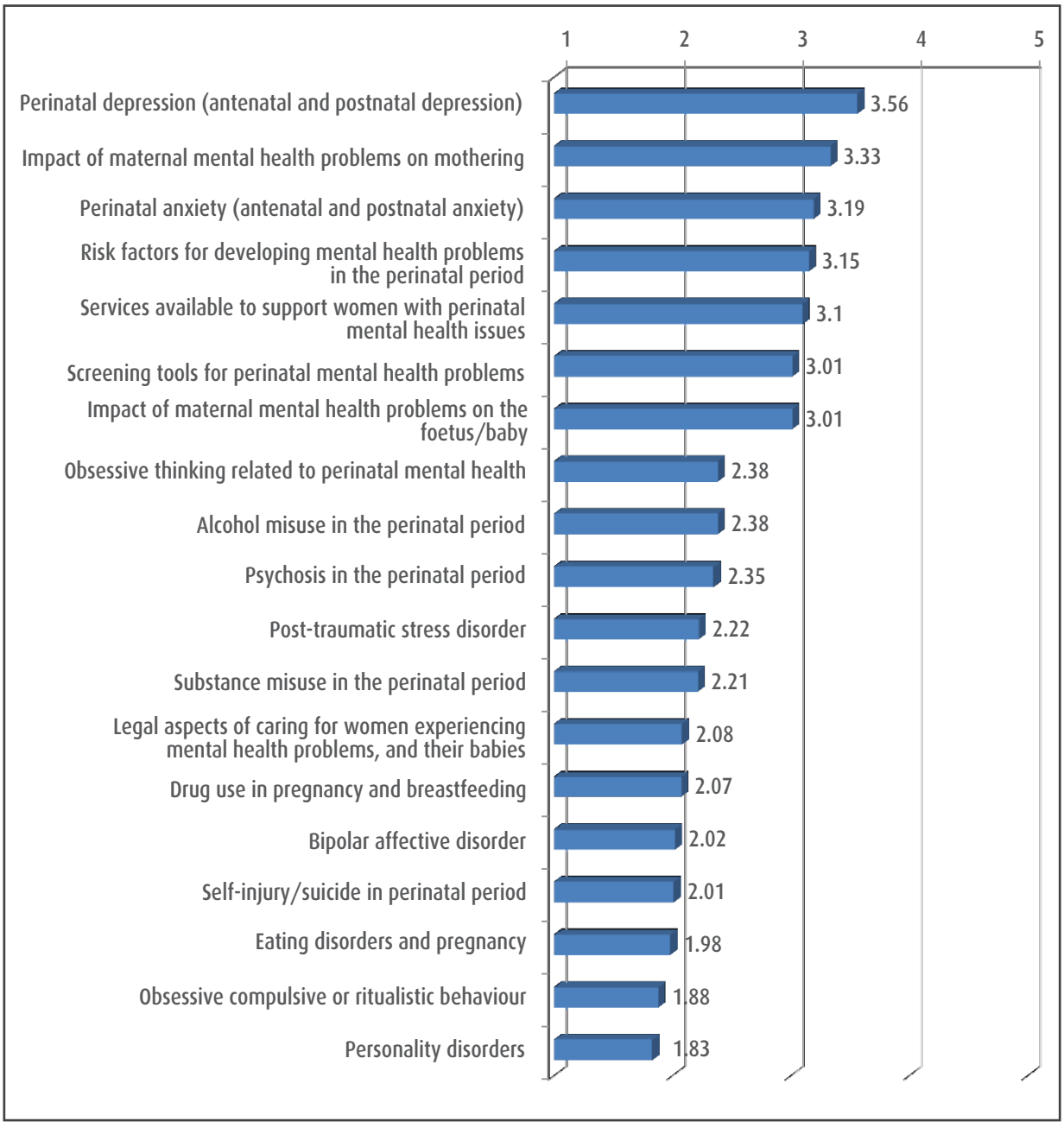
Figure 3.2: Perinatal mental health assessment



Knowledge of perinatal mental health

PHNs were asked to rate their knowledge on 19 items related to perinatal mental health on a scale of 1 (not at all knowledgeable) to 5 (very knowledgeable). Seven of the 19 items were rated above 3 on the five point scale, suggesting that PHNs had good knowledge in these areas. However all other items were rated below the midpoint, with the lowest mean rating being achieved in relation to personality disorders, obsessive compulsive or ritualistic behaviour, eating disorders and pregnancy, self-injury/suicide in perinatal period, bipolar affective disorder, drug use in pregnancy and breastfeeding, and legal aspects of caring for women experiencing mental health problems, and their babies (See figure 3.3). The standard deviation of all items is included in appendix 2a.

Figure 3.3: Self-rated knowledge of perinatal mental health (n=138)



Skills in undertaking perinatal mental health activities

PHNs were asked to rate, on a scale of 1 (not at all skilled) to 5 (very skilled), their skill in undertaking a range of activities. The 35 activities listed addressed six key areas: opening a discussion with women; providing support to women; developing a plan of care; discussing the need for referral; providing support to partners/family members; and asking colleagues for advice or assistance.

On opening a discussion with women, PHNs' self-rated skill ranged from 1.89 in asking women about sexual abuse/sexual violence to 3.26 in relation to asking women about mood. PHNs reported greater skill in asking about mood and anxiety, than they did in the other 6 issues listed. Opening a discussion and asking women about eating behaviours, psychosis, IPV and sexual abuse/violence were all rated below the midpoint of the skill scale.

In relation to providing support to women, PHNs rated their skill highest in providing support to women traumatised by their birth experience (M=3.61) and lowest in providing support to women who were concerned about taking psychotropic medication (M=2.66) or concerned about the hereditary nature of mental health problems (M=2.55).

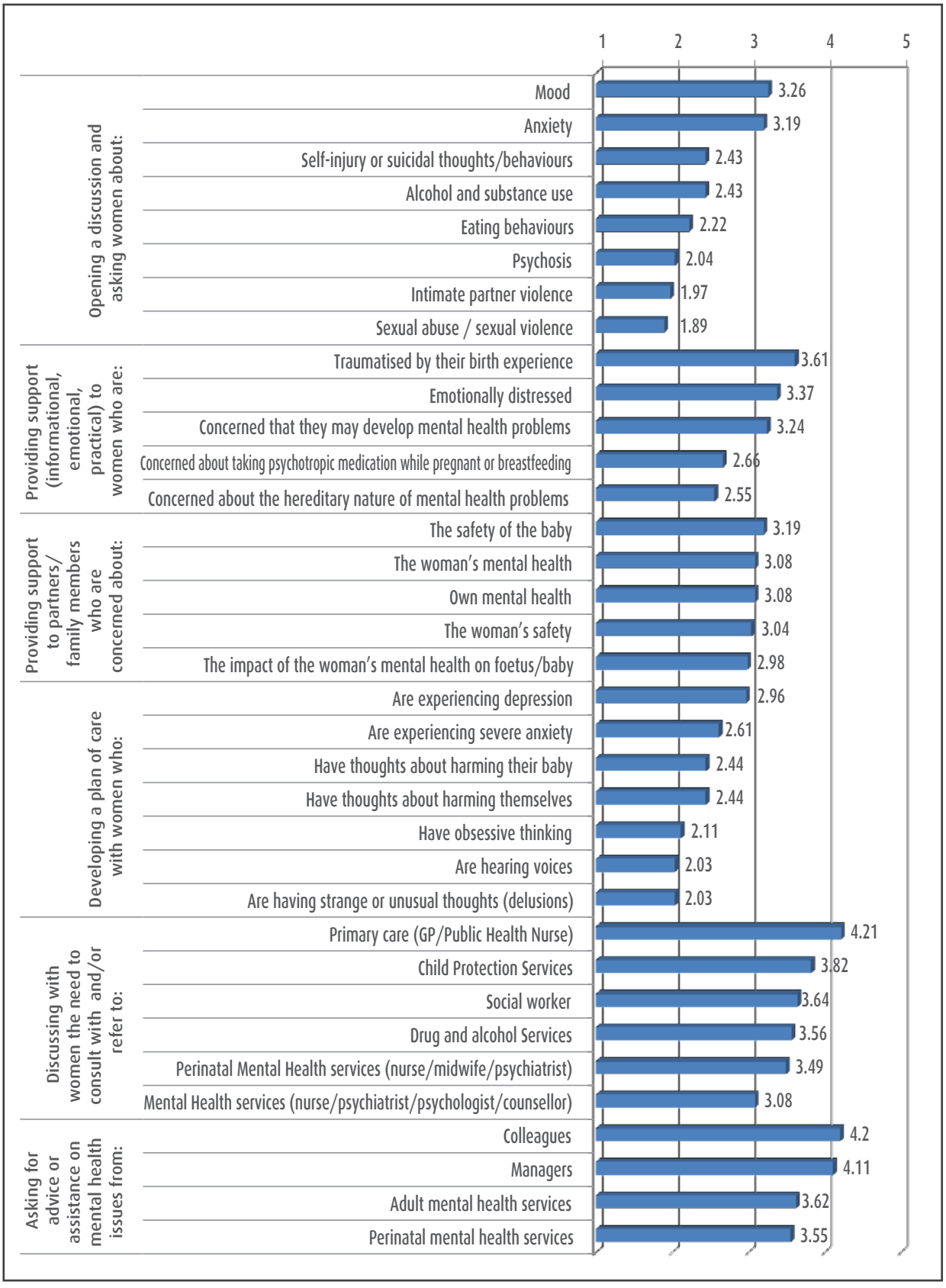
Corresponding with their skill rating in opening a discussion, PHNs rated their skill in developing care plans with women experiencing depression (M=2.96) and severe anxiety (M=2.61) highest, and lowest in developing care plans with women with thoughts of harming themselves (M=2.44) or the baby (M=2.44), or were experiencing obsessive thoughts (M=2.11), delusions (M=2.03) or hearing voices (M=2.03).

In relation to discussing with women the need to consult with and/or refer to other professionals or services, PHNs' scores were above the midpoint of the scale on all items, with self-reported skill ranging from 4.21 in relation to referring to primary care to 3.08 in relation to referring to mental health services.

Providing support to women's partners/family members and responding to their questions and concerns is also a role of the PHN. However, PHNs' skill level in supporting partners/family members who were concerned about the impact of the woman's mental health on the foetus/baby (M=2.98) or concerned about the safety of the baby (M=3.19), was either just at or below the midpoint of the scale.

In terms of seeking advice from others, PHNs considered themselves more skilled in seeking advice from colleagues (M=4.20) and less skilled when it came to seeking assistance from perinatal mental health services (M=3.55) (See figure 3.4). The number and standard deviation of all items is included in appendix 2b.

Figure 3.4: Self-rated skills in undertaking perinatal mental health activities



Overall skill and confidence

PHNs were asked to rate their skill and confidence in relation to their activities in perinatal mental healthcare on a scale from 1 (not at all confident/skilled) to 10 (very confident/skilled). The mean for both scales was 5.24, just below the midpoint of the scale (See table 3.4).

Table 3.4: Overall skill and confidence

	N	Minimum	Maximum	Mean	SD
Overall Skill	131	1	9	5.24	1.93
Overall Confidence	131	1	9	5.24	1.96

Factors related to skill, confidence and knowledge

Further analysis showed that there were no statistically significant differences in mean skill and confidence scores based on either age [H(6)= 5.795, p>.05; F(6, 124)= .315, p>.05], educational level (undergraduate or postgraduate) [t(129)= -1.563, p>.05; t(129)= -1.848, p>.05] or duration of time in role [F(3, 127)= .302, p>.05; F(3, 127)= .262, p>.05]. However, those that had some PMH education rated themselves as having higher confidence and skill than those without any PMH education (See table 3.5), and they also had higher scores on all knowledge items compared to those without PMH education (See appendix 2c), and the differences were all statistically significant.

Table 3.5: Skill and confidence among those with and without education

	Some Education in PMH						T-Test
	Yes			No			
	N	Mean	SD	N	Mean	SD	
Overall Skill	81	5.69	1.78	50	4.50	1.95	t(129)= 3.588, p<.001
Overall Confidence	81	5.69	1.78	50	4.50	2.04	t(93.128)=3.40, p<.001

PHNs who reported dealing with women with PMH issues had statistically significant higher scores in both skill and confidence than those who reported not dealing with women with PMH issues, and had statistically significant higher scores on 9/19 knowledge items (See table 3.6).

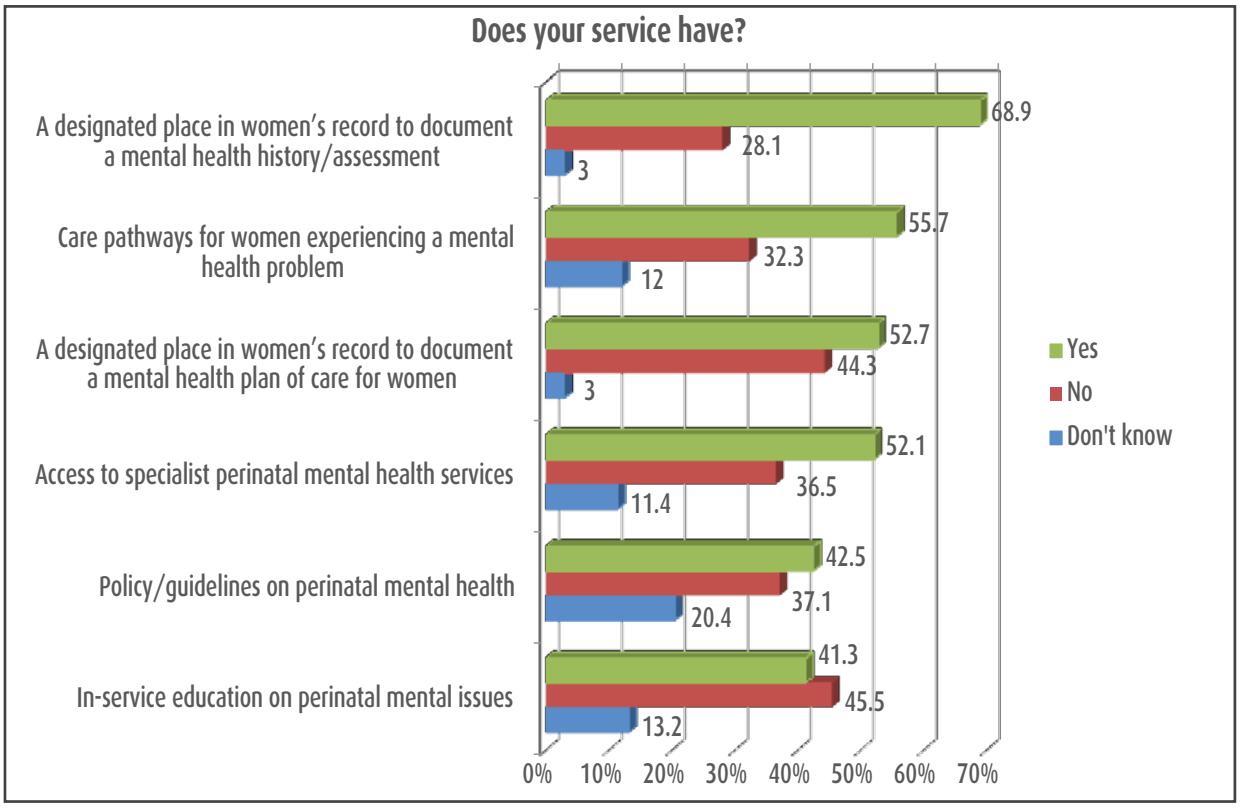
Table 3.6: Skill, confidence and knowledge among those PHNs dealing with women with perinatal mental health issues and those not

	Deal with women with PMH issues						T-Test
	Yes			No			
	N	Mean	SD	N	Mean	SD	
Overall Skill	93	5.47	1.90	38	4.66	1.89	t(129)= 2.228, p<.05
Overall Confidence	93	5.51	1.95	38	4.58	1.87	t(129)= 2.498, p<.05
Knowledge							
Risk factors for developing mental health problems in the perinatal period	97	3.38	.78	41	2.61	1.05	t(59.808)= 4.248, p<.001
Perinatal depression (antenatal and postnatal depression)	97	3.68	.84	41	3.27	.74	t(136)= 2.733, p<.01
Perinatal anxiety (antenatal and postnatal anxiety)	97	3.33	.94	41	2.85	.96	t(136)= 2.693, p<.01
Obsessive thinking related to perinatal mental health	97	2.51	1.04	41	2.10	.92	t(136)= 2.173 , p<.05
Screening tools for perinatal mental health problems	97	3.27	1.08	41	2.41	1.16	t(136)= 4.160, p<.001
Post-traumatic stress disorder	97	2.35	1.00	41	1.90	.86	t(136)= 2.502, p<.05
Psychotropic drug use in pregnancy and breastfeeding	97	2.19	.98	41	1.80	.84	t(136)= 2.166, p<.05
Obsessive compulsive or ritualistic behaviour	97	2.01	.95	41	1.59	.67	t(136)= 2.597, p<.01
Services available to support women with perinatal mental health issues	97	3.25	1.00	41	2.76	.94	t(136)= 2.681, p<.01

Perinatal mental health services and guidelines

PHNs were asked whether the service they worked within had services, education and guidelines related to perinatal mental health. Whilst 42.5% (n=71) indicated that there were policies or guidelines on perinatal mental health within their service nearly 60% either did not know (20.4%, n=34) or reported an absence of policies or guidelines on perinatal mental health (37.1%, n=62). Just over half reported that there was access to specialist perinatal mental health services (52.1%, n=87) and that there was care pathways available for women (55.7%, n=93). Approximately two thirds of PHNs reported that the service in which they were employed had a designated place in women's record to document a mental health history/assessment (68.9%, n=115) and over half indicated that there was a designated place in women's record to document a mental health plan of care for women (52.7%, n=88). PHNs reported a greater absence of in-service education on perinatal mental health within services rather than presence (45.5%, n=76 vs 41.3%, n=69) (See figure 3.5).

Figure 3.5: Perinatal mental health services and guidelines



Barriers to discussing mental health issues

PHNs were asked to what extent they considered a range of issues to be barriers to discussing mental health issues with women. Four response categories were given: 'to no extent'; 'to a little extent'; 'to a moderate extent'; and 'to a great extent'. The responses are shown in appendix 2d. For the purpose of analysis, 'to no extent' and 'to a little extent' were collapsed and 'to a moderate extent' and 'to a great extent' were merged (See figure 3.6).

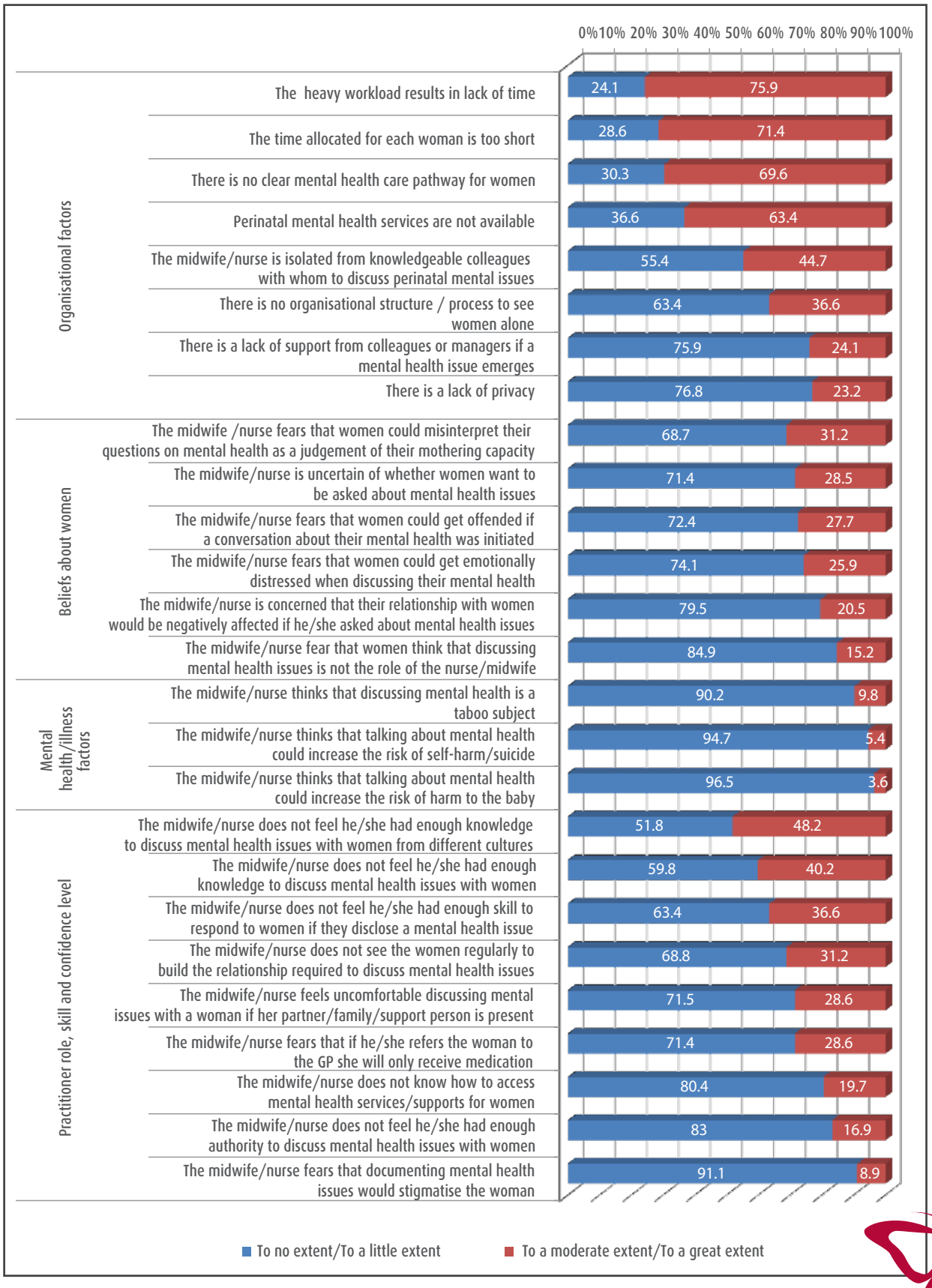
The greatest barriers identified were organisational; namely heavy workload (75.9%), short time allocated to women (71.4%), lack of a clear pathway (69.6%) and the lack of available perinatal mental health services (63%). A lack of organisational structures and processes to facilitate seeing women alone (36.6%) as well as being isolated from knowledgeable colleagues (44.7%) also acted as significant barriers.

Practitioner related barriers were the next significant group identified; 40%-50% of the sample reported that lack of knowledge of mental health (40.2%) and particularly in relation to women from different cultures (48.2%) were barriers. In addition, 25% to 35% of the sample reported that not having the skill to respond to women who disclose a mental health issue (36.6%), not seeing women regularly enough to establish a relationship (31.2%) and being uncomfortable speaking to women when their partner/family is present (28.6%), all acted as barriers. In addition, fearing that women would only receive medication if they referred them to the GP (28.6%) or that their relationship with women would be negatively affected if they asked them about mental health issues (20.5%), inhibited discussion.

Between 20%-30% of the sample reported women related barriers, such as fearing women might misinterpret a question as a judgement of their mothering capacity (31.2%), uncertainty about whether women want to be asked about mental health issues (28.5%), as well as fearing women might get offended (27.7%) or get emotionally distressed (25.9%).

The number of PHNs who considered the other issues listed to be barriers was less than 20%: namely, not knowing how to access mental health services/supports for women (19.7%); not feeling he/she had enough authority to discuss mental health issues with women (16.9%); fear that women think that discussing mental health issues is not the role of the nurse/midwife (15.2%); and, fear that documenting mental health issues would stigmatise the woman (8.6%).

Figure 3.6: Barriers to discussing mental health issues



There were statistically significant differences between those who reported dealing with women with PMH issues and those who didn't on 14/26 of the barrier items, with those not dealing with women with PMH issues having higher mean scores which indicated that they perceive the item to be a greater barrier than those who deal with women with PMH issues (See table 3.7).

Table 3.7: Perceived barriers among those dealing with women with perinatal mental health issues and those not

Barriers	Deal with women with PMH issues						T-Test
	Yes			No			
	N	M	SD	N	M	SD	
There is no clear mental healthcare pathway for women	80	2.80	.97	32	3.22	.87	t(110)= -2.118, p<.05
There is no organisational structure/ process to see women alone	80	2.04	.91	32	2.59	1.19	t(46.143)= -2.386, p<.05
The midwife/nurse is isolated from knowledgeable colleagues with whom to discuss perinatal mental issues	80	2.19	1.03	32	2.69	1.09	t(110)= -2.279, p<.05
The midwife/nurse fears that women could get emotionally distressed when discussing their mental health	80	1.86	.87	32	2.38	.94	t(110)= -2.755, p<.01
The midwife/nurse is uncertain of whether women want to be asked about mental health issues	80	1.93	.91	32	2.34	.97	t(110)= -2.157, p<.05
The midwife/nurse fear that women think that discussing MH issues is not the role of the nurse/midwife	80	1.51	.78	32	1.94	.95	t(110)= -2.447, p<.05
The midwife/ nurse is concerned that their relationship with women would be negatively affected if he/she asked about MH issues	80	1.74	.85	32	2.19	1.09	t(46.925)= -2.092, p<.05
The midwife/nurse does not feel he/she had enough authority to discuss mental health issues with women	80	1.59	.77	32	2.28	.99	t(110)= -3.942, p<.001
The midwife/nurse does not feel he/she had enough knowledge to discuss mental health issues with women	80	2.13	.97	32	2.78	.94	t(110)= -3.255, p<.01
The midwife/nurse does not feel he/she had enough knowledge to discuss MH issues with women from different cultures	80	2.38	1.01	32	2.97	1.03	t(110)= -2.792, p<.01
The midwife/nurse does not feel he/she had enough skill to respond to women if they disclose a mental health issue	80	2.09	.94	32	2.72	.81	t(110)= -3.321, p<.01
The midwife/nurse does not see women regularly to build the relationship required to discuss MH issues	80	1.99	.85	32	2.38	.98	t(110)= -2.089, p<.05
The midwife/nurse does not know how to access mental health services/supports for women	80	1.70	.77	32	2.16	.95	t(110)= -2.641, p<.01
The nurse/midwife fears that documenting mental health issues would stigmatise the woman	80	1.39	.67	32	1.72	.77	t(110)= -2.272, p<.05

Public health nurses' educational priorities

PHNs were asked to list three educational priorities on perinatal mental health that would assist them with their clinical practice. Analysis of responses resulted in three categories: knowledge of PMH issues and related topics, skill development in relation to PMH and delivery/format of education (See table 3.8).

The educational priorities listed included gaining knowledge about all types of perinatal mental health issues, including causes and risk factors. Medication, its impact and uses during pregnancy, also featured regularly. PHNs also listed knowledge about cultural differences in mental illness, and attachment and bonding in the perinatal period.

Skills identified as educational priorities included counselling skills, communication skills and clinical interviewing skills. PHNs requested skills in mental health assessment, use of assessment/screening tools and skills in recognising indications of the presence of a perinatal mental health issue. PHNs also identified the need for the development of skills in opening a conversation on mental health issues, as well as skills in supporting and advising women. In addition, many of the comments reflected the educational format that PHNs would like, with suggestions encompassing regular, up-to-date education that incorporated the MDT, mental health specialist input and practical application.

Table 3.8: Public health nurses' educational priorities

Category	Item
Knowledge of PMH issues and related topics	• All types of perinatal mental health issues • Causes & risk factors of perinatal mental health issues • Signs and symptoms of PMH issue • Attachment and bonding • Cultural issues around mental health • Medication: side effects and implication re breastfeeding • Suicide prevention
Skill development	• Assessment: interviewing skills, taking a mental health history, using assessment tools, assessing risk of harm to mother or baby • Communication and counselling skills: opening conversation, engaging with women who are reluctant to speak, building rapport and communicating with women and their partner and families; general support skills
Delivery of education	• Continuous in-service training/study days/regular updates • Discussions, case studies, role play, reflective practice sessions • Education based on up-to-date research • Education to be multidisciplinary focused • Education to include input from mental health specialist • Education to be standardised on screening and management

Public health nurses' change priorities

PHNs were asked to list three changes they would like to see in the area of perinatal mental healthcare. Following analysis, responses were categorised into seven categories: increased supports and services for women and their partners/families; enhanced evidence based strategies to improve organisation and continuity of care; better integration and communication between services and disciplines; greater awareness of perinatal mental health issues; education for women and their families; education and guidance for staff and increased human resources (See table 3.9).

A host of resources and services were identified as being needed to support women and their families, ranging from access to specialist perinatal mental services, crisis services, counselling services/talking therapies, support groups, parenting groups and practical supports to the provision of debriefing post a traumatic birth. In addition to resources, a high number of PHNs mentioned the need for enhanced evidence-based strategies to improve organisation and continuity of care for women. Care pathways, guidelines, protocols and policies were mentioned by the majority of participants who included a response to this question. It was clear from many of the responses made that PHNs were of the view that by having guidelines and care pathways consistency in screening, assessment and referral could be improved. PHNs also expressed a strong desire for more guidance around care planning and better documentation that highlighted mental health. The third area PHNs requested change was in the area of integration and communication between services and disciplines. PHNs clearly viewed the need for better communication and liaison between practitioners and services, with a MDT approach to care being regarded as essential to ensuring continuity of care for women and seamless transitions of care.

In terms of raising awareness of mental health, PHNs were of the view that in order to encourage greater openness and discussion about the topic there was a need for the taboo around mental health and perinatal mental health to be challenged. Additionally, advertising was identified as a way of raising awareness about the impact of alcohol and non-prescription drugs on pregnancy. In addition to general education on mental health and perinatal mental health, PHNs deemed antenatal and postnatal education for women and their families as a priority, with some emphasising the need to educate partners.

Several priorities were identified under the category 'education and guidance for staff', including PHNs having access to the support and guidance of expert mental health practitioners in their day to day work, and the inclusion of perinatal mental health in the education and training of all midwives and nurses. The final category of 'increased human resources' included the need for more time to assess and support women, and the addition of more mental health nurses to primary care teams (See table 3.9).

Table 3.9: Public health nurses' change priorities

Category	Item
Increased supports and services for women and their partners/families	• Access to MH services/ specialist PMH services/dedicated PMH teams • An emergency referral area when there is a crisis and not have woman sent to a regular Accident and Emergency dept. • Increase in counselling services/affordable and accessible talking therapies • Mental health nurses to run clinics for mothers in local areas • Reduced waiting time for community psychology/ psychiatry/ counselling services • Provision of therapeutic day and outpatient facilities • Support services targeted at women who may be at risk • Parenting groups/parenting and infant programmes • Family support services /wellness support groups • Helplines • Development of PND programs at primary care level • Practical supports: e.g. affordable childcare/childminding; home help; transport • Provision of debrief after traumatic birth
Enhanced evidence based strategies to improve organisation and continuity of care	• Care pathway/referral pathways/follow-up pathways • Guiding policies/protocols • Protocol for referral by GP • Direct referral - PHN be allowed refer to community mental health team (not allowed currently) • MDT care planning/pathways (developed antenatally for the postnatal period) • Standardised National Operation Procedures for Nurses on PMH • Standardised local policy on screening for PND e.g. screening antenatally and postnatally with women asked about MH at first booking and first postnatal visit/screening as standard practice • Guidelines/checklists re prompter to appropriate questions that facilitate identifying mental health issues • Clear documentation that includes MH issues and plan reviewed • More MDT meetings to review care • Going back to doing the 3 month child assessment at home as clinics too busy
Better integration and communication between services and disciplines	• Between mental health services and colleagues in the community; between disciplines/services; between PHN and community CPN; between hospital (on discharge of women) and GP/PHN • More information sharing between practitioners regarding care of women e.g. more feedback from community mental health teams and GP colleagues following referral by PHN
Greater awareness of perinatal mental health issues among the public	• Destigmatisation of perinatal mental health problems • More open discussion on mental health in public • Public awareness campaigns and seminars • Advertising on impact of alcohol and non-prescription drugs on pregnancy

Category	Item
Education for women and their families	• Antenatal and postnatal education on mental health issues • Coping skills • Education for partners on signs of PMH issue
Education and guidance for staff	• Greater access to mental health service expertise (e.g. nurse/ clinical specialist) within the community for advice • Support for PHN in the area of PNMH with clinical work • Midwifery training to incorporate community settings • PMH focus in GN/PHN/RGN/training • Directory of local services, including mental health to be made available nationally
Increased human resources	• More time to support women • More time to complete assessments with women • Addition of more CPNs to Primary Care Teams/Network • An AMP based in community to provide ongoing education

Summary

- In total 186 PHNs completed the surveys. The majority were Registered General Nurses, educated to postgraduate diploma level and over 45 years of age.
- Over 70% of PHNs reported caring for women with perinatal mental health problems in their current role, with the majority reporting caring for between 1-5 women in the previous 6 months.
- Approximately 40% reported that they had never received education in perinatal mental health. Of those who did receive education, 40% had attended in-service education, with the largest number indicating that their source of learning was as part of their nursing/midwifery training, which given the age profile would appear to have been some time ago. Just 41% reported the presence of perinatal mental health education within their service.
- Whilst 42% indicated that there were policies or guidelines on perinatal mental health within their service, nearly 60% either did not know or reported an absence of policies or guidelines on perinatal mental health. Just over 50% reported that there was access to specialist perinatal mental health services and that there was care pathways available for women, with two thirds reporting that the service in which they were employed had a designated place in women's record to document a mental health history/assessment.
- Whilst 73% reported identifying women at risk of perinatal mental health problems, just 60% reported discussing women's concerns related to psychopharmacology in pregnancy and breastfeeding, and only 55% reported developing a care plan with women who had a pre-existing mental health diagnosis or providing information on perinatal mental health problems to women's partners/family. The small number of PHNs who reported developing a care plan may also be related to the fact that nearly half indicated that there was not a designated place in the woman record to document a mental health plan of care.
- In relation to assessment, 85% reported asking all women, or women they deemed at risk, about mood disorder, coping strategies, and psychological support available to them; 75% reported identifying protective/coping strategies and discussing the nature of perinatal mental health problems with women; however, between 70-80% of PHNs never ask any woman about sexual abuse/sexual violence, IPV, or experience of eating disorders. Half reported never asking women about past and current alcohol use (52.1%) or substance use (52.1%), with between 30-40% never asking any women about psychosis, self-injury/suicide thoughts, past trauma/grief or anxiety/panic/OCD.
- In relation to knowledge of specific topics, whilst PHNs reported good knowledge on depression, anxiety, risk factors, screening tools, and impact of PMH problems on mother and baby as high, areas such as personality disorders, obsessive compulsive or ritualistic behaviour, eating disorders and pregnancy, self-injury/suicide in perinatal period, bipolar affective disorder, drug use in pregnancy and breastfeeding, and legal aspects were all rated below the midpoint of the scale provided.
- PHNs rated their overall skill and confidence just below the midpoint of the scale provided. They reported greater skill in asking about mood and anxiety, discussing with women the need for referral to primary care service/GP, providing support to women who were emotionally distressed or traumatised by their birth experience, or requesting support from colleagues. However, they reported being less skilled in opening a discussion and asking women about eating behaviours, psychosis, IPV, and sexual abuse/violence, which corresponds with their reported lack of knowledge as well as their lack of engagement with these areas within their current practice.

- Corresponding with their skill rating in opening a discussion, PHNs rated their skill in developing care plans on depression and severe anxiety highest, and lowest in developing care plans with women who had thoughts of harming themselves or the baby, or experiencing obsessive thoughts, delusions or hearing voices. Their reported skill level in providing support to women who were concerned about taking psychotropic medication or concerned about the hereditary nature of mental health problems was also below the midpoint of the scale.
- The greatest barriers identified by PHNs were organisational, namely, heavy workload, short time allocated to women, lack of clear care pathways and the lack of available perinatal mental health services. Practitioner related barriers were the next significant group, with 40-50% reporting that lack of knowledge of mental health, and particularly in relation to women from different cultures was a barrier.
- Reflecting the findings above, PHNs' educational priorities centred around greater knowledge on all aspects of perinatal mental health, including cultural aspects, medication and suicide, as well as education to enhance interviewing, assessment, support and counselling skills.
- Similarly, PHNs' change priorities were also congruent with the findings of the closed survey questions. The changes prioritised included: increasing specialist perinatal mental health services and supports for women and their partners/families; developing care pathways, protocols, and guidelines to improve organisation, consistency and continuity of care; improving the integration of, and communication between services and disciplines; enhancing knowledge of perinatal mental health issues among the general public, women and all clinical staff; as well as increasing the amount of time available to PHNs to support women during the perinatal period.

Chapter 4:
FINDINGS FROM MIDWIVES

Introduction

This chapter presents the results of midwives' survey responses. The demographic background of the midwives is first profiled before their education on and experience in perinatal mental health is described. Next, an overview of the range of perinatal mental health activities which midwives perform is given, while their self-perceived knowledge of perinatal mental health, and their self-reported skills and confidence in undertaking perinatal mental health activities is presented. The availability of services, education and guidelines in the services in which midwives work is presented while their perceptions of barriers to discussing mental health issues is outlined. Lastly, an overview of the educational priorities identified by midwives and the perinatal mental healthcare changes that they would like to see implemented is presented.

Sample profile

Overall 458 participants who work in maternity settings completed the surveys. Of the 453 who provided information on gender, all but two were female (99.6%, n=451). Approximately 12-15% were represented in each age group, with a slightly lower proportion aged 20-24 (5.1%). The highest level of education obtained by the sample was a primary degree (35.7%), followed by a postgraduate diploma (26.7%). 437 participants were Registered Midwives, 339 were Registered General Nurses and 29 were Registered Nurse/Midwife prescribers. The majority were employed as midwives in the public health service (87.8%), just over a tenth were employed as nurses[5] in maternity care services (11.6%) and three were self-employed midwives. The majority were working in a stand-alone maternity hospital (56.1%) and were in their current role over 11 years (53.7%). See table 4.1 for a full profile.

[5] Irrespective of the participants' employment or registrations status, for ease of reporting all participants working in maternity services are referred to as midwives in the remainder of the report.

Table 4.1: Demographic profile

		N	%
Age	20-24 years	23	5.1
	25-29 years	64	14.2
	30-34 years	54	12.0
	35-39 years	61	13.5
	40-44 years	68	15.1
	45-49 years	60	13.3
	50-54 years	62	13.7
	55+	59	13.1
Highest level of qualification	Certificate	52	11.5
	Diploma	51	11.2
	Degree	162	35.7
	Postgraduate diploma	121	26.7
	Masters	68	15.0
Midwifery/Nursing Qualification*	RM	437	-
	RGN	339	-
	RPN	2	-
	RSCN	12	-
	RNID	2	-
	RANP/RAMP	3	-
	RNP/RMP	29	-
Current role	Midwife in public health service	402	87.8
	Self Employed Midwife	3	.7
	Nurse in maternity care services	53	11.6
If working within hospital-based maternity service, which one?	Stand Alone Maternity Hospital	244	56.1
	Maternity Unit within a General Hospital	191	43.9
Length of time in role	0-2	62	13.5
	3-5	67	14.6
	6-10	83	18.1
	11 years+	246	53.7

*Participants could select more than one answer

Approximately a fifth of those working in maternity services were working in postnatal care (21%), a fifth in labour and delivery care (20.1%) and 17% reported working in antenatal care. 15% indicated that they were working in more than one area of the maternity service (See table 4.2).

Table 4.2: Area employed

	N	%
Postnatal care – hospital based	96	21.0
Labour and delivery care	92	20.1
Antenatal care - hospital based	78	17.1
Early pregnancy/Gynae unit	34	7.4
NICU/SCBU care	14	3.1
DOMINO / home birth hospital services	13	2.8
Community services	8	1.8
Early discharge home postnatal services	6	1.3
Public health nursing services	4	.9
GP practice	3	.7
Midwifery-led unit	2	.4
More than one area	69	15.1
Other (eg education, management, bereavement, ultrasound	38	8.3

Education on perinatal mental health

Approximately two-thirds of the midwives (63.6%, n=287/451) indicated that they received education in perinatal mental health. The biggest source of learning was during their training programme, either as a student midwife (n=212) or student nurse (n=79), followed by in-service education or study days (n=89). Self-directed learning (n=64), learning from colleagues with expertise in perinatal mental health (n=61) and through a standalone module was also important sources of learning (See table 4.3).

Table 4.3: Education on perinatal mental health

Source of Education	N*
As part of midwifery/nurse training -Midwifery training (n=212) -Nurse training (n=79)	291
In-service education / study day	89
Self-directed learning	64
Colleagues with expertise in perinatal mental health	61
Stand Alone Module delivered by third level institution	20
Post-graduate educational programme	6
Other (workshop on birth trauma)	12

*Participants could select more than one answer

Caseload of women with perinatal mental health problems

The majority of participants reported caring for women with perinatal mental health problems in their current role (91.6%, n=417). In relation to the question on the number of women experiencing a mental health issue that they had cared for in the previous six months, the majority reported caring for between 1-10 women (62.7%), with approximately 22% caring for more than 21 women (See table 4.4).

Table 4.4: No. of women experiencing perinatal mental health issues cared for in the past 6 months

No. of women	N=415	%
1-5	170	41.0
6-10	90	21.7
11-15	33	8.0
16-20	28	6.7
21-25	17	4.1
25+	77	18.6

Current practice in relation to perinatal mental healthcare

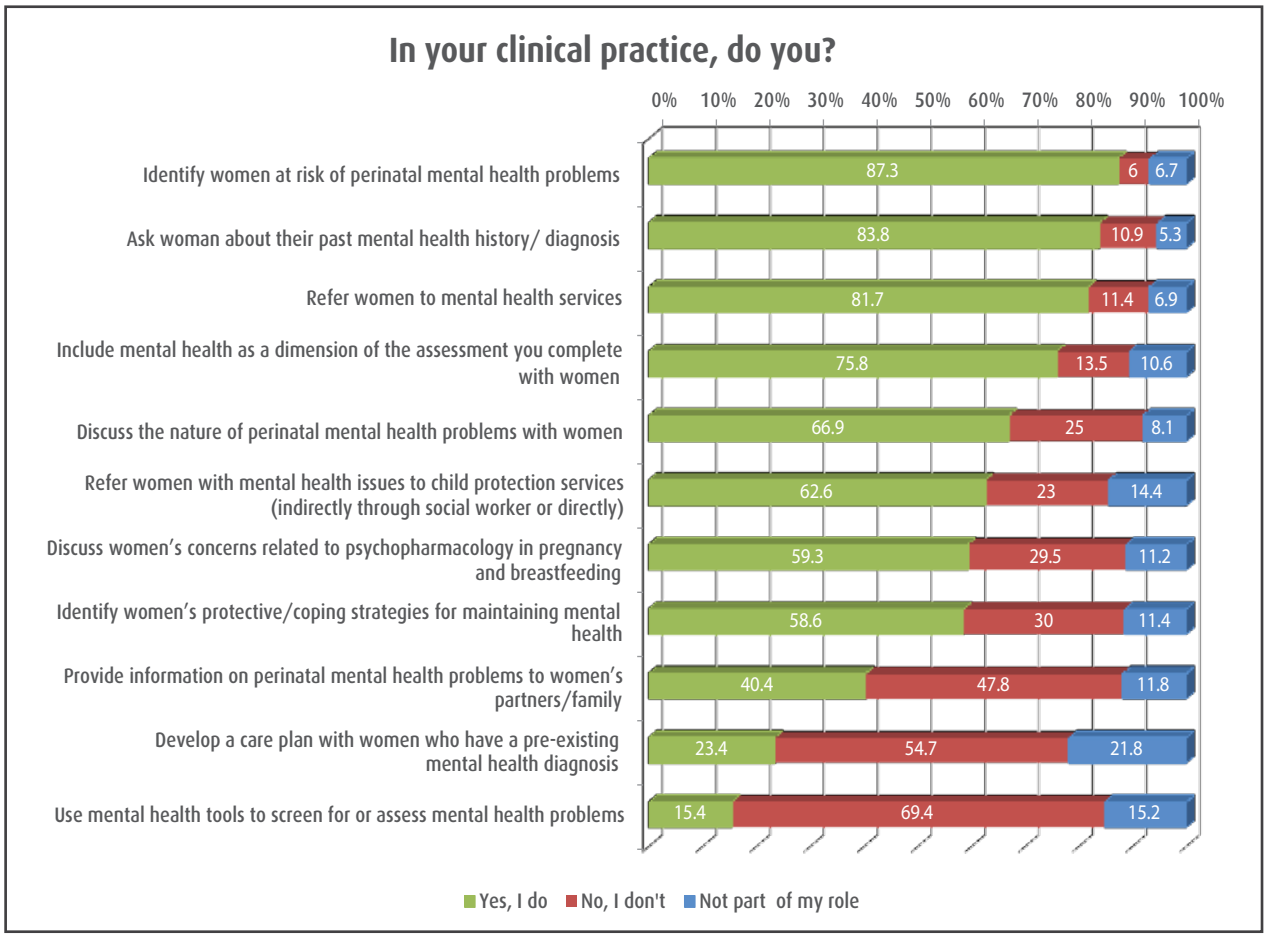
The participants were asked to indicate if they were currently undertaking, as part of their role, any of the eleven perinatal mental healthcare activities listed. Between 6-15% indicated that the activities listed were not part of their current role, with 21% indicating that developing a plan of care with women with a history of mental health issues was not part of their role. Figure 4.1 shows these activities ranked in order of highest to lowest participation.

In relation to assessment activities, whilst over three quarters of the sample reported including mental health as a dimension of their assessment with women (75.8%, n=342), identifying women at risk of perinatal mental health problems (87.3%, n=393) and asking about past mental health history/diagnosis (83.8%, n=377), nearly 70% reported not using any mental health tools (69.4%, n=310).

In relation to planning care and discussing issues with women, while two-thirds reported discussing the nature of perinatal mental health problems with women (66.9%, n=297), less than 60% said that they discuss concerns related to psychopharmacology in pregnancy and breastfeeding (59.3%, n=265) or women's protective/coping strategies (58.6%, n=114).

In relation to developing a plan of care with women with a pre-existing mental health diagnosis, despite a significant number reporting that they referred women to mental health services (81.7%, n=365) and child protection services either directly or indirectly through a social worker (62.6%, n=278), over half (54.7%, n=243) reported that they did not develop a plan of care, and a fifth stated it wasn't part of their role (21.8%, n =97). In relation to providing information on perinatal mental health problems to women's partners/family members, more midwives reported not doing it compared to those who reported doing so (47.8%, n=214 vs. 40.4%, n=181) (See figure 4.1).

Figure 4.1: Current perinatal mental health activities

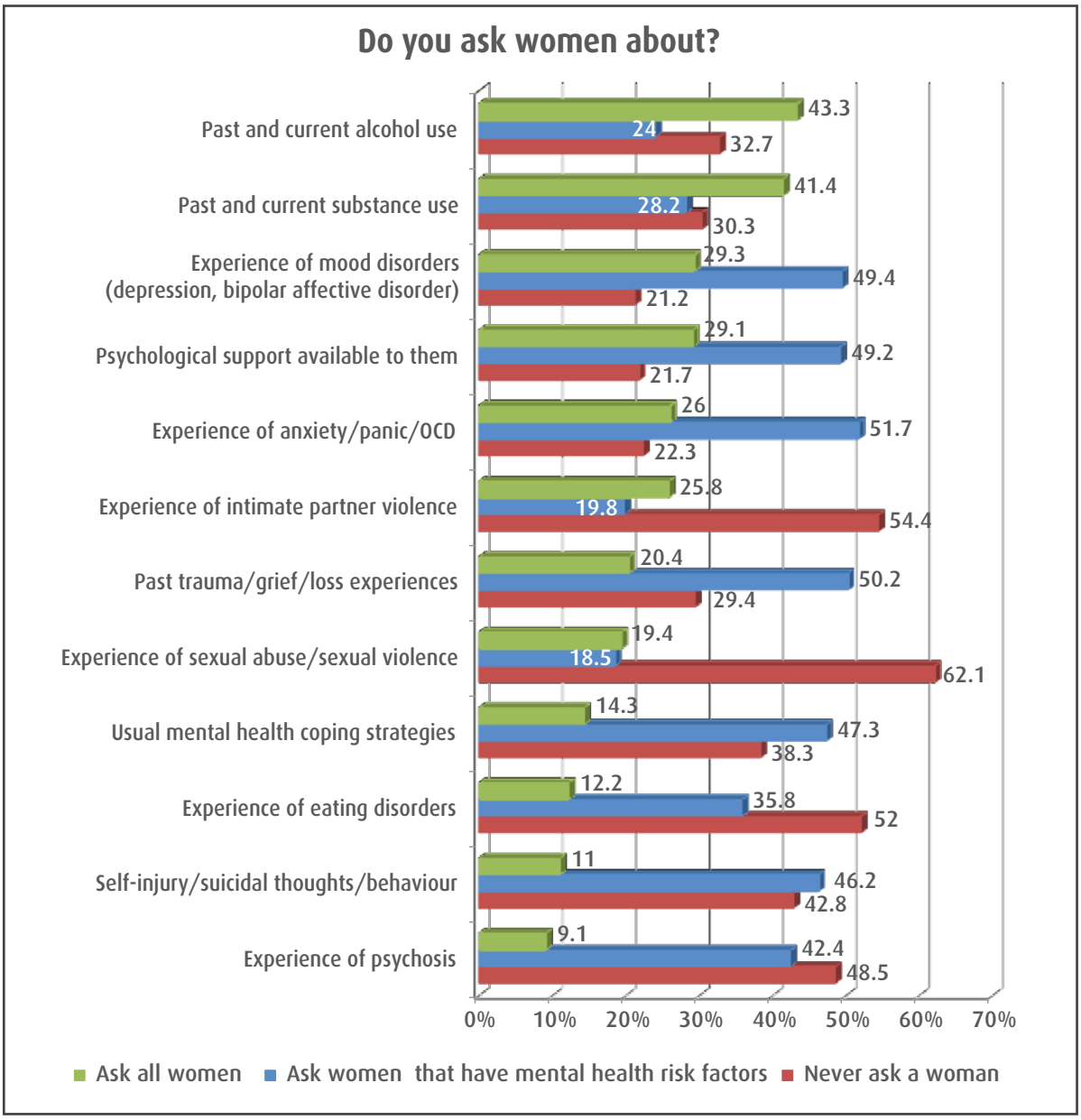


Current practice in relation to perinatal mental health assessment

To get a greater understanding of what was included in the mental health assessment completed and with what group of women, midwives were asked to indicate if they asked, all women or just women who have mental health risk indicators, about 12 mental health issues (See figure 4.2). Findings from this suggest that while 25-30% ask all women about mood, anxiety, IPV and psychological supports available to them, approximately 50-60% never ask women about experience of sexual abuse/sexual violence (62.1%, n=269), IPV (54.4%, n=236), eating disorders (52%, n=225) or psychosis (48.5%, n=214).

A higher proportion of midwives reported asking all women about past and current alcohol abuse (43.3%, n=188) and substance abuse (41.4%, n=179) compared to those who never asked (32.7%, n=142 & 30.3%, n=131 respectively) and those who only asked women with mental health risk factors (24%, n=104 & 28.2%, n=122 respectively). A higher proportion reported asking women with mental health risk factors about self-injury/suicidal thoughts or behaviours (46.2%, n=201) rather than never asking or asking all women (42.8%, n=186 & 11%, n=48 respectively). Similarly, a higher proportion reported asking women that have mental health risk factors about their use of mental health coping strategies (47.3%, n=205) compared to those who reported never asking or asking all women (38.3%, n=166 & 14.3%, n=62 respectively) (See figure 4.2).

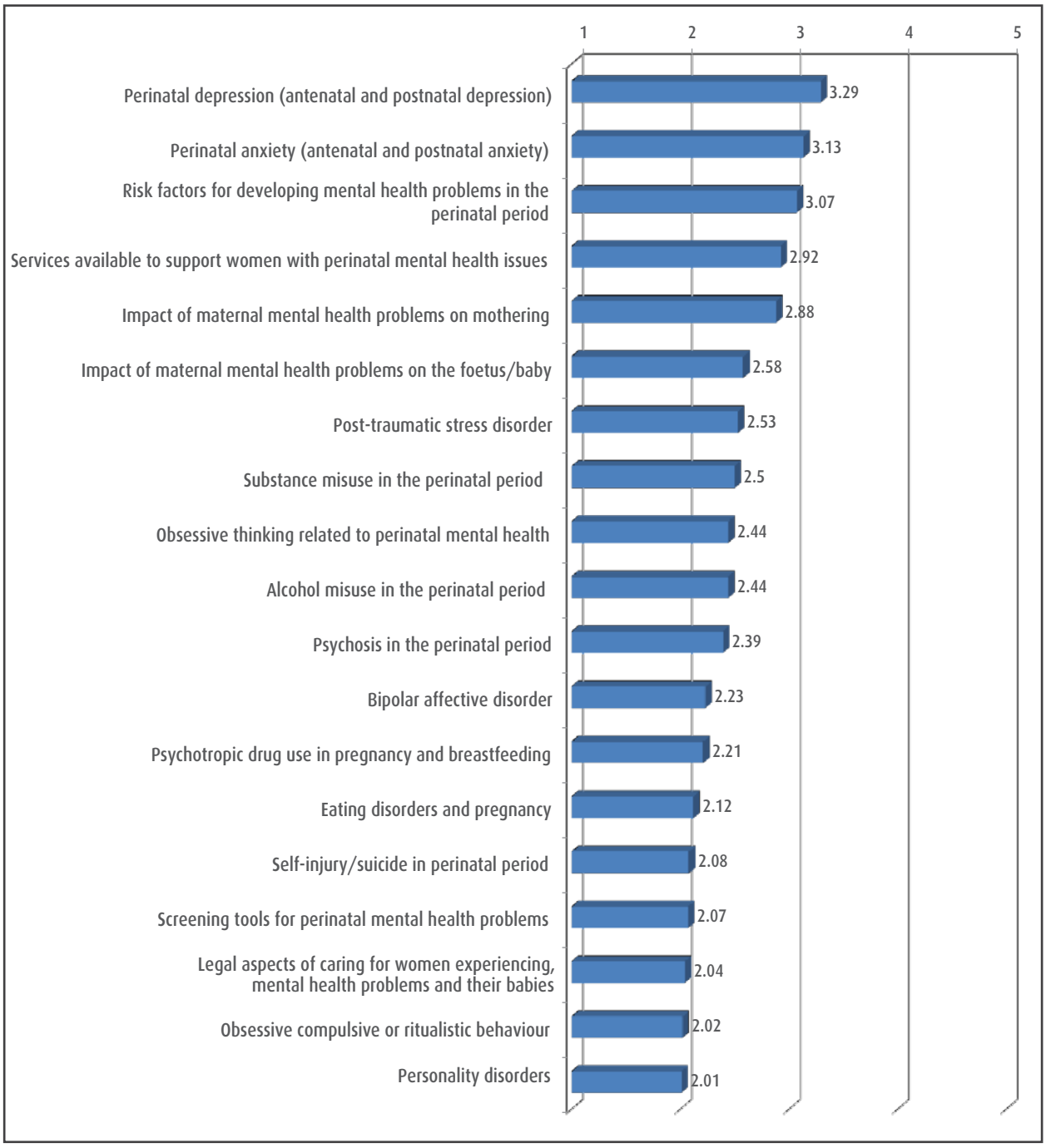
Figure 4.2: Perinatal mental health assessment



Knowledge of perinatal mental health

Midwives were asked to rate a 19 item knowledge of perinatal mental health scale (1=not at all knowledgeable; 5=very knowledgeable). Three items were rated at or above the midpoint of the scale. Knowledge on all remaining items ranged from 2.01 to 2.92, below the midpoint of the scale (See figure 4.3). The number and standard deviation of all items is included in appendix 3b.

Figure 4.3: Self-rated knowledge of perinatal mental health



Skills in undertaking perinatal mental health activities

Midwives were asked to rate, on a scale of 1 (not at all skilled) to 5 (very skilled), their skill in undertaking a range of activities. The 35 activities listed addressed six key areas: opening a discussion with women; providing support to women; developing a plan of care; discussing the need for referral; providing support to partners/family members; and asking colleagues for advice or assistance.

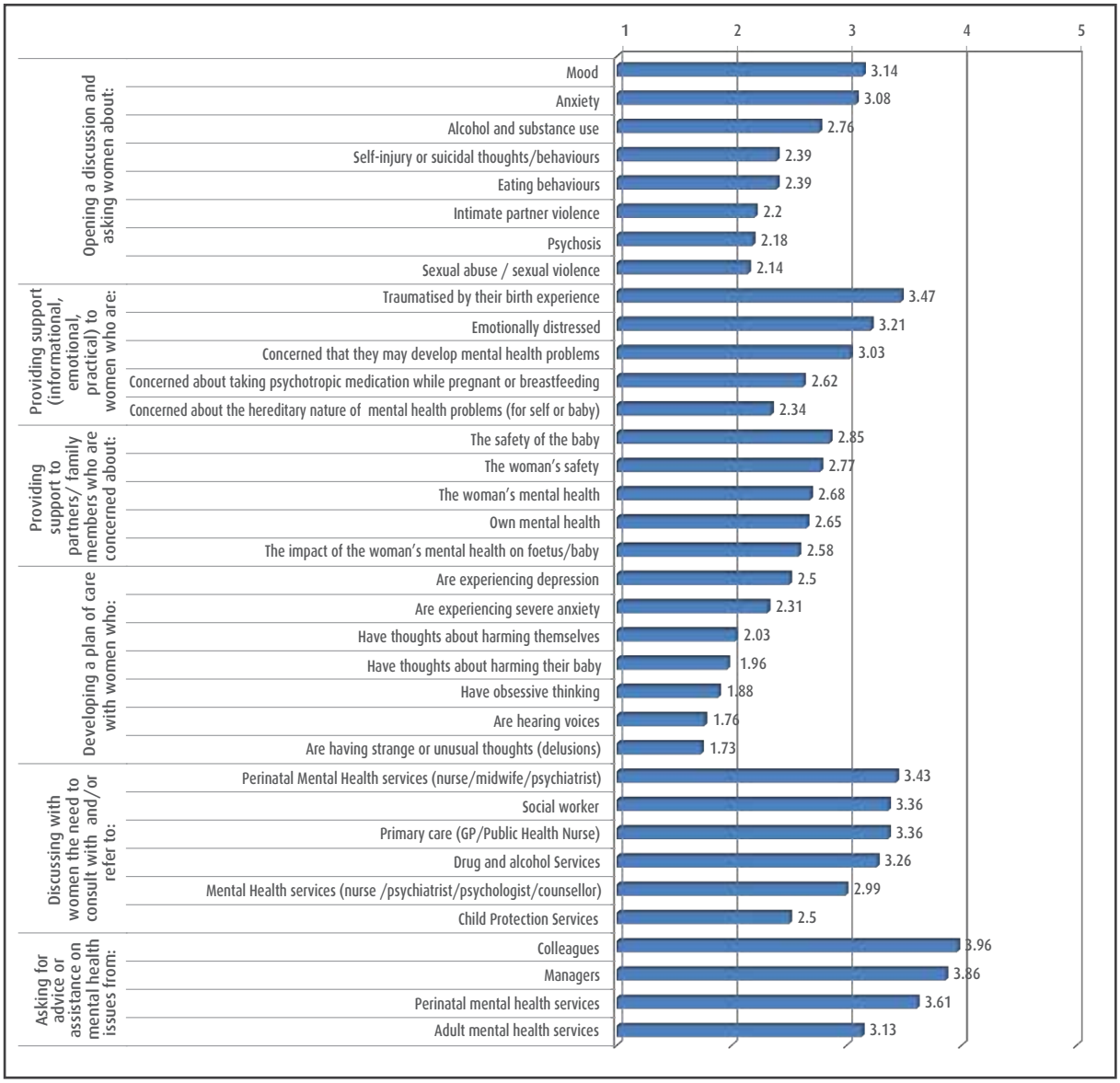
On opening a discussion and asking women about various topics, midwives reported greater skill in asking about mood, anxiety and alcohol/substance misuse than they did on psychosis, IPV or sexual abuse, which were all rated below the midpoint of the scale.

In relation to providing support to women, midwives rated their skill highest in providing support to women traumatised by their birth experience (M=3.47) and emotionally distressed (M=3.21), and lowest in providing support to women concerned about the hereditary nature of mental health problems (M=2.34). Corresponding with their skill rating in opening a discussion, midwives considered themselves to have greatest skill in developing care plans with women experiencing depression (M=2.50) and lowest in relation to developing care plans for women who considered harming themselves (M=2.03), their baby (M=1.96), or experiencing obsessive thinking (M=1.88), delusions (M=1.73) or hearing voices (M=1.76). In relation to discussing with women the need to consult with and/or refer to other professionals or services, midwives mean ratings for all items was above the midpoint of the scale, with the exception of discussion on referring to a mental health service or child protection service.

In relation to providing support to women's partners/family members, mean scores ranged from 2.58 in relation to supporting partners/family members concerned about the impact of the woman's mental health on the foetus/baby to 2.85 with regard to supporting partners/family members concerned about the safety of the baby.

In terms of seeking advice, the mean rating was highest on seeking advice from colleagues (M=3.96) and lowest on seeking assistance from adult mental health services (M=3.13) (See figure 4.4). The number and standard deviation of all items is included in appendix 3c.

Figure 4.4: Self-rated skills in undertaking perinatal mental health activities



Overall skill and confidence

Midwives were also asked to rate their skill and confidence in relation to their activities in perinatal mental healthcare on a scale from 1 (not at all confident/skilled) to 10 (very confident/skilled). The mean scores were 4.46 for overall skill and 4.35 for overall confidence, both below the midpoint of the scale (See table 4.5).

Table 4.5: Overall skill and confidence

	N	Minimum	Maximum	Mean	SD
Overall Skill	450	1	10	4.46	1.85
Overall Confidence	450	1	10	4.35	1.87

Factors related to skill, confidence and knowledge

Further analysis showed that there were no statistically significant differences in mean skill and confidence scores based on either age [H(7)=2.432. p>.05; H(7)=3.679, p>.05], educational level (undergraduate or postgraduate) [t(444)= -.987, p>.05; t(444)= -.657, p>.05] or duration of time in role [F(3, 446)=.673, p>.05; H(3)=5.595, p>.05]. However, those that had some PMH education rated themselves as having higher confidence and skill than those without any PMH education (See table 4.6), and they also had higher scores on all knowledge items compared to those without PMH education (See appendix 3d), differences which were all statistically significant.

Table 4.6: Skill and confidence among those with and without education

	Some Education in PMH						T-Test
	Yes			No			
	N	Mean	SD	N	Mean	SD	
Overall Skill	282	4.83	1.85	162	3.82	1.69	t(442)= 5.696, p<.001
Overall Confidence	283	4.73	1.84	161	3.67	1.75	t(442)= 5.930, p<.001

Midwives who reported dealing with women with PMH issues had statistically significant higher scores in both skill and confidence than those who reported not dealing with women with PMH issues, and had statistically significant higher scores on 5/19 knowledge items (See table 4.7).

Table 4.7: Skill, confidence and knowledge among those dealing with women with perinatal mental health issues and those not

	Deal with women with PMH issues						T-Test
	Yes			No			
	N	Mean	SD	N	Mean	SD	
Overall Skill	411	4.55	1.82	36	3.44	1.95	t(445)= 3.475, p<.001
Overall Confidence	411	4.44	1.85	36	3.28	1.91	t(445)= 3.616, p<.001
Knowledge							
Risk factors for developing mental health problems in the perinatal period	410	3.11	.87	410	3.11	.87	t(41.484)= 2.319, p<.05
Perinatal depression (antenatal and postnatal depression)	409	3.32	.81	409	3.32	.81	t(40.246)= 2.235, p<.05
Perinatal anxiety (antenatal and postnatal anxiety)	408	3.17	.85	408	3.17	.85	t(444)= 3.486, p<.001
Psychosis in the perinatal period	412	2.43	1.00	412	2.43	1.00	t(448)= 2.370, p<.05
Post-traumatic stress disorder	410	2.58	1.07	410	2.58	1.07	t(445)= 3.481, p<.001

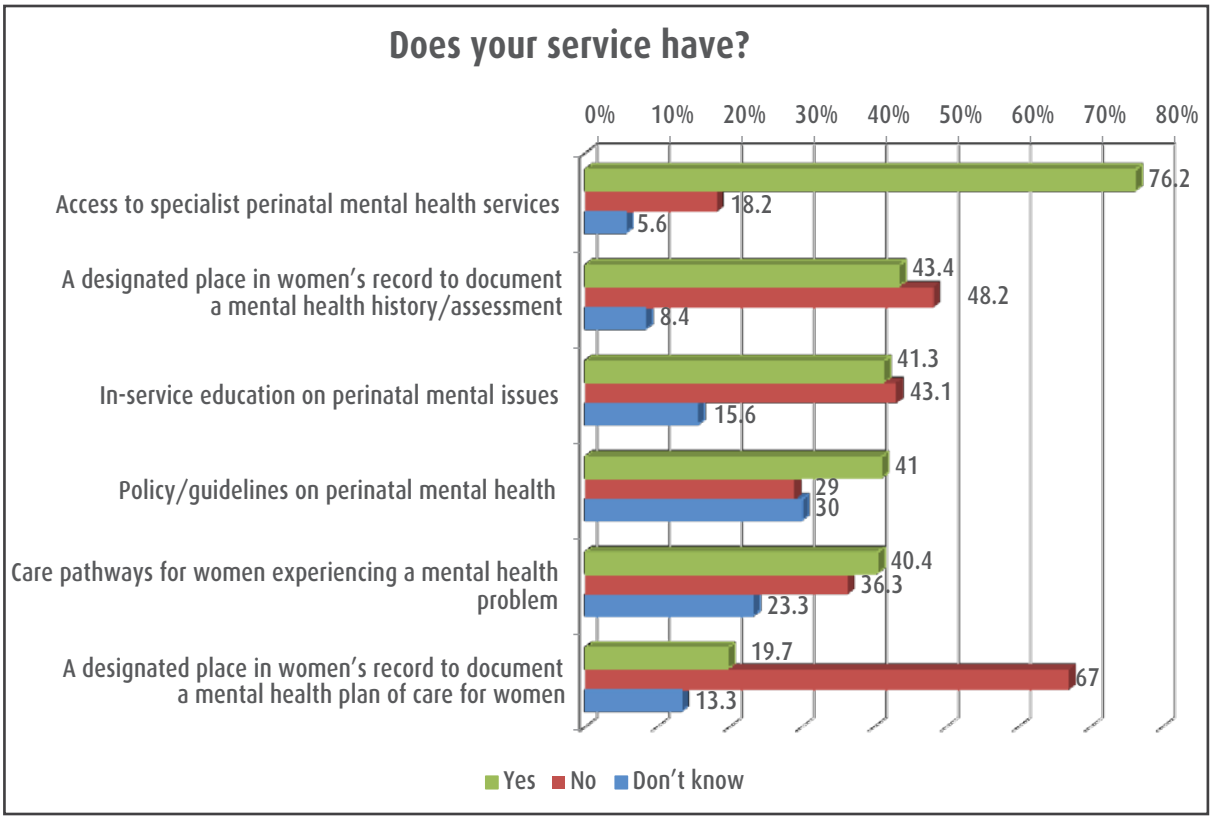
Perinatal mental health service and guidelines

Midwives were asked whether the service they worked within had services, education, and guidelines related to perinatal mental health.

Approximately three quarters of midwives reported access to specialist perinatal mental health services (76.2%, n=339). However, only 41% (n=178) reported the presence of policies or guidelines on perinatal mental health within their service while 29% (n=126) reported there wasn't and 30% (n=130) were unsure. 40% (n=177) reported that there was care pathways for women experiencing a mental health problem compared to approximately 36% (n=159) who stated there wasn't care pathways and 23% (n=102) who did not know if there were.

Nearly 50% reported that there was no designated place in women's record to document a mental health history/assessment (48.2%, n=213), with two-thirds of the sample reporting that there was no designated place in women's record to document a mental health plan of care (67%, n=293). Midwives reported a greater absence of in-service education on perinatal mental health issues compared to those who stated that there was in-service education (43.1%, n=188 vs. 41.3%, n=180) (See figure 4.5).

Figure 4.5: Perinatal mental health service and guidelines



Barriers to discussing mental health issues

Midwives were asked to what extent they considered a range of issues to be barriers to discussing mental health issues with women. Four response categories were given: 'to no extent'; 'to a little extent'; 'to a moderate extent'; and 'to a great extent'. For the purpose of analysis, 'to no extent' and 'to a little extent' were merged and 'to a moderate extent' and 'to a great extent' were merged (The responses are shown in appendix 3e).

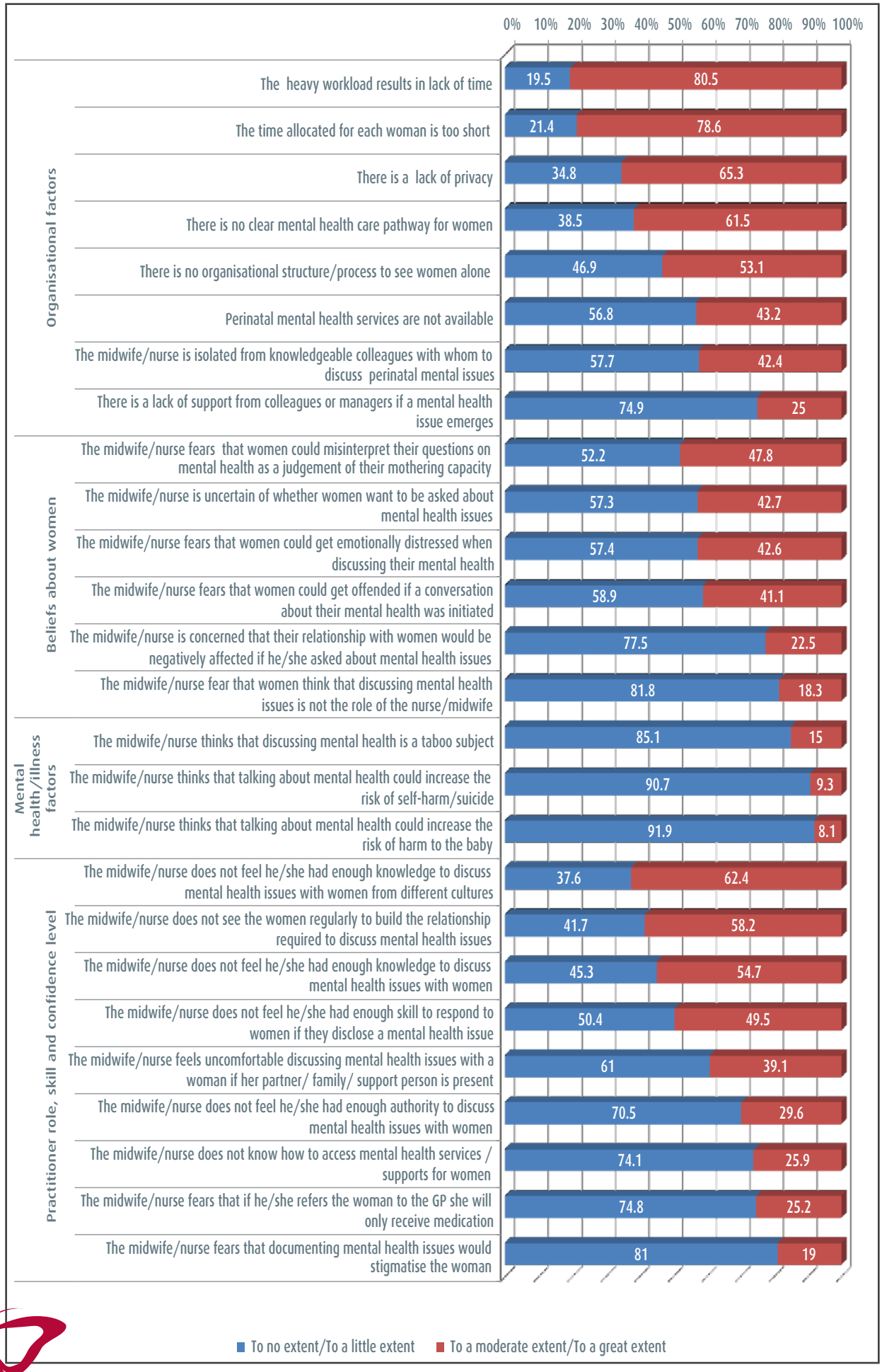
The greatest barriers identified were organisational: approximately four fifths of the sample viewed heavy workload (80.5%) and short time allocated to women (78.6%) as major barriers to discussion. Between 42-65% were of the view that a lack of privacy (65.3%), lack of mental healthcare pathway (61.5%), lack of organisational structures to support women being seen alone (53.1%), lack of perinatal mental health services (43.2%), together with midwives being isolated from knowledgeable colleagues (42.4%) were key barriers.

Practitioner knowledge and skills were the next significant group of barriers identified: lacking knowledge on how to discuss mental health with women (54.7%), particularly with women from different cultures (62.4%); not seeing women regularly enough to establish relationship (58.2%); and not having the skill to respond to women who disclose a mental health issue (49.5%) were reported as greatly inhibiting discussion.

Approximately 40% identified discomfort due to the presence of a woman's partner/family member as a barrier to a moderate/great extent (39.1%), with approximately a quarter of the sample feeling they did not have enough authority to discuss mental health issues with women (29.6%); did not know how to access mental health services/supports for women (25.9%); feared that if they referred the woman to the GP she would only receive medication (25.2%); or that by documenting a mental health issue the woman would be stigmatised (19%).

41-50% of midwives reported barriers that centred around their beliefs about women including: fear that women could misinterpret their questions as a judgement of their mothering capacity (47.8%); get emotionally distressed (42.6%); or get offended (41.1%), which no doubt is a reflection of the fact that 42.7% reported that their uncertainty about whether women want to be asked about mental health issues inhibited discussion (See figure 4.6).

Figure 4.6: Barriers to discussing mental health issues



There were statistically significant differences between those who reported dealing with women with PMH issues and those who didn't on 7/26 of the barrier items, with those not dealing with women with PMH issues having higher mean scores, which indicated that they perceive the item to be a greater barrier than those who deal with women with PMH issues (See table 4.8).

Table 4.8: Perceived barriers among midwives dealing with women with perinatal mental health issues and those not

Barriers	Deal with women with PMH issues						T-Test
	Yes			No			
	N	Mean	SD	N	Mean	SD	
There is no clear mental healthcare pathway for women	278	2.70	1.10	159	3.02	1.02	t(349.944)= -3.070, p<.05
There is a lack of support from colleagues or managers if a mental health issues emerges	278	1.85	.84	160	2.03	.92	t(436)= -2.001, p<.05
The midwife/nurse does not feel he/she had enough authority to discuss mental health issues with women	281	1.93	.92	160	2.13	1.02	t(439)= -2.065, p<.001
The midwife/nurse does not feel he/she had enough knowledge to discuss mental health issues with women	279	2.52	.96	161	2.78	1.04	t(445)= -2.641, p<.05
The midwife/nurse does not feel he/she had enough knowledge to discuss MH issues with women from different cultures	280	2.69	.95	161	2.98	.98	t(439)= -3.042, p<.05
The midwife/nurse does not feel he/she had enough skill to respond to women if they disclose a mental health issue	281	2.40	.94	161	2.63	.98	t(440)= -2.536, p<.05
The midwife/nurse does not know how to access mental health services/ supports for women	280	1.92	.85	162	2.14	.97	t(301.077)= -2.346, p<.05

Midwives' educational priorities

Midwives were asked to list three educational priorities on perinatal mental health that would assist them with their clinical practice. Analysis of responses resulted in three categories: knowledge of PMH issues and related topics; skill development in relation to PMH; and delivery/ format of education.

In relation to knowledge, midwives' priorities included knowledge about the types, incidence and risk factors for developing perinatal mental health problems. Midwives also identified a range of other areas in which they needed knowledge and these included: trauma-birth/PTSD, bipolar disorder, psychosis, IPV, eating disorders, difference between grief and depression, anxiety, depression, self-harm/suicide, substance misuse, OCD, bereavement, attachment and bonding, safety of mother and new-born, cultural issues around mental health, side effects of pharmacological treatment and legal issues related to perinatal mental health. The recognition and

assessment of perinatal mental health was identified as an area in which training was required, particularly in relation to identifying the signs of a perinatal mental health issue, and the use of screening tools, checklists and other mechanisms to assess mental health in the perinatal period. In terms of how care is organised, midwives identified needing guidance in relation to care and referral pathways, follow-up procedures and procedures in the event of emergencies.

Skills in a number of areas were identified as priorities within education; many of the issues identified fell within the area of communication, with particular emphasis placed on interviewing skills, opening a discussion on mental health with women, asking questions as part of a screening process, enabling women to disclose and addressing women's fears. In addition, skills to discuss issues with family were also listed, as were team communication and documentation skills.

Various modes of educational delivery were suggested including online learning, local study days and workshops. Mental health expertise input into education and input from members of the MDT were both recognised as important aspects in the delivery of education, as was incorporating real life scenarios, role play and opportunities to work with people with expertise in the area. Many emphasised the need for perinatal mental health to be incorporated in all nursing and midwifery programmes, with some mentioning the need for NMBI course approval, and possibly making education in perinatal mental health mandatory. The full range of educational priorities identified are listed in table 4.9.

Table 4.9: Midwives' educational priorities

Category	Item
Knowledge of PMH issues and related topics	• Mental illnesses and distress e.g. trauma-birth/ PTSD, bipolar, psychosis, IPV, eating disorders, difference between grief and depression, anxiety, depression, self-harm/suicide, substance misuse, OCD, Bereavement • Incidence/prevalence of PMH issues • Risk factors/screening tools • Family planning/contraception • Safety of new-born and mother • Attachment and bonding • Medication: side effects, breastfeeding and medication • Cultural issues around mental health • Legal issues related to PMH i.e. child protection • The role of the midwife in PMH care • What to do in an emergency
Skill development	• Interviewing skills: e.g. strategies for indirect approaches to discussing MH; Appropriate language to use; • Identifying women at risk: screening tools, questions best to ask/avoid; practical strategies for getting women to disclose • Counselling/support skills: addressing women's fears, challenges and stigma around talking with women about MH • Communication with family: How best to involve family/partner • Team communication: Liaising with psychiatric services; Liaison between community and acute PMH providers • Documentation skills: documenting sensitive information

Category	Item
Types of education	• National education programme • Included in nurse/midwife education for undergraduates and post-graduate course in mental health • Stand-alone module on PMH in third level • Online education sessions through HSE Land • Ongoing in-service education/continuous professional development/local study days/updates/refresher courses • MDT education • NMBI course approval • Mandatory study days • Research updates/further reading • Input from experts e.g. Lecture from a specialised perinatal psychiatrist; Social worker; MH team/psychiatric services; external support groups • Midwifery-specific workshops with real life scenarios and role play/ discussion groups • Clinical skills: more exposure to PMH services in the hospital; experience in clinics

Midwives' change priorities

Midwives were asked to list three changes they would like to see in the area of perinatal mental healthcare. Analysis of the responses resulted in nine categories: organisation of care; better assessment and early recognition; better documentation; better communication/liaison; increased services and supports for women; better access to services; education and support of women and their families; support for staff; and raising awareness of the public (See table 4.10). Midwives firstly prioritised the need for better national policies and guidelines in the area of perinatal mental healthcare, including guidelines on assessment, medication use, emergencies, discharge home and referral. They also expressed a strong desire for more guidance around care planning, and caring for women who were violent or suicidal. They also called for greater flexibility in the referral process to allow for self-referral and direct referrals. Better follow-up care was also viewed as being required.

Another area identified for change was the assessment of women for the presence of a perinatal mental health issue. It was recommended that all women undergo screening as a matter of course, with early recognition being viewed as optimal in both the antenatal and postnatal periods. Various means of screening were put forward including the use of checklists, self-completed health questionnaires, mental health score sheets and assessment tools to facilitate structured questioning, while more informal ways of discussing perinatal mental health issues were also viewed as valuable. Longer booking times were viewed as necessary to enable midwives to conduct thorough screening. More comprehensive documentation was also cited as a change which needed to be implemented in terms of having designated places within women's records to record their mental health history, care plan and so on.

Many midwives felt that changes in the ways practitioners and services communicated information and liaised with each other in the care of women needed to be implemented in order to improve co-ordination and integration of care. Better communication between disciplines, teams, departments, and between hospital and community services was cited as being required. In addition, a range of resources and services were identified as being needed to support women, including increases in specialist perinatal mental health services, the number of health practitioners with expertise in mental health (psychology, psychiatry, nursing/midwifery), PMH

clinics, mother and baby units and helplines. It was also considered a priority that women have access to non-pharmacological treatments, particularly treatments aimed at stress management and enhancing coping skills. The full list is displayed in table 4.10.

Many midwives identified smoother access to services as an issue which needed to be addressed by broadening access to care through the provision of 24 hour services and reducing waiting times in clinics. Education for both women and their partners/family members was deemed important as was providing them with information which was culturally appropriate, available in their first language and available both in booklet format and online. In addition to providing education to empower women to address their mental health in the perinatal period, midwives underlined the importance of shifting the culture away from stigmatisation towards more openness among the general public. A gap in support and guidance for staff was identified. In this regard, it was felt that access to support from specialists in mental health and midwifery as well as a list of services and professionals available to support women with perinatal mental health issues would better guide midwives in their clinical practice.

Table 4.10: Midwives' change priorities

Category	Item
Organisation of care	• Clear nationwide pathway of care; national guidelines; better care plans/pathways/guidelines/policies; mental healthcare plan, policy and guideline • Clinical guidelines for medication use; for emergencies; for discharge home; for referral/escalation • Protocol to manage patients who are aggressive, going through withdrawal and have suicidal tendencies • Clear guidelines to support women with MH issues rather than referring to psychiatric services • All antenatal women with any history of MH issue to come in contact with MHS as routine • Referral: referral pathways; designated person to refer; midwives having authority to refer, not waiting for the doctor to refer; women able to self-refer easily; direct referral for women with existing mental health problems into maternity system • Appropriate follow-up and follow up procedures; better follow-up care for women/community follow-up postnatally/routine antenatal and postnatal follow-up
Better assessment and early recognition	• Screening of all women/routine questions asked at antenatal booking/ routine open discussion about MH at visits/assessment of mothers of extremely sick and premature infants, congenital abnormalities; ongoing risk assessments in community • Use of screening tools: Women asked to complete health questionnaires antenatally and postnatally; • More structured questions for everyone at booking visits; using Checklists; Assessment tools used routinely; Risk assessment - mental health score sheet • Change to documentation: questions included in chart re domestic violence, sexual abuse etc./admission checklist and postnatal checklist to include MH • More informal ways of discussing MH with women • Time: longer booking times to better assess mental health

Category	Item
Better documentation	• Charts have a history section to identify and highlighted mental health history; designated place in women's notes to record mental healthcare plan and progress • History of depression documented at booking visit • Documentation of services made available to women
Better communication/ liaison	• Better link up with hospital to improve access to services and management of PMH • Better communication; between disciplines and departments; between MHS/MSW/PMH team and midwives/maternity services; between hospital and community; within MDT • Regular psychiatric input into maternity liaison services • More open disclosure on women's mental health issues in booking letter from GP • More interdisciplinary meetings and input e.g. case conferences
Increased services and supports for women	• More PMH services/specialists (e.g. psychiatry, psychology, midwives, PHNs, advanced practice nurses/consultants/teams/ clinical nurse specialist • Dedicated mental health liaison nurse/midwife; More mental health liaison nurses; Link psychiatric nurse for perinatal health; • Clinics: A PMH clinic; joint obstetric and psychiatric and mental health midwife specialist clinics; specialised antenatal clinics; drop-in clinic for women admitted/for women in the postpartum period • A larger mental health team within maternity settings/more staff on MH team • Mother and baby beds; mother and baby units; national treatment centre for mothers and babies • Better primary care services • More community/local supports e.g. home help for women • 24hour helpline service; an overnight support service in the postnatal period • More support networks on postnatal ward • More perinatal drop in discussion groups for mothers • More emphasis on non-pharmacological interventions • Therapies available to women: Relaxation sessions in hospital for women; More psychotherapy/counsellors; counselling visit as part of the 6 week postnatal check for mother and baby • Birth debriefing for those with PTSD • Alternative therapies; relaxation and coping skills/strategies; stress management techniques; practical strategies to help with distress; mindfulness, CBT, yoga, hypnotherapy, reflexology, self-care taught to mothers
Better access to services	• Smoother access to psychiatry especially in emergency • 24 hour access to appropriately trained PMH staff • Shorter waiting times in clinics • Experienced mental health midwives on wards at weekends • Better access to clinical nurse specialist; social workers; MHS • Free and accessible outpatient services

Category	Item
Education and support for women and their families	• Antenatal and postnatal education with emphasis on MH • Leaflets/booklets for women e.g. postnatal depression education leaflet • Online access to information for women • DVD education sessions for women on antenatal/postnatal wards • Information available in other languages • Parenting training • Support services for partners • More posters/advertising around hospital/outpatient departments/ clinics • Positive perinatal well-being events in hospital • Women more empowered re mental health
Raising awareness among public	• More publicity re mental health • More public info/discussion • Less stigma
Support for staff	• Staff support and advice available e.g. debriefing • More support for midwifery specialists in this role • More staff support for own mental health and self-care • Access to a support person trained from both mental health and midwifery • An identified lead psychiatric nurse/doctor to liaise with midwives to discuss on going worries/concerns • More information for midwives in services/facilities available and who to contact when needed • Clear information on services available • Referral reference guides: e.g. a national database with contacts such as social workers and clinical psychologists; List of support services; handbook in each department - quick reference guide of referral system and service

Summary

- Overall 458 midwives completed the surveys. The majority were female, over 35 years of age, in their current role for over 11 years (53.7%), employed as midwives in the public health service (87.8%), working in a stand-alone maternity hospital (56.1%) and educated to degree or postgraduate diploma/masters level (77%).
- The majority reported caring for women with perinatal mental health problems in their current role (91.6%) and reported caring for between 1-10 women (62.7%) in the previous six month, with approximately one in five (23%) reporting caring for more than 21 women.
- Approximately two-thirds (63.6%) indicated that they received education in perinatal mental health. The biggest source of learning was during nursing/midwifery training programmes, followed by in-service/study days and self-directed learning. However, only 41% reported the presence of in-service education on perinatal mental health issues within their service.
- Approximately three quarters of midwives reported that they had access to specialist perinatal mental health services (76.2%); however, only 41% reported the presence of policies or guidelines on perinatal mental health within their service, with 30% being unsure as to whether they existed. 40% reported that there was care pathways for women experiencing a mental health problem while 23% did not know if they existed. With regard to designated places within women's record to document information, around two-thirds of the sample reported that there was no such space to document a

mental health plan of care for women (67%) and 48% reported that there was no place to document a mental health history/assessment. Midwives reported a greater absence of in-service education on perinatal mental health issues compared to those who stated that there was in-service education (43.1% vs.41.3%).

- While over three quarters of midwives were including mental health in their assessment (75.8%), identifying women at risk of PMH problems (87.3%) and enquiring about past mental health (83.8%), approximately 70% reported not using any mental health screening tools. Furthermore, the majority did not develop a plan of care with women who had a pre-existing mental health diagnosis (54.7%), with a fifth stating that it wasn't part of their role (21.8%).
- In terms of the topics discussed during perinatal mental health assessments, there were none that midwives routinely asked of all women. The topics most discussed with all women included past and current alcohol abuse (43.3%), substance abuse (41.4%), experience of mood disorders (29.3%) and psychological support available (29.1%), while around a quarter reported asking all women about experience of anxiety (26%) and IPV (25.8%).
- Approximately 50-60% reported never asking women about experience of sexual abuse/ sexual violence (62.1%), IPV (54.4%), eating disorders (52%) or psychosis (48.5%). Some topics were directed more so at those that had mental health risk factors rather than being asked of all women or never being asked. These included: experience of anxiety/panic/OCD (51.7%); past trauma/grief/loss experiences (50.2%); experience of mood disorder (49.4%); psychological support available (49.2%); mental health coping strategies (47.3%); and self-injury/suicidal thoughts/behaviour (46.2%).
- Midwives' knowledge was highest on perinatal depression, perinatal anxiety and risk factors for developing mental health problems in the perinatal period. Knowledge was relatively low on obsessive thinking, alcohol misuse, psychosis, bipolar disorder, psychotropic drugs, eating disorders, personality disorders, obsessive compulsive or ritualistic behaviour, legal aspects, screening tools and self-injury/suicide in the perinatal period.
- Overall midwives rated their skill and confidence below the midpoint of the scale. Self-reported skill was higher in relation to discussing mood and anxiety with women compared to discussing sexual abuse, IPV, psychosis, eating disorders, or self-harm/ suicidal thoughts, areas which corresponds with midwives' reported lack of knowledge and engagement within their current practice. Skill was rated higher on providing support to women who were traumatised by their birth experience and who were emotionally distressed compared to providing support to women where the issue was related to a mental health problem. The area in which skill was rated lowest among midwives was in relation to developing care plans for women, particularly in relation to developing plans for those experiencing delusions or compulsive behaviour, for those hearing voices and for those that had thoughts of harming themselves or their baby.
- Midwives reported greatest skill in discussing with women referral to perinatal mental health services, in contrast skills in discussing referral to mental health services and child protection services were below the midpoint of the scale.
- Whilst midwives were skilled in seeking advice from colleagues, managers and perinatal mental health services, they were less skilled in liaising with mental health services.
- The greatest barriers to discussing mental health issues identified by midwives were organisational, particularly the heavy workload and the short time allocated to women but also the lack of privacy, clear care pathways and organisational processes which do not facilitate seeing women alone. Practitioner related barriers were the next significant

group, with 50-62% reporting that a lack of knowledge of mental health, particularly in relation to women from different cultures, not seeing women regularly enough to build relationships and not having enough skill to respond to mental health issues were barriers to discussion to a moderate/great extent.

- Reflecting the findings above, midwives' educational priorities centred around greater knowledge on all aspects of perinatal mental health, including specific types, incidence and risk factors as well as broader topics such as bonding and attachment, and cultural and legal issues related to mental health. Communication and documentation skills were cited as being needed to aid assessment and disclosure of mental health issues.
- Similarly, midwives identified change priorities echoed the findings of the closed survey questions in terms of where service gaps exist. The changes prioritised included: developing care pathways, protocols, guidelines and documentation to improve organisation, consistency and continuity of care; early recognition of perinatal mental health issues through improved screening processes; improving the integration of, and communication between services and disciplines as well as increasing specialist perinatal services and supports for women in order to improve access to care; education of women, their partners/family members as well as education of the public; and access to support for staff working in perinatal mental healthcare.

Chapter 5:
FINDINGS FROM PRACTICE NURSES

Introduction

This chapter presents the results of practice nurses' survey responses. The demographic background of the practice nurses is first profiled before their education on and experience in perinatal mental health is described. Next, an overview of the range of perinatal mental health activities which practice nurses perform is given, while their self-perceived knowledge of perinatal mental health, and their self-reported skills and confidence in undertaking perinatal mental health activities is presented. The availability of services, education and guidelines in the services in which practice nurses work is presented while their perceptions of barriers to discussing mental health issues is outlined. Lastly, an overview of the educational priorities identified by practice nurses and the perinatal mental healthcare changes that they would like to see implemented is presented.

Sample profile

In total, 185 practice nurses completed the survey. All but one practice nurse identified themselves as female, with over half aged over 45 years (56.2%). The highest level of qualification attained was a primary degree (28.1%), followed by a diploma (24.9%) and a postgraduate diploma (22.2%). 176 participants were registered general nurses with the next biggest group being registered midwives (n=72). Approximately 3% were working outside GP services, which included two participants working in health services within third level colleges (See table 5.1).

Table 5.1: Demographic profile

		N	%
Age	25-29 years	6	3.2
	30-34 years	19	10.3
	35-39 years	19	10.3
	40-44 years	37	20.0
	45-49 years	33	17.8
	50-54 years	37	20.0
	55+	34	18.4
Highest level of qualification	Certificate	34	18.4
	Diploma	46	24.9
	Primary Degree	52	28.1
	Postgraduate diploma	41	22.2
	Masters	10	5.4
	PhD	2	1.1
Midwifery/Nursing Qualification*	RGN	176	-
	RM	72	-
	RPN	7	-
	RSCN	20	-
	RNP/RMP	10	-
	RNID	2	-
	RANP/RAMP	1	-
Area employed	GP practice	181	97.8
	Other	4	2.2
Length of time in role	0-2	21	11.4
	3-5	27	14.6
	6-10	57	30.8
	11 years+	80	43.2

*Participants could select more than one answer

Caseload of women with perinatal mental health problems

Under half of practice nurses (45.9%, n=85) reported dealing with women with perinatal mental health problems in their current role. These participants were then asked how many women experiencing a mental health issue had they cared for in the previous six months, with the majority reporting that they had cared for 1-5 women (78.2%, n=67) (See table 5.2).

Table 5.2: No. of women experiencing perinatal mental health issues cared for in the past 6 months

No. of women	N=85	%
1-5	67	78.8
6-10	10	11.8
11-15	3	3.5
16-20	3	3.5
21-25	2	2.4
25+	0	0

Education on perinatal mental health

One fifth of practice nurses (20.7%, n=38/184) indicated that they received education in perinatal mental health. The biggest source of learning was student training (n=31), followed by in-service education or study days (n=13), learning from colleagues with expertise in perinatal mental health (n=10) and self-directed learning (n=10) (See table 5.3).

Table 5.3: Education on perinatal mental health

Source of Education	N*
As part of my student training: -Student midwife training (n= 24) -Student nurse training (n=6) -Public health nurse training (n=1)	31
In-service education/study day	13
Colleagues with expertise in perinatal mental health	10
Self-directed learning	14
Post-graduate educational programme	2
Stand Alone Module delivered by third level institution	0

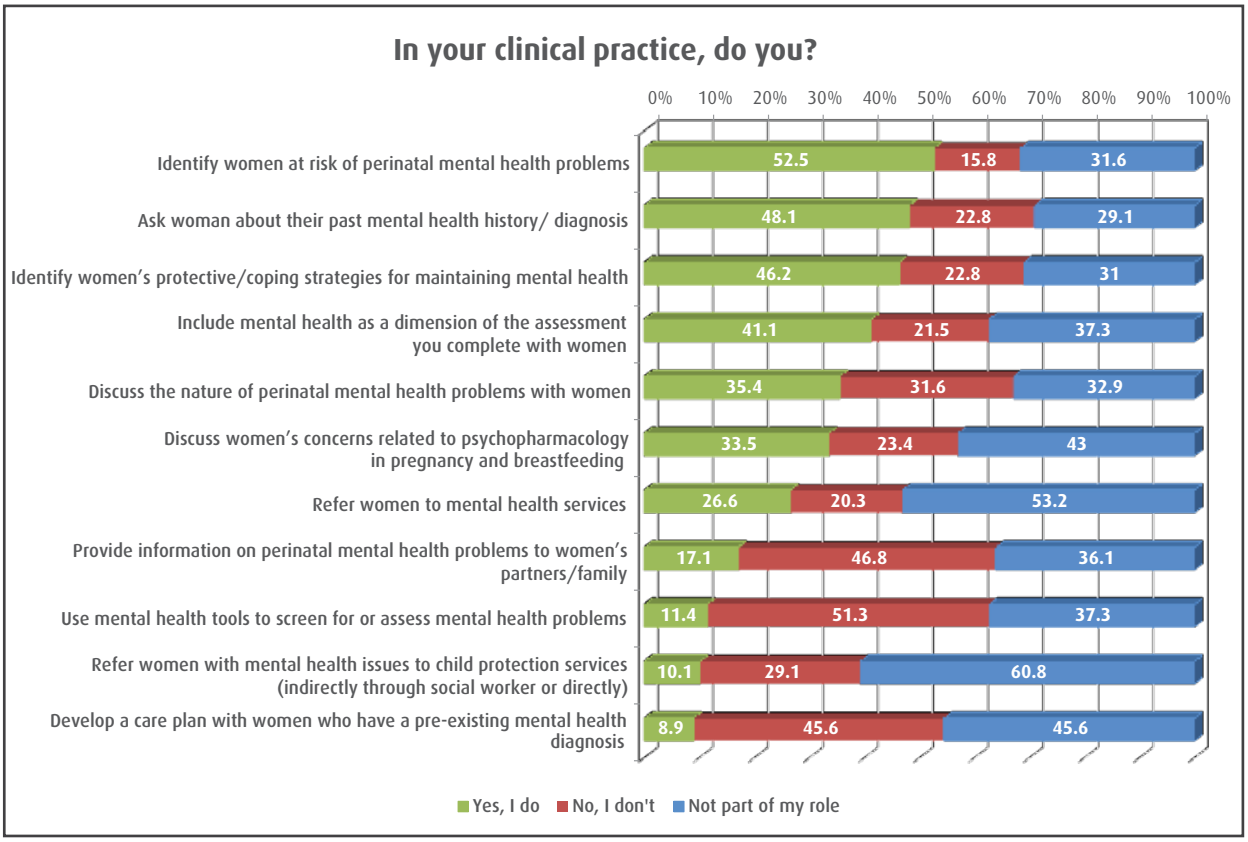
*Participants could select more than one answer

Current practice in relation to perinatal mental healthcare

Practice nurses were asked to indicate which activities, from a list of eleven, were part of their current clinical practice. Figure 5.1 shows these activities ranked in order of highest to lowest participation. Between 30-60% indicated that the activities listed were not part of their current role, with over 50% indicating that making referrals to mental health services or child protection was not part of their role. Approximately 40% indicated that including mental health as a dimension of assessment, using tools to assess mental health, or developing a plan of care with women with mental health issues was also not part of their role. Whilst approximately a third

to a half of practice nurses reported that they identify women at risk of perinatal mental health problems (52.5%, n=83), ask women about their past mental health history/diagnosis (48.1%, n=76), include mental health as a dimension of the assessment (41.1%, n=65), identify women's protective/coping strategies for maintaining mental health (46.2%, n=73), discuss the nature of perinatal mental health problems with women (35.4%, n=56) and discuss women's concerns related to psychopharmacology in pregnancy and breastfeeding (33.5%, n=53), the numbers of practice nurses who carried out the other actives listed fell between 8%-30%.

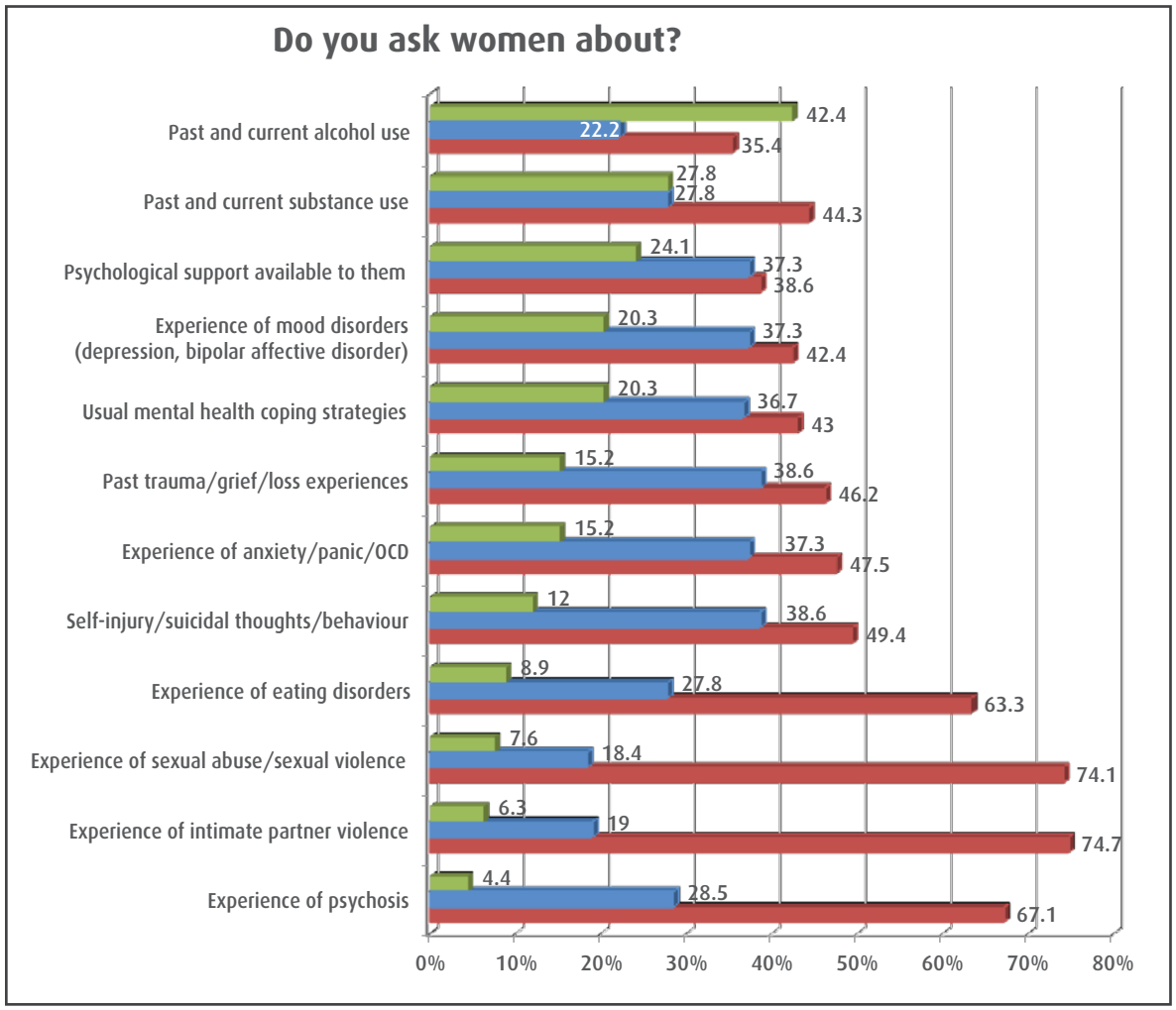
Figure 5.1: Current perinatal mental health activities



Current practice in relation to perinatal mental health assessment

Practice nurses were also asked detailed questions about what they include in a mental health assessment with all women and with women who have identifiable mental health risk factors. Approximately half of the sample reported asking all women or women who have mental health risk factors about substance misuse (55.6%, n=88), experience of mood disorders (57.6%, n=91) and mental health coping strategies (57%, n=90), while over 60% reported asking about psychological support (61.4%, n=97) and past and current alcohol use (64.6%, n=102). However, figure 5.2 shows that between 60%-75% never asked any woman about experience of IPV (74.7%, n=118), sexual abuse/sexual violence (74.1%, n=117), psychosis (67.1%, n=106) or eating disorders (63.3%, n=100). Half of practice nurses reported never asking about self-injury/ suicidal thoughts or behaviours (49.4%, n=78).

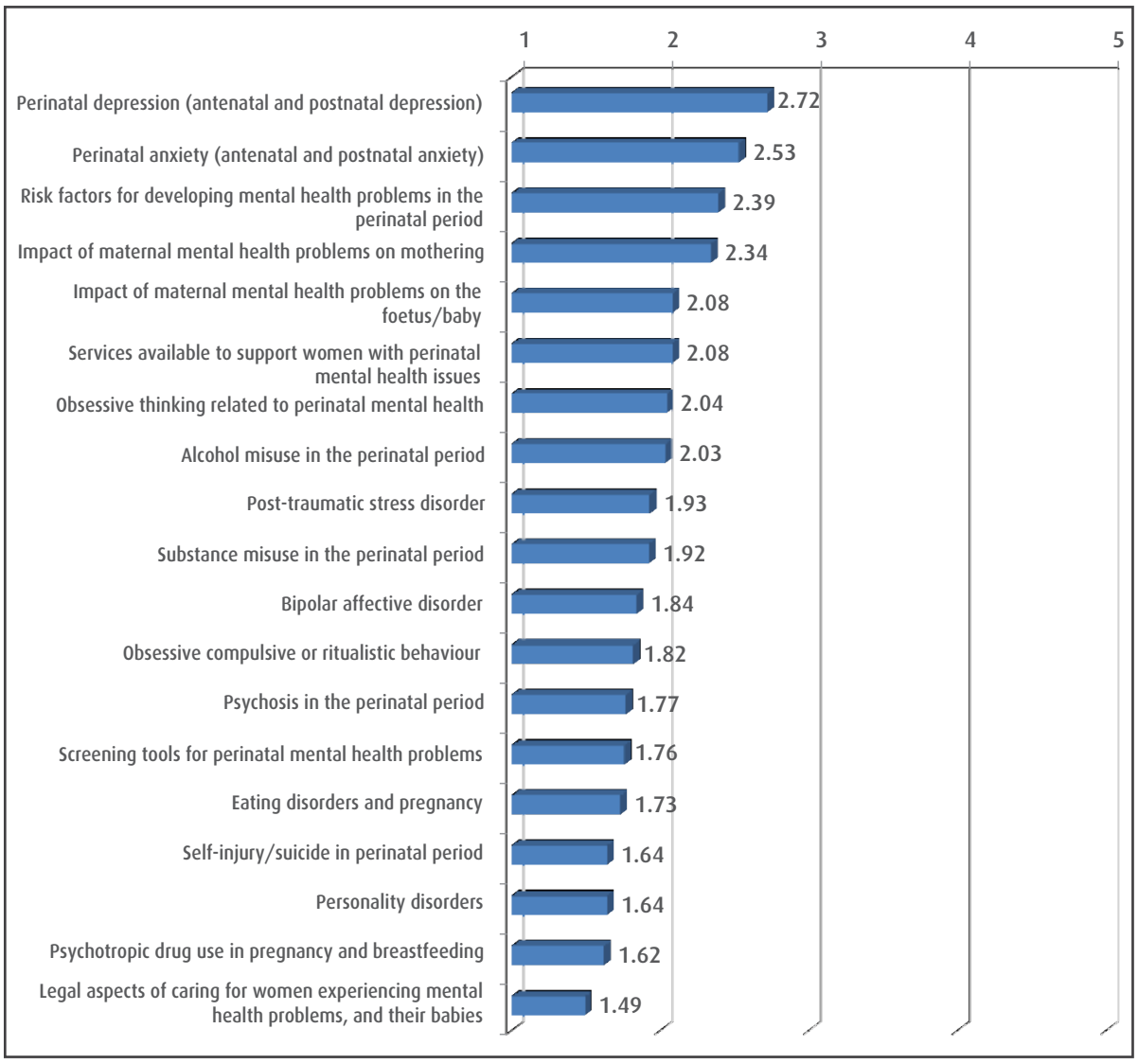
Figure 5.2: Perinatal mental health assessment



Knowledge of perinatal mental health

Practice nurses were asked to rate their knowledge on 19 items related to perinatal mental health on a scale of 1 (not at all knowledgeable) to 5 (very knowledgeable). All items were rated lower than the midpoint of the scales. The highest rated items included knowledge of perinatal depression (M=2.72) and knowledge of perinatal anxiety (M=2.53). Practice nurses rated knowledge of psychotropic drug use in pregnancy and legal aspects of caring for women lowest (See figure 5.3). The number and standard deviation of all items is included in appendix 4a.

Figure 5.3: Self-rated knowledge of perinatal mental health (n=146)



Skills in undertaking perinatal mental health activities

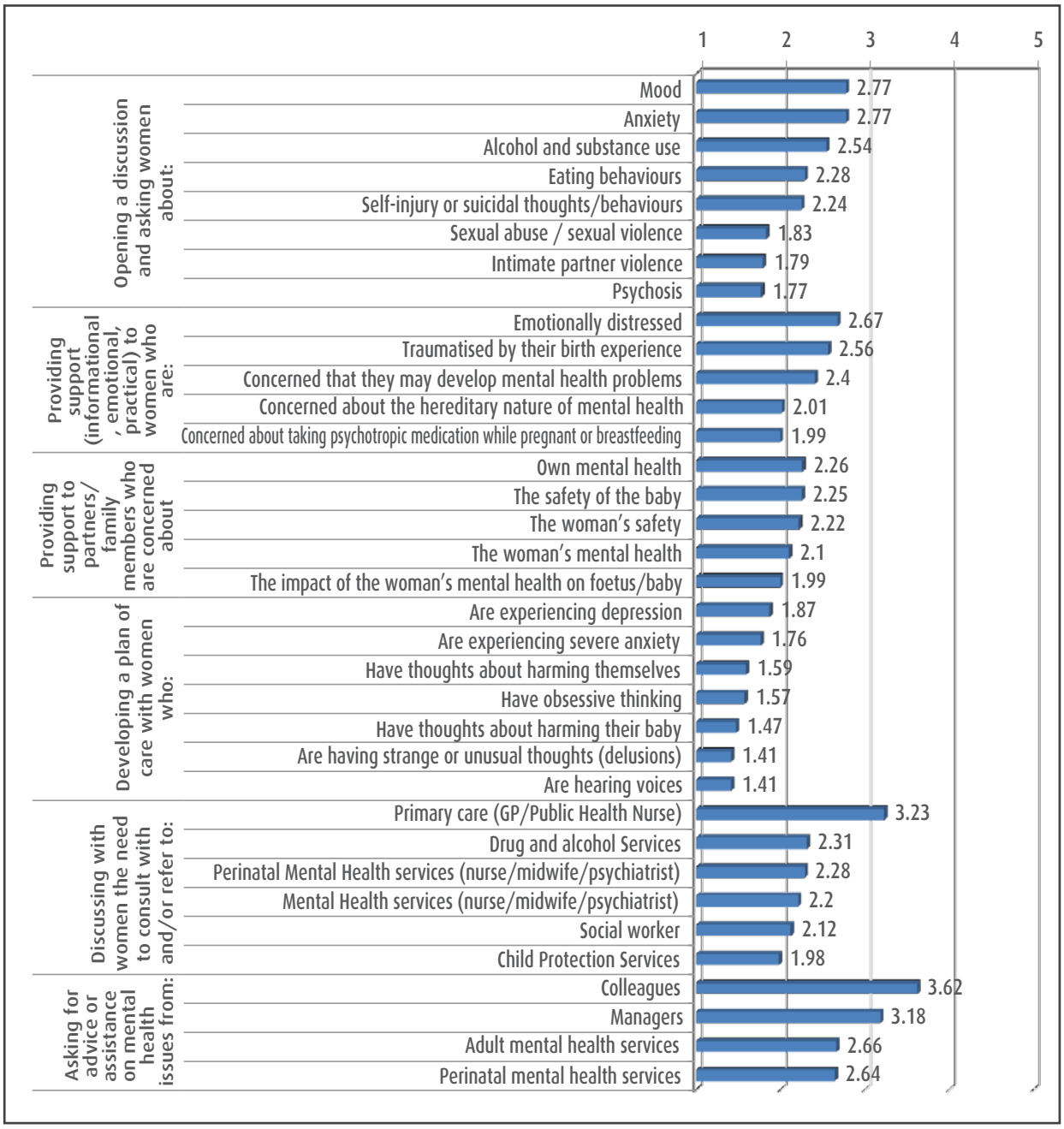
Practice nurses were asked to rate their skill in undertaking a range of activities (See figure 5.4) on a scale of 1 (not at all skilled) to 5 (very skilled). With the exception of discussing with women the need to refer to the GP/PHN and asking for advice from colleagues/managers, all of the other items listed were rated below the midpoint of the scale.

On opening a discussion and asking women about various topics, self-rated skill ranged from 1.77 in relation to asking women about psychosis to 2.77 in relation to asking women about mood. In terms of providing support to women, practice nurses rated their skill highest in providing support to women experiencing emotional distress (M=2.67) and lowest in relation to concerns about taking psychotropic medication while pregnant or breastfeeding (M=1.99). Items on providing support to women's partners/family members ranged from 1.99 on supporting those concerned about the impact of the woman's mental health on the foetus/baby to 2.26 with regard to supporting family members' concerns about their own mental health.

Self-rated skill in developing care plans with women was higher for women experiencing depression (M=1.87) and anxiety (M=1.76) compared to developing care plans with women hearing voices (M=1.41), having strange thoughts (M=1.41), or having thoughts about harming their baby (M=1.47). On discussing with women the need to consult with and/or refer to other healthcare professionals or services, self-rated skill ranged from 1.98 in relation to referring to child protection services to 3.23 in relation to referring women to primary care.

In terms of seeking advice, skill was rated highest on seeking advice from colleagues (M=3.62) and lowest on seeking assistance from perinatal mental health services (M=2.64). The number and standard deviation of all items is included in appendix 4b.

Figure 5.4: Self-rated skills in undertaking perinatal mental health activities



Overall skill and confidence

Practice nurses were also asked to rate their overall skill and confidence in relation to their activities in perinatal mental healthcare on a scale from 1 (not at all confident/skilled) to 10 (very confident/skilled). The mean score for overall skill was 3.17 and the mean score for overall confidence was 3.15, both well below the midpoint of the scale (See table 5.4).

Table 5.4: Overall skill and confidence

	N	Minimum	Maximum	Mean	SD
Overall Skill	138	1	9	3.17	1.99
Overall Confidence	138	1	10	3.15	2.02

Factors related to skill, confidence and knowledge

Further analysis showed that there were no statistically significant differences in mean skill and confidence scores based on either age [$F(6, 131)=1.840$, $p>.05$; $F(6, 131)=1.345$, $p>.05$] or duration of time in role [$F(3, 134)= .388$, $p>.05$; $F(3, 134)= .435$, $p>.05$]. Compared to practice nurses educated to undergraduate level, practice nurses educated to postgraduate level had higher means scores in both overall skill ($M=3.8$, $SD=2.21$ vs. $M=2.86$, $SD=1.81$) and confidence ($M=3.8$, $SD=2.26$ vs. $M=2.83$, $SD=1.81$), which were statistically significant [$t(75.995)= -2.515$, $p<.05$; $t(74.876)= -2.556$, $p<.05$]. Those that had some PMH education rated themselves as having higher confidence and skill than those without any PMH education (See table 5.5), and they also had higher scores on all knowledge items compared to those without PMH education (See appendix 4c), differences which were all statistically significant.

Table 5.5: Skill and confidence among those with and without education

	Some Education in PMH						T-Test
	Yes			No			
	N	Mean	SD	N	Mean	SD	
Overall Skill	31	5.16	1.97	107	2.60	1.60	$t(136)= 7.460$, $p<.001$
Overall Confidence	31	5.13	2.06	107	2.58	1.61	$t(136)= 7.274$, $p<.001$

Practice nurses who reported dealing with women with PMH issues had statistically significant higher scores in both skill and confidence than those who reported not dealing with women with PMH issues (See table 5.6), and had statistically significant higher scores on all knowledge items (See appendix 4d).

Table 5.6: Skill and confidence among those dealing with women with perinatal mental health issues and those not

	Deal with women with PMH issues						T-Test
	Yes			No			
	N	Mean	SD	N	Mean	SD	
Overall Skill	70	4.23	1.99	68	2.09	1.29	$t(118.587)= 7.508$, $p<.001$
Overall Confidence	70	4.16	2.07	68	2.12	1.33	$t(118.331)= 6.904$, $p<.001$

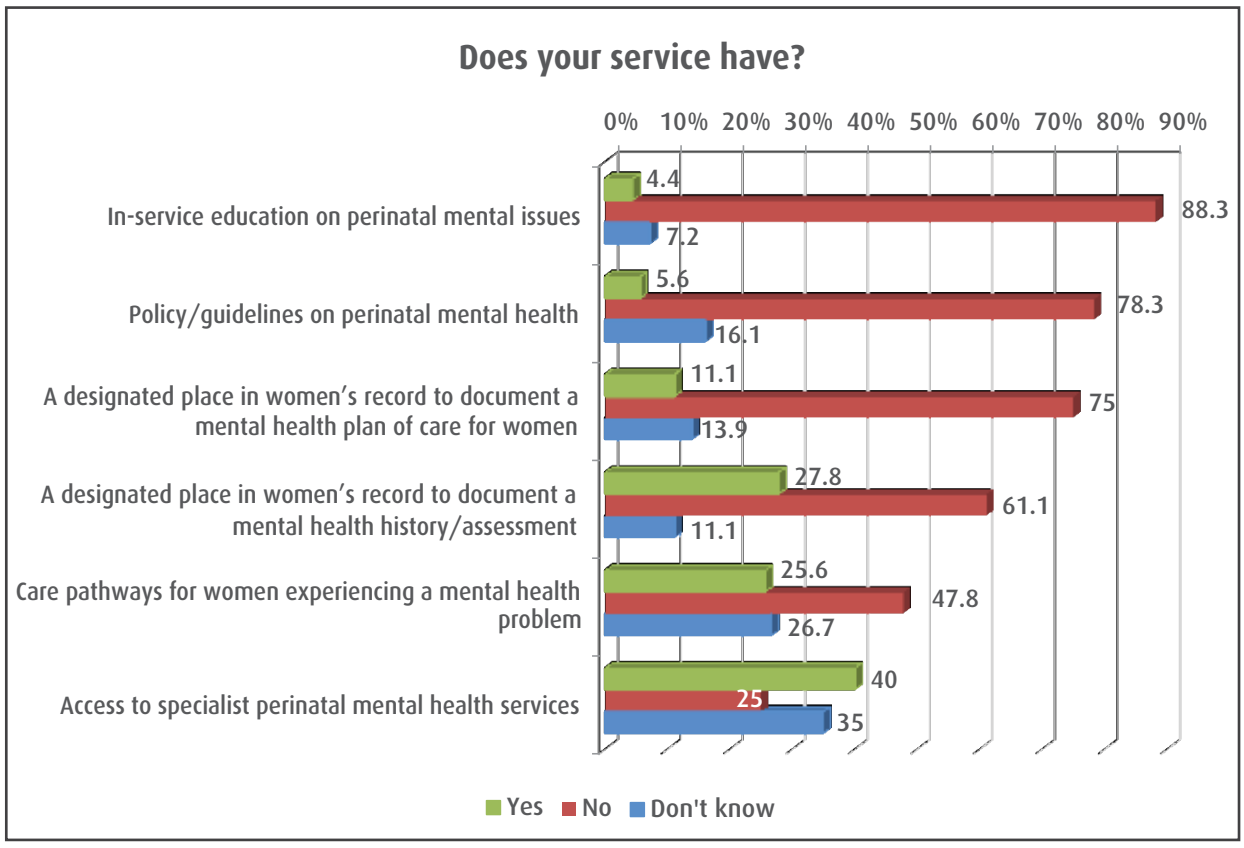
Perinatal mental health service and guidelines

Practice nurses were asked whether the service they worked within had services, education, and guidelines related to perinatal mental health. Nearly 90% of practice nurses reported that the service in which they were employed did not have in-service education on perinatal mental

health issues (88.3%, n=159). Nearly four fifths reported that there were no policies or guidelines on perinatal mental health within their service (78.3%, n=141). Just under half of practice nurses reported that there were no care pathways for women with a mental health problem (47.8%, n=86) within their service, with approximately a quarter of practice nurses unsure whether they existed (26.7%, n=48). Two-fifths reported that they had access to specialist perinatal mental health services (40%, n=72).

Three quarters of the sample reported that there wasn't a designated place in women's record to document a mental health plan of care for women (75%, n=135), while approximately 60% said there was not a designated place in women's record to document a mental health history/ assessment (61.1%, n=110) (See figure 5.5).

Figure 5.5: Perinatal mental health service and guidelines



Barriers to discussing mental health issues

Practice nurses were asked to what extent they considered a range of issues to be barriers to discussing mental health issues with women. Four response categories were given: 'to no extent'; 'to a little extent'; 'to a moderate extent'; and 'to a great extent'. For the purpose of analysis, 'to no extent' and 'to a little extent' were collapsed and 'to a moderate extent' and 'to a great extent' were merged. The responses are shown in full in appendix 4e.

Organisational-related factors and practitioner knowledge and skills were rated as the largest barriers to discussing mental health issues with women (See figure 5.6). Seventy percent of the sample viewed 'no clear mental healthcare pathway for women' (71.2%), the short time allocated to women (65.3%) and the lack of time due to heavy workload (62.7%) as significant barriers. Approximately two-thirds of practice nurses considered that a lack of knowledge on how to discuss mental health with women (63.5%), particularly with women from different cultures (68.6%), were also major inhibitors to discussion.

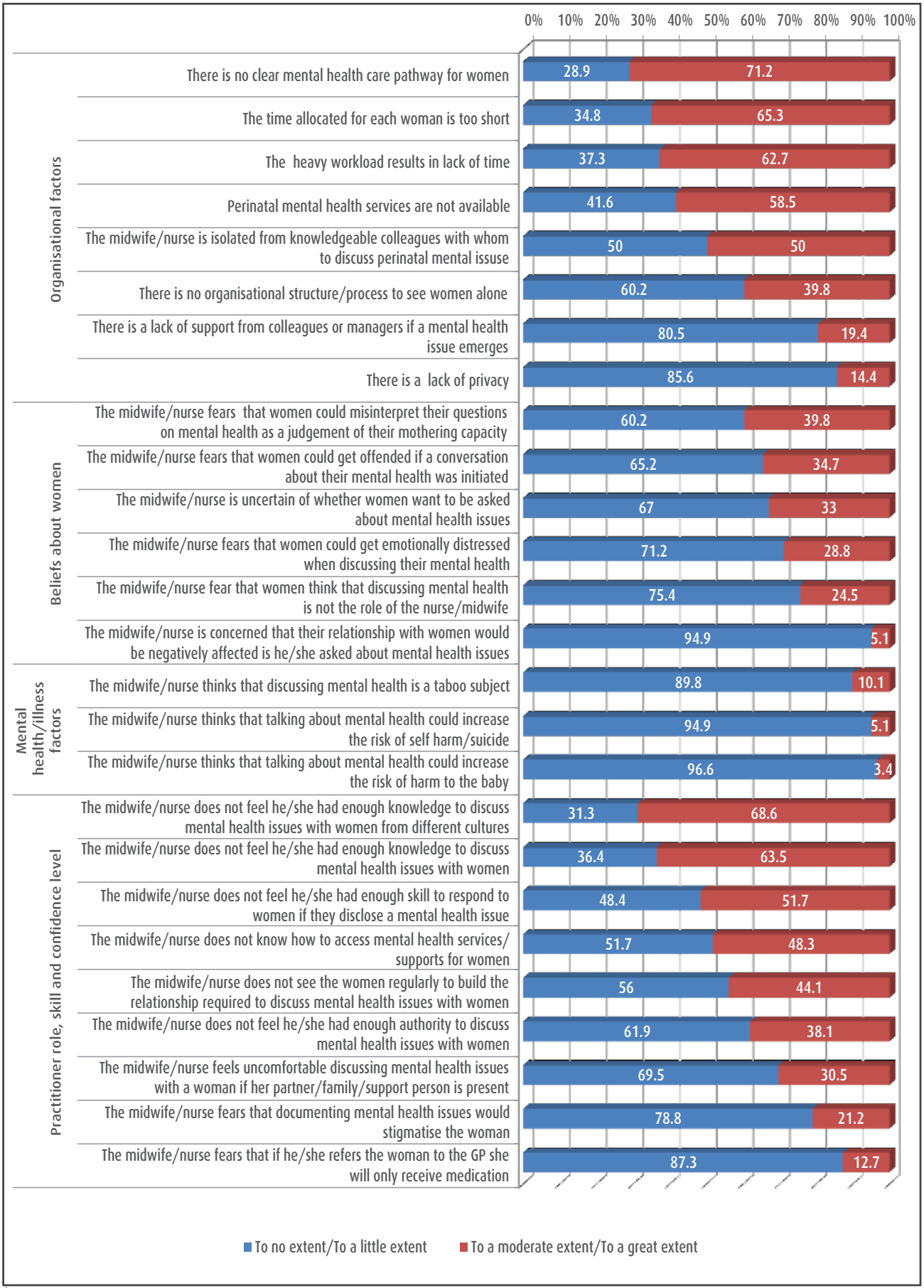
Between 50%-60% of the sample were of the view that a lack of available perinatal mental health services (58.5%), practice nurses lacking skill to respond to women who disclose a mental health problem (51.7%), and being isolated from knowledgeable colleagues with whom to discuss perinatal mental health issues (50%) were all significant barriers.

Between 40%-50% of the sample reported that a lack of knowledge on how to access supports and services for women (48.3%) and not seeing women regularly enough to establish a relationship (44.1%) greatly prohibited discussion.

Between 30% to 40% reported fears around asking questions which might be interpreted by women as a judgement of their mothering capacity (39.8%), fear that women could get offended if a conversation about their mental health was initiated (34.7%), uncertainty about whether women want to be asked about mental health issues (33%) and discomfort speaking to women when their partner/family member is present (30.5%) were barriers to discussion to a moderate/great extent.

A lack of organisational structures and processes to facilitate seeing women alone (39.8%) and a lack of authority to discuss issues with women (38.1%) were also identified as barriers to a moderate/great extent.

Figure 5.6: Barriers to discussing mental health issues



There were statistically significant differences between those who reported dealing with women with PMH issues and those who didn't on 12/26 of the barrier items, with those not dealing with women with PMH issues having higher mean scores which indicated that they perceive the item to be a greater barrier than those who deal with women with PMH issues (See table 5.7).

Table 5.7: Perceived barriers to discussion among those dealing with women with perinatal mental health issues and those not

Barriers	Deal with women with PMH issues						T-Test
	Yes			No			
	N	M	SD	N	M	SD	
The midwife/nurse fears that women could get emotionally distressed when discussing their mental health	61	1.89	.80	57	2.19	.88	t(116)= -1.998, p<.05
The midwife/nurse is uncertain of whether women want to be asked about mental health issues	61	1.98	.74	57	2.39	.88	t(109.752)= -2.674 , p<.01
The midwife/nurse fears that women could misinterpret their questions on MH as a judgement of their mothering capacity	61	2.08	.76	57	2.56	.93	t(108.489)= -3.063, p<.01
The midwife/nurse fear that women think that discussing MH issues is not the role of the nurse/midwife	61	1.67	.72	57	2.14	.95	t(104.343)= -2.990, p<.01
The midwife/nurse is concerned that their relationship with women would be negatively affected if he/she asked about MH issues	61	1.64	.71	57	2.16	.88	t(116)= -3.533, p<.001
The nurse/midwife thinks that discussing mental health is a taboo subject	61	1.31	.50	57	1.77	.80	t(92.803)= -3.709, p<.001
The nurse/midwife does not feel he/she had enough authority to discuss mental health issues with women	61	2.00	.91	57	2.58	1.07	t(110.489)= -3.155, p<.01
The nurse/midwife does not feel he/she had enough knowledge to discuss mental health issues with women	61	2.52	1.01	57	3.21	.96	t(116)= -3.778, p<.001
The nurse/midwife does not feel he/she had enough knowledge to discuss MH issues with women from different cultures	61	2.72	.92	57	3.28	1.01	t(116)= -3.150, p<.01
The nurse/midwife does not feel he/she had enough skill to respond to women if they disclose a mental health issue	61	2.26	.96	57	3.05	.99	t(116)= -4.393, p<.001
The nurse/midwife does not see the women regularly to build the relationship required to discuss mental health issues	61	2.10	1.06	57	2.67	1.02	t(116)= -2.959, p<.01
The nurse/midwife fears that documenting mental health issues would stigmatise the woman	61	1.49	.77	57	1.98	.99	t(116)= -3.020, p<.01

Practice nurses' educational priorities

Practice nurses were asked to list three educational priorities on perinatal mental health that would assist them with their clinical practice. Analysis of responses resulted in three categories: knowledge of PMH issues and related topics; skill development; and types of education. Practice nurses' educational priorities included accumulating more knowledge about the types of mental health problems which can occur in the perinatal period, the incidence of such problems, and the effects on the mother/baby, especially in the context of safety issues. They also expressed a desire to learn about cultural issues around mental health and the promotion of positive mental health.

In relation to skill development, the identification and assessment of perinatal mental health issues was deemed an educational priority with training being sought in relation to conducting a mental health assessment, opening a discussion on perinatal mental health and using tools and checklists to screen for the presence of a perinatal mental health issue. Practice nurses also expressed a desire to develop skills in counselling women and communicating with women and their partners/family members. Examples of the skills sought under each category are shown in table 5.8.

Suggested modes of educational delivery included online learning as well as local study days and workshops. Suggestions also included training which is informed by mental health specialist input and involves the MDT. Practice nurses also requested opportunities to develop their clinical practice skills through shadowing more experienced clinicians or mental health nurses. The full range of priorities identified are listed in table 5.8.

Table 5.8: Practice nurses' educational priorities

Category	Item
Knowledge of PMH issues and related topics	• Statistics on PMH • Mental illnesses and distress e.g. psychosis, eating disorders, substance abuse, depression, IPV types • Signs and symptoms of PMH issue/effects of PMH issues on mother and baby, including safety issues • Cultural issues around mental health • Promoting positive mental health
Skill development	• Assessing mental health history/using validated and appropriate tools to support assessment in community /using MH checklist • Opening a discussion e.g. talking about MH, asking the right questions, strategies for raising topic of MH • Counselling skills e.g. CBT training, giving advice and information, teaching coping strategies • Communicating with women and their partners/families
Types of education	• Regular in service training/workshops/structured study days/study evenings from PMH midwives • ELearning modules • Access to up-to-date research/journal articles/resource material • MDT education • MH specialist input into education • Practice nurse meetings • Assist develop clinical skills e.g. shadowing experienced practitioner, spending time in PMH nurse clinics

Practice nurses' change priorities

Practice nurses were asked to list three changes they would like to see in the area of perinatal mental healthcare. Following analysis, responses were categorised into seven groups: organisation of care; supports and services for women and their partners/families; better access; better communication/liaison; better assessment; support and guidance for staff and raising awareness (See table 5.9).

With regard to organisation of care, guidelines, pathways and protocols for managing perinatal mental health and more follow-up support were requested while easier referral processes, including self-referral and direct referral by practice nurses were viewed as being needed. A variety of support services for women were also listed as changes desired by practice nurses, and these included more local/community services, supports groups, alternative treatments, as well as more resources for women to avail of in the form of liaison mental health midwives and perinatal mental health clinics. In addition, education for both women and their partner/family member was deemed an important form of support. As well as desiring more services and supports for women, practice nurses expressed a wish for services to be more accessible to women by being available out of hours, being accessible without the need for referral or appointment and being available in a timely fashion. Improved communication and liaison within the MDT, and between practitioners across primary, secondary and tertiary care were identified as important changes to be implemented. Better assessment of women's mental health was identified as an area which required change, with more antenatal visits, routine assessment and documentation of assessments sought. Enhanced support for staff was also envisioned as a change required, with both managerial support and primary care guidance about managing perinatal mental health being identified as important. The final category was concerned with raising awareness and reducing stigma around perinatal mental health through public awareness campaigns and promotional activities.

Table 5.9: Practice nurses' change priorities

Category	Item
Organisation of care	• Protocols/pathways/guidelines for managing PMH/referral • Care pathways and care planning • Better referral pathways/access points • Women able to self-refer • Direct referral to specialist nurse/midwife positions linked with primary care to maternity hospitals • More follow-up and support
Supports and services for women	• More community based services/local MHS/more professionals to refer women onto/more designated staff for MH • A liaison service for primary care e.g. liaison mental health midwife available/liaison nurse who could be geographically attached to GPs surgery /nurses in GPs • Specialist nurses/midwife posts • Perinatal mental health clinics • Support groups • Alternative treatments • Antenatal and postnatal education • Education for family/partners • Information/resources for women/written information leaflets for women
Better access	• Open access to clinics without need for appointment for at risk women • After hours services • Timely and easier access to PMH services/clinics; psychiatrist in maternity services; hospital admission; to secondary care; to specialised care • Availability of appointments when referred • Reduced waiting lists • Support network info available • Better promotion of PMH services available • Better dissemination of available services to those working in General Practice • Communication from hospitals/specialists re services available
Better communication/ liaison	• Between primary and secondary care • Between GP and hospital • Between support services • With hospital staff/midwives • Within MDT
Better assessment	• Clear assessment guidelines • MH included as part of routine antenatal and postnatal checklists and care plans • More antenatal visits in schedule • Documented evidence of MH questions asked before hospital discharge
Support and guidance for staff	• Managerial support • Specific protocol within my workplace re managing mental health issues within primary care
Raising awareness	• More public awareness campaigns • Better promotion of MH well-being, PMH and services available • More awareness of mental health in perinatal care • Less stigma – more discussion

Summary

- In total 185 practice nurses completed the surveys. The majority were Registered General Nurses, educated to primary degree level (28.1%), with over half aged over 45 years (56.2%).
- Under half of practice nurses (45.9%) reported caring for women with perinatal mental health problems in their current role, with the majority reporting caring for between 1-5 women in the previous 6 months.
- One fifth of practice nurses (20.7%) reported that they received education in perinatal mental health, with the largest number indicating that their source of learning was as part of their student training, which given the age profile would appear to have been some time ago for many practice nurses. Just 4.4% reported the presence of perinatal mental health education within their service.
- The majority of practice nurses reported that there were no policies or guidelines on perinatal mental health within their service (78.3%), and that there was no designated place in women's record to document a mental health plan of care (75%) or a mental health history/assessment (61.1%). 40% of practice nurses reported that there was access to specialist perinatal mental health services and approximately a quarter were aware of care pathways available for women within their services; however, just over a quarter were unsure whether they existed.
- Whilst approximately 40-50% of the practice nurses reported that they identify women at risk of perinatal mental health problems (52.5%), ask women about their past mental health history/diagnosis (48.1%), identify women's protective/coping strategies for maintaining mental health (46.2%) and include mental health as a dimension of the assessment (41.1%), the numbers of practice nurses who engaged in other perinatal mental health activities fell to between 8%-35%. Furthermore, over a third of practice nurses did not view several activities as part of their role, including developing a plan of care with women with mental health issues (45.6%) and making referrals to mental health services (53.2%).
- In relation to assessment, approximately half of the sample asked all women or women who have mental health risk factors about experience of mood disorders (57.6%), mental health coping strategies (57%) and substance misuse (55.6%), while over 60% reported asking about psychological support (61.4%) and past and current alcohol use (64.6%). However, between 60-70% never asked any women about experience of IPV (74.7%), sexual abuse/sexual violence (74.1%), psychosis (67.1%) or eating disorders (63.3%) while half reported never asking about self-injury/suicidal thoughts or behaviours (49.4%).
- Knowledge of perinatal mental health issues was low among practice nurses, with all items rated lower than the scale's midpoint. The highest rated items included knowledge of perinatal depression and perinatal anxiety, while knowledge of psychotropic drug use in pregnancy and legal aspects of caring for women with mental health issues rated lowest.
- Practice nurses rated their skill level in undertaking the majority of prenatal mental health activates below the midpoint of the scale, with the exception of discussing with women the need to refer to the GP/PHN and asking for advice from colleagues/managers. Skill was rated lowest of all in the area of developing plans of care for women with mental health concerns. In addition, practice nurses also rated their overall skill and confidence below the midpoint of the scale.
- The greatest barriers to discussing mental health issues with women identified by practice nurses were related to organisational constraints and a lack of practitioner knowledge

and skill. Organisational barriers included: no clear mental healthcare pathway for women (71.2%); short time allocated to women (65.3%); and lack of time due to heavy workload (62.7%). Approximately two-thirds of practice nurses considered that a lack of knowledge on how to discuss mental health with women (63.5%), particularly with women from different cultures (68.6%), was also a major inhibitor to discussion.

- Practice nurses' educational priorities included acquiring knowledge about the types of perinatal mental health problems and their effects, especially in the context of safety issues. In addition to knowledge, skill development was sought in the areas of the identification and assessment of perinatal mental health issues, counselling women and communicating with women and their partner/family members.
- Areas for change identified by practice nurses including: better organisation of care in terms of having guidance in relation to care pathways, and referral and follow-up procedures; more supports and services for women and their partner/family members; care being made more accessible by being available out of hours and having timely access; improved communication and liaison within the MDT and between practitioners across primary, secondary and tertiary care; better assessment of women in the perinatal period; enhanced support for staff dealing with perinatal mental health issues; and increased awareness of perinatal mental health at a societal level.

Chapter 6:
DOCUMENTARY ANALYSIS

Introduction

This chapter presents the findings of the documentary analysis conducted to explore the guidelines, policies and any other documentation in existence on perinatal mental health submitted by maternity and primary care services.

Response rate

A total of 58 documents were submitted from 12 services. See table 6.1 for an overview of the documentation received.

Table 6.1: Types of documents received

Type	N	%
Guideline/policy documents	11	19.0
Screening/assessment documents	11	19.0
Carer plan documentation	2	3.4
Decision pathways/flow charts	8	13.8
Referral letters/forms	4	6.9
Audit forms	4	6.9
Education of women	7	12.1
Education of practitioners	2	3.4
Miscellaneous	9	15.5
Total	**58**	**100**

Policy/guideline documents (n=11)

In terms of language used within these documents, the words policy, procedure and guideline appeared to be used interchangeably with some documents termed clinical guidelines and others nursing/midwifery guidelines. Similarly, some documents have the word 'procedure' or 'policy' in the title. Four of the documents reviewed were developed for PHNs, two for midwives, one for social work while two were MDT focused and two were service focused. Some were written in a principle based manner, while others although titled a policy were more procedural in orientation (See table 6.2).

Table 6.2: List of policy/ guideline documents

Focus	Topics addressed
PHN (n=4)	• Screening for depression • Management/provision of interventions • Post-natal examination
Midwifery (n=2)	• Detection and management of mental health problems • Postnatal care of a woman
Service (n=2)	• Specialist perinatal mental health services
Social worker (n=1)	• Antenatal referrals
MDT (n=2)	• Perinatal mental health care • Transfer to an approved mental health centre

PHN focused documents: All four of the PHN documents focused on screening for depression in the antenatal and postnatal period. The screening procedures outlined in the documents include inquiring about the woman's mental health history, emotional well-being, coping strategies and family/social support during the first and all subsequent encounters. Three documents direct the PHN to ask about the 'resolution of baby blues' at the first postnatal visit (10-14 days after birth). In two of the documents the procedure includes the use of the Whooley questions (Whooley *et al.* 1997) and the EPDS (Cox *et al.* 1987) if concerns persist following the initial screening with the Whooley questions. In the other two documents, the screening procedure begins at the 4-6 week postnatal meeting. In all four documents, the Whooley questions are indicted as the primary screening mechanism at 4-6 weeks and at 12-16 weeks postnatal, while the EPDS is recommended as a subsequent assessment if deemed appropriate by the PHN.

In three of the documents, similar guidance is provided on administering the EPDS, scoring, interpreting and repeat screening. Three documents also outline actions to be taken if there is a positive score on item 10 of the EPDS, or any indication of self-harm, suicidal ideation or puerperal psychosis, although little information is provided on how to identify or assess for psychosis. One document also mentions the importance of assessing for domestic violence if signs are present. Three documents mention the use of a 'clinical interview' to explore responses to the EPDS and to make a more accurate assessment of mood; however, only one provides details of what that entails. Three documents provide guidance on the provision of listening/support visits, which are defined as 'a 4-6 week programme in the home, each session lasting up to one hour that combines active listening and problem solving'. Although all four mention the importance of recording outcomes and actions, one states that 'listening visit content is not to be documented'. All documents emphasis the need for informed consent, with two including guidance should a woman 'refuse' to complete the EPDS, which includes informing the woman that 'the PHN has a duty of care to inform the GP'. In one document there is mention of completing an encrypted 'long data sheet' for high scoring mothers, which is sent to the Assistant Director of Public Health Nursing; however, the rational for this action is unclear. This sheet includes yes/no questions on history of depression or postnatal depression, EPDS scores, clinical interview scores, referrals made and PHN comments. Three documents provide referral pathways and advise liaison with the community mental health services, if women have an existing mental health disorder.

Midwifery focused documents: One document outlines procedures for midwives to follow at the booking visit and during subsequent care encounters. The document recommends that women are asked the Whooley questions at first contact with services and that the EPDS be used to screen women postnatally. It also recommends that PHNs be informed of any women identified as high risk. Whilst, reference is made to the need to ensure that postnatal depression is not used as a generic term for all types of mental health problems, the only reference to psychosis is a brief reference to the risk factors for puerperal psychosis. The second document stipulates that midwives should discuss the woman's birth experience and enquire about the woman's emotional and psychological well-being at each postnatal contact. In addition, the document state that signs of domestic abuse and child abuse within the family should be assessed, although the detail to support this recommendation is sparse.

Service focused documents: The two service focused documents outline the aims, objectives and interventions provided by specialist perinatal mental health services within two maternity hospitals. Whilst the nature of the services provided varied, they included early detection and management of perinatal mental health problems, preconception counselling, medication review, psychoeducation for women/family, behavioural family therapy, cognitive behaviour therapy and educational programmes for practitioners. One service was provided by a RANP in perinatal mental health who carried her own caseload, and had the authority to accept and make referrals

to a range of professionals within and outside the service. The other service was staffed by midwives. Both documents advise on the screening and referral processes to the PMHS and the care management pathways to be adopted by the PMHS upon referral.

Social work focused document: This document outlines procedures for caring for women when they come to the attention of, or are referred to the maternity social work team. It includes procedures to be followed for women experiencing acute and non-acute mental health problems, who refuse social work intervention and if child welfare concerns emerge. It also outlines procedures for liaising and following-up with health professionals including the GP, the Clinical Midwifery Manager, midwives and public health nurses.

MDT focused documents: One document provides guidance on the prediction, detection and treatment of maternal mental ill health through the antenatal and postnatal periods. Much of the document is based on the NICE (2014) guideline and is written with all members of the MDT in mind, including maternity and mental health teams. Guidance is provided on what questions to ask women at the initial maternity booking visit which, similar to all the other documents, include personal and family history of mental illness and the Whooley questions. Guidance on the routine assessment of domestic violence is provided in line with the recommendations of the Royal College of Physicians of Ireland (2012). There is also guidance on assessment and care planning in pregnancy and in the postnatal period (for the psychiatric team), breastfeeding and psychotropic medication, dealing with women concerns around psychotropic medication, supporting partners/families and providing support to women who experience traumatic birth, stillbirth and miscarriage.

For a small minority of women, rapid admission to an approved in-patient mental health unit may be indicated. Should that be required, women may be admitted either involuntarily using the Mental Health Act 2001 or as a voluntary patient. Only one document was received that addressed this possibility and this document was received from a maternity service. The document states that the transfer of a woman is the responsibility of the consultant psychiatrist in consultation with the obstetric multidisciplinary team. It directs that the Assistant Director of Midwifery be informed of the decision to transfer, who will organise an escort if required. The document also states that, in the absence of a mother and baby unit, the baby may be discharged into the care of the father/family or admitted to the Neonatal Intensive Care Unit. Detailed guidance on how midwifery staff might care for, and meet the support and information needs of, the woman and her family are sparse.

Screening documentation (n=11)

There are two basic approaches to screening for perinatal mental health issues: the use of recognised validated questionnaires or oral questions. Both types of screening approaches were being used in services. Five copies of the Edinburgh Postnatal Depression Scale (EPDS) (Cox *et al.* 1987) were received, four from PHN services and one from a maternity service. Three of the documents directed women to complete the questionnaire with reference to how they felt in the past seven days, one used the language of the 'last week' and two had no directions included. One document included an extra question that asked women had they 'ever suffered from depression?'. Two had the key for scoring included with a space at the end for recording the final score.

In addition to the validated EPDS, six other documents were received. Two documents received included the Whooley questions. These were used by PHNs/Midwives in two different regions to screen women 12-14 weeks postnatally. These screening documents also asked about history of

depression, if the woman was taking prescribed medication and if a referral to a GP was made. All the answers to the questions were recorded as yes/no responses.

Four other documents described as screening tools were received. Two focused on antenatal and two on postnatal periods. One antenatal document listed an array of mental health issues including: previous PND; puerperal psychosis; anorexia nervosa; schizophrenia; suicide attempt; bulimia nervosa; severe pre-menstrual tension; and current and past depression. It also listed 'nervous breakdown' and 'psychiatric problem', but exactly what these terms meant and how they differed from the previous terms were not explained. Similarly, the other antenatal document listed puerperal psychosis, depression, schizo-affective disorder and 'other'. It also included substance misuse, including alcohol, prescription and non-prescription drugs, and illicit drugs. Although this form had a section for the woman's history, the primary focus was on physical health; however, under the section on father and father's immediate family, a heading for history of 'mental illness' was included. The two postnatal forms were to be used by PHNs; they included reference to postnatal blues and depression. Both documents also asked PHNs to tick if postnatal depression was 'discussed/advised'. If a signature was required on the documentation it was the clinician's signature; there was no place for women to sign the record.

Decision pathways/flowcharts (n=8)

Eight documents were categorised as decision pathways/flowcharts. Three pathways were to be used by PHNs and guided them through the steps of using the Whooley questions, the EPDS, the clinical interview, provision of listening visits and referral to services, including the GP and the mental health team. Two were pathways to be followed by midwives, one focused on the initial antenatal booking hospital visit, and the other focused on the antenatal and postnatal period. Both pathways contained similar screening questions to aid decision-making regarding referral and to prompt referral action. These common questions included: the Whooley questions, current or a previous history of PND/mental illness, current or previous use of medication, and current or previous use of mental health services. The pathway which covered both the antenatal and postnatal period contained additional screening questions regarding feelings about the pregnancy/baby. It also contained a multitude of referral pathways depending on the responses given which included documentation in the woman's record, liaising with other health professionals, escalating care, signposting to supports/services or offering a referral.

A separate pathway, which covered practitioners working in general practice and hospital settings, guided GPs, practice nurses and midwives through the use of the Whooley questions and the EPDS, and highlighted referral pathways pertinent to each setting at each stage of the pregnancy and postnatal period. The referral pathways in all included: Obstetricians, GPs, PHNs, Psychiatrists, RANPs, Community Psychiatric Nurses and specialist perinatal mental health services. In addition, two documents provided guidance on when to refer a woman with a history of depression to the social work department.

Care plan documentation (n=2)

Care planning documents are integral to practitioner's day to day practice. They are critical for recording assessments, interventions and outcomes, and communication and information sharing with others, including members of the multidisciplinary team. Long-term they are also the source of information for audits and the means by which decision-making processes are defended if questions around care arise. Each of the documents received were reviewed for the presence of care plan templates. Only one document was identified that had a space for problem, goal, intervention and evaluation. Whilst a second document had a space to record 'findings' and had

a heading called 'care plan' the space for recording was so limited, that it could not be described as a care plan document.

Referral forms/letters (n=4)

In total four documents were received that were categorised as referral forms/letters. Two were to be completed by the PHN when referring a woman to the GP. One was to be completed prior to referring a woman to specialist perinatal mental health services within the maternity hospital and one was a standard form used for requesting a psychiatric consultation. The referral form to the GP included reference to: overall EPDS score, with specific reference to statement 10 on the EPDS; 'positive' outcomes to Whooley questions; and whether women had been offered, accepted or 'refused' support/listening visits, or 'refused' to complete the EPDS form. All information was recorded in the form of yes/no tick boxes. The other two forms were less structured and provided space for practitioner 'concerns/clinical information' to be written; the form for referral to the specialist perinatal mental health services also included questions on psychotropic medication, psychiatric history, attendance at other psychiatric services and included tick box questions on reasons for referral as well as information on stage of pregnancy.

Audit documentation (n=4)

Four documents submitted were tools designed to audit documentation in relation to aspects of perinatal assessment and care. Three were submitted from PHN services and one from maternity services. All audits included questions on whether women were screened using the Whooley questions or the EPDS, and whether women were referred and managed appropriately. In addition, two audits made reference to the EPDS being calculated correctly; however, none of the EPDS copies received had guidelines on how to calculate the EPDS scores. Only one of the audit tools made reference to a care plan being completed. Whilst the tools to be used in the PHN services asked about antenatal and postnatal care and interventions, the focus of the three tools was on depression. All four tools used binary categories of yes/no answers, with a section for comments. All audits included space for the date and name of person conducting the audit. Two included a scoring system for each question; however, only one had a clear section for action as an outcome of the audit.

Education materials for mothers and family members (n=7)

Seven documents designed to educate women and family were received. Six were designed in the form of a booklet/information leaflet to be given directly to women and one was a pack hosted on the hospital's website. Two were leaflets which contained general wellness 'tips for mothers', without any mention of mental health while the third was a booklet which contained general information on pregnancy, including a short section on emotional well-being and wellness tips. Whilst depression and anxiety are mentioned as common mental health problems within the booklet, in the case of the latter, little other information is provided on perinatal mental health. The fourth document, a very short informative leaflet, highlights symptoms and risk factors of depression, and directs the woman to supports available through the midwifery service within the hospital. The fifth document, a more comprehensive booklet, addresses 'baby blues' and postnatal depression, including symptoms of both. Signs of postnatal depression cited included suffering from anxiety, having thoughts of suicide and psychotic symptoms. This booklet also contains information about birth trauma and domestic violence, and provides advice on seeking help and phone numbers. The sixth document is a booklet titled *'Postnatal depression a guide for mothers, families and friends',* which was published by the HSE in 2008. It contains sections on 'baby blues' and postnatal depression, including causes, signs, self-help strategies,

treatment options and advice for family and friends. Although titled 'postnatal depression', it makes reference to puerperal psychosis. The information pack hosted on the hospital's website covers the topics of emotional and mental well-being, 'baby blues' and postnatal depression. The information covered includes symptoms of 'baby blues', postnatal depression, IPV, self-help strategies, treatment options and contact phone numbers for services to support women experiencing IPV. It provides information on how to differentiate between normal adjustment changes and depression, includes a brief mention of the Edinburgh Post Natal Depression questionnaire and the importance of not stopping antidepressant medication abruptly.

A more in-depth analysis of the booklets and information received clearly highlights an emphasis on postnatal 'depression', as opposed to mental health issues prior to, or during pregnancy. All include information on the symptoms of depression; however, in one booklet whilst 'irritable and angry, sometimes for no reason' is included as a symptom, a change in mood is omitted. Although anxiety is mentioned in two of the booklets, it appears to be conflated with depression, as anxiety, panic attacks and obsessive behaviour are listed as symptoms of depression. Similarly, the information provided on postnatal psychosis is confusing and inadequate. In one booklet it is described as a 'form of depression' and in another it is listed as a 'symptom' of postnatal depression. In addition, it is described as 'hearing voices or 'having unusual beliefs' in one booklet while in another it is described as the 'loss of contact with reality'; thus, the level of explanation provided is inadequate. In terms of risk factors for perinatal mental health problems, whilst there is mention of previous history of depression and other psychosocial issues, such as stress, support and birth experience, there is no mention of risk factors associated with psychosis, such as previous diagnosis of bipolar disorder, schizophrenia or other psychotic disorders as well as a personal or family history of postpartum psychosis. Whilst one booklet acknowledges the lack of evidence around impact of hormonal changes on mental health, two of booklets include this as an explanation for mental health problems.

Education targeted at health professionals (n=2)

Two educational documents related to training for health professionals were submitted. One of these was a poster of a lecture series on perinatal mental health for health professionals. The topics covered included: depression and anxiety in pregnancy; medication and mental health issues in pregnancy; psychosis, schizophrenia and bipolar disorder in pregnancy (including PTSD); self-harm/risk of suicide in pregnancy; and the role of the medical social worker and the physiotherapist in perinatal mental health. The second document was a unit of training aimed at public health nurses and doctors. The document addressed child health screening, surveillance and health promotion. The only reference to perinatal mental health was a brief mention on the incidence of postnatal depression and the importance of mothers having family support 'to promote the development of attachment'.

Miscellaneous (n=9)

A number of other documents were received (N=9) that were not directly relevant to perinatal mental health. These included: an audit tool for postnatal examination; a guideline on the use of language interpreting services; a policy on supporting people with communication/intellectual disability using acute care services; a disability policy statement which included outline of services available to women with disability (physical/sensory); a procedure for exchange of information between mental health services and social work department; and a philosophy of learning in clinical practice. Two other documents, although related to perinatal mental health, were not deemed relevant to the objectives of the study; namely a copy of the NICE (2007) guidelines and a terms of reference for a perinatal mental health group.

Summary

- Of the 58 documents analysed, the majority were classified as policy/procedure documents or screening/assessment documents.
- All documents submitted, including policy, screening, pathways, audit and education documents tended to focus on depression as opposed to anxiety and psychosis.
- Generally all documents recommend that women be asked the Whooley questions at first contact with services (midwifery, PHN) and that the EPDS be used to screen women postnatally. Some policy documents also recommend the use of a 'clinical interview'.
- Some documents mention the importance of assessing domestic violence; however, this was not consistent across documents and neither was there in-depth guidance given in this area.
- Some policy documents recommend that PHNs provide listening/support visits, although this was not consistent across all PHN policy documents.
- For a small minority of women, rapid admission to an approved in-patient mental health unit may be indicated. Despite this, only one document was received that addressed this possibility.
- Audits tended to focus on whether women were screened using the Whooley questions or the EPDS, and whether the EPDS was calculated correctly; however, only one of the audit tools made reference to a care plan being completed.
- The education materials developed for women tended to focus on postnatal depression, with little information provided on anxiety or postnatal psychosis.
- If anxiety is mentioned, it appears to be conflated with depression and listed as a symptom of depression. The explanation provided on postnatal psychosis is both confusing and inadequate, as it describes psychosis as a 'form of depression' or lists it as a 'symptom' of postnatal depression.

Chapter 7:
DISCUSSION AND RECOMMENDATIONS

Introduction

This is the first study in Ireland that explored practices, policies and processes around perinatal mental health from the perspectives of midwives, public health nurses and practice nurses. As such, it is in line with the national maternity strategy which emphasises the need 'to analyse the training needs associated with the implementation of the new model of care to ensure that the current and future maternity workforce have the necessary skills and competencies to deliver safe high quality maternity care' (Department of Health 2016: 7). Data for the study were collected using a mixed method design involving an anonymous, self-completed survey and documentary analysis. In total 829 surveys and 58 documents were analysed. Ethical approval to conduct the study was granted by the Research Ethics Committee of the Faculty of Health Sciences in Trinity College Dublin, the ethics committee associated with each of the participating midwifery sites, and the ethics committee that approves studies involving public health nurses. This chapter discusses the key findings from both data sources, and concludes with the limitations of the study and recommendations for policy, practice, research and education.

Response to surveys and documentary requests

A total of 829 survey responses were analysed, over half of which came from midwives (n=458, 55.2%), with the remainder split evenly between public health nurses (n=186, 22.4%) and practice nurses (n=185, 22.3%). Though it is not possible to ascertain an exact response rate given that the target sample population is unknown, an estimate based on national figures suggest that approximately a quarter of all midwives nationally responded to the survey, while 13% of public health nurses and 10% of practice nurses participated. The overwhelming majority of respondents across the three groups were female. Over half of public health nurses and practice nurses were aged over 45, while midwives had a slightly younger age profile. The majority of those who completed the surveys were registered general nurses, with 148/186 public health nurses, 72/185 practice nurses and 437/458 of those working in the maternity services holding a midwifery qualification. A much smaller number were registered psychiatric nurses (41/186 PHNs, 2/458 midwives and 7/185 practice nurses). Over half of public health nurses and midwives and 43% of practice nurses had been in their role over 11 years. Education to postgraduate level and above was highest for public health nurses (72%), followed by midwives (42%), and lastly by practice nurses (29%). The majority of public health nurses worked in public health nursing services while the majority of practice nurses were based in GP services. Most midwives worked in public maternity services (88%), with the majority worked in a stand-alone maternity hospital (56%).

In total 58 documents were received which included guideline/policy documents, screening/assessment documents, decision pathways, care plan documentation and educational materials.

Caseload

It was common for both midwives and public health nurses to be involved in caring for women with perinatal mental health problems in their practice (92% and 71% respectively) while under half of practice nurses reported doing so (46%). Caring for between 1 and 10 women with PMHPs in the previous six months was reported at 91% among public health nurses and practice nurses, and at 63% among midwives, with the latter reporting a heavier caseload, caring for more than 21 women during that period (22%). Given the rates of perinatal mental health problems recorded in the literature these estimations appear to be low, suggesting that some women in need of mental health support are not being identified.

In line with the finding that over half of practice nurses reported not caring for women with perinatal mental health problems, between 29% and 61% did not perceive a range of perinatal mental health activities listed in the survey as part of their role; this contrasted with a much smaller group of PHNs (6-13%) and midwives (6-15%) who considered the activities listed not part of their role.

Mental health screening and assessment

Over three quarters of public health nurses and midwives and 40% of practice nurses reported including mental health as a dimension of their assessment with women, asked women about their past mental health history/diagnosis and reported identifying women at risk of perinatal mental health problems. A closer analysis of what participants included in their mental health screening revealed a more nuanced picture. While there were variations among the three groups, there was a trend towards participants asking women (either all or those that have mental health risk factors) about their experience of mood disorders, anxiety, alcohol use, substance use and about past grief/loss experiences. However, high numbers reported never asking any woman about trauma history (IPV, sexual abuse/sexual violence), self-injury/suicidal thoughts, eating disorders and psychosis. The low rate of inclusion of these issues may be a reflection of the practitioner's lack of skill in raising and opening a discussion with women in these areas. In comparison to their self-rating on depression and anxiety, participants rated their skill level on opening a discussion around eating behaviours, psychosis, IPV, sexual abuse/violence, and with women with thoughts of harming themselves or their baby, way below the midpoint of the scale.

Whilst the findings are positive in terms of participants' willingness to engage with mental health, they do raise questions about what aspects of women's lives participants are enquiring about. Whilst history of mood and anxiety are important, given that a diagnosis of bipolar disorder and schizophrenia is associated with postnatal psychosis, risk of suicide in the postnatal period and Post-Traumatic Stress Disorder (PTSD) in perinatal women, particularly in those that have already been affected by childhood abuse or traumatic experiences (NICE 2007; Seng *et al.* 2010; Hinton *et al.* 2015), there is a need for practitioners to adopt a more comprehensive approach to thinking about and engaging with mental health. The fact that some practitioners only ask women whom they deem to have mental health risk factors also raises issues. This suggests that women who do not have risk factors can be identified without having a conversation or enquiring about past experiences, including trauma history. This is significant given Anding *et al.'s* (2015) finding that relying solely on clinical judgement can result in midwives missing up to 50% of mothers with high EPDS scores.

Several studies found that midwives, PHNs and to a lesser degree practice nurses consider mental health is part of their role, especially PND (Sanders 2006; Ross-Davie *et al.* 2006; Baldwin and Griffiths 2009; Rush 2012; Rollans *et al.* 2013b; Tammentie *et al*. 2013; Borglin *et al.* 2015; Hauck *et al.* 2015). However, similar to our study, there is wide variability in terms of what is included within the assessment. An audit of women's records in the UK found that PHNs/health visitors tended to assess and document general risk factors for postnatal depression (family composition (67%); support from partner (55%) or extended family (47%)) but less frequently assessed risk factors, such as negative birth experience (0%), social isolation (3%), history of self-harm/ suicidal thoughts (3%) and domestic violence (5%) (Baldwin and Griffiths 2009). Practitioners in Rollans *et al.'s* (2013b) study reported difficulty asking women about history of sexual buse or domestic violence, with some not asking at all or only asking about sexual abuse if they received a positive response to the question of domestic violence. Other studies reported that PHNs/ health visitors found it hard to distinguish signs of early depression and clinical depression, and tended to attribute depression to a lack of family and social support, as well as financial problems

and unemployment (Agapidaki *et al.* 2014). Similarly, studies involving midwives reported that they found it difficult to ask about mental health at the booking visit (Ross-Davie *et al*. 2006), and were more likely to ask about general anxiety and concerns about caring for their infant rather than asking directly about issues such as relationships, past sexual abuse and domestic violence (McLachlan *et al.* 2011). Other studies reported that midwives did not feel comfortable assessing for suicide risk (Lau *et al.* 2015), with one study reporting that the percentage of midwives who asked women about depression (25.1%), domestic violence (49.5%) and substance abuse (61.1%) was less than desired (Sanders 2006). Practice nurses involvement in screening for domestic violence among pregnant women appears non-existent, with only one study on domestic violence in primary care finding that 1% of practice nurses routinely asked all pregnant women about domestic violence (Ramsay *et al.* 2012).

In terms of assessment methods, while the studies available mainly focus on depression, they do point to variable practices (Lees *et al.* 2009; McCauley *et al*. 2011) and a lack of consistency in approach, even when clear guidelines and protocols were available (Rollans *et al.* 2013b). Within these studies practitioners used a combination of interview skills (Gibb & Hundley 2007; Baldwin and Griffiths 2009; McCauley *et al*. 2011; Rush 2012; Rollans *et al.* 2013b; Tammentie *et al.* 2013; Borglin *et al.* 2015), observation (Baldwin and Griffiths 2009; Rush 2012; Rollans *et al.* 2013b; Tammentie *et al.* 2013; Borglin *et al*. 2015; Noonan *et al*. 2017a), screening tools (Clark 2000; Brown and Bacigalupo 2006; Rush 2012; Rollans *et al.* 2013b) and intuition (Chew-Graham *et al.* 2008; Rollans *et al.* 2013b; Jomeen *et al*. 2013; Borglin *et al.* 2015; Noonan *et al.* 2017a) to assess women's mental health. Whilst a combined approach is the ideal method, some practitioners relied solely on intuitive practice, or observation of the mother and baby, in the belief that there was no need to ask psychosocial questions if the baby was progressing and developing (Rollans *et al.* 2013a; Agapidaki *et al.* 2014).

Use of screening tools

In relation to the routine use of mental health tools as part of the screening process, 70% of public health nurses in our study compared to 15% of midwives and 11% of practice nurses reported using mental health tools as part of the screening process. The high rate among public health nurses may reflect the emphasis on the use of the EPDS and the Whoooly questions within the policy, care pathway and audit documentation received from public health nursing services. Studies into the use of screening tools among PHNs and midwives, focused mainly on their use of the EPDS scale in the postnatal period. Findings from these studies show that an inconsistent approach is adopted in spite of clear guidelines and protocols existing (Rollans *et al.* 2013b), with PHNs in a number of studies reported that they did not use any tools (Brown and Bacigalupo 2006; Chew-Graham *et al.* 2008; Baldwin and Griffiths 2009; Rush 2012). The reasons for this varied and included: a lack of education on their use; a belief that the EPDS was over used, open to 'manipulation' and added nothing to the consultation (Brown and Bacigalupo 2006); as well as tools being considered 'too confronting' for women (Rush 2012). In Jomeen *et al.*'s (2013) study, PHNs reported not using the EPDS as it had been replaced with Whooley questions and, in their view, the EPDS was not required as in many situations problems were obvious. Reporting on the use of screening tools by midwives, Jones *et al.* (2012) found that two-thirds of midwives screened for antenatal and postpartum depression using instruments, with just over half using the EPDS (54%) and the remainder using a raft of other mechanisms and instruments. Similar to PHNs, midwives in some studies highlighted a lack of knowledge on the function, use and limitations of screening tools (Jones *et al*. 2011; McCauley *et al.* 2011; Hauck *et al.* 2015).

Within the literature, those PHNs and midwives who supported the use of screening tools, and especially the EPDS, reported finding it useful, easy to administer and explain to women. In

their view, it helped shift the focus from the baby to the mother, was an ideal way of introducing mental health issues and getting to know women better (Clark 2000; Brown and Bacigalupo 2006; Jones *et al.* 2011; Borglin *et al.* 2015) as it acted as a 'a door opener' and a 'starting point for conversation' (Glavin *et al.* 2010; Rush 2012; Rollans *et al.* 2013b). They also reported that it was 'easy to use' (Glavin *et al.* 2010; Jones *et al.* 2011; Rush 2012), allowed women to report feelings more objectively (Brown and Bacigalupo 2006) and was helpful for referral purposes (Borglin *et al.* 2015).

Development of a care plan with women

Whilst screening and enquiring about past mental health problems or trauma experiences is important, screening and assessment is only of value if followed by a plan of care, which is developed in collaboration with women. Despite the high rates of participants indicating that they included mental health as part of their assessment, care planning was not routinely practised among participants in any group. Although PHNs engaged in it more than the other groups, the reported rates were low for all (PHNs 55%; MWs 23%; PNs 9%).

The low rates of developing a care plan in relation to mental health may be related to the fact that not all services have a designated place in women's records to document a mental health history (PHNs 69%; MWs 43%; PNs 28%) or a place to document a mental health plan of care (PHNs 53%; MWs 20%; PNs 25%). The lack of care plan documentation was supported in the documentary analysis as little or no care plan templates were received. The absence of a place to record a mental health assessment and plan of care is a significant issue as care plans are a core aspect of practice providing documentation of assessments, interventions and outcomes. Used correctly, they are fundamental to communication and information sharing with others, including members of the multidisciplinary team and the women themselves (NICE 2014; NMBI 2015a, 2015b). In addition, they provide a legal means to demonstrate that reasonable attempts have been taken to provide evidence-based care to women (NMBI 2015b).

The low rates may also be related to a perceived lack of skill in the area of care planning as participants self-rated skill level was below the midpoint of the scale on all of the items listed in relation to care planning. Compared to reported skills in developing a plan of care with women who were experiencing depression and anxiety, participants reported much lower skill level in developing a plan of care with women who were experiencing obsessive thinking, having thoughts of harming themselves or their baby, and hearing voices or having delusional thinking.

Provision of information to women

The provision of information on all aspects of mental health, including risk factors for developing mental health problems in the perinatal period, not only enables all women to consider their mental health but, for women who have a prior diagnosis of a mental health issue, it can help reduce the stigma and fear around disclosure. This group of women also have significant concerns, worries and questions around medication. Findings from this study suggest that the majority of PHNs and midwives discussed the nature of mental health issues with women (PHNs 74%; MWs 70%) and discussed their concerns related to psychopharmacology in pregnancy and breastfeeding (PHNs 60%; MWs 59%), with much lower numbers of practice nurses discussing both issues with women (17% and 33% respectively). Notwithstanding this, all three groups rated their skill level in providing information and support to women around medication and breastfeeding and to those concerned about the hereditary nature of mental health problems, below the midpoint of the scale.

An important means of providing information to women is through information booklets or online resources. Written information in booklet or online format enables women to revisit the information on a number of occasions and at a time convenient to them. Notwithstanding the fact that the research team may not have received copies of all information on perinatal mental health made available to women, what was received tended to focus on postnatal depression or conflate all mental health problems under a depression label, reinforcing women's views that there is a 'conspiracy of silence' around other mental health issues such as psychosis (Higgins *et al.* 2016b). Where information on psychosis was provided it tended to be confusing and inadequate, and failed to highlight the risk factors for psychosis or how the woman herself or a family member might recognise its development.

Referral to services/other practitioners

The best model of care for women who have a prior history of mental health problems or develop a mental health problem during the perinatal period, is a model of care that is multidisciplinary and one where referral across disciplines, services and organisations is seamless and co-ordinated (Department of Health 2016). It is also one where women, where possible, are involved in decision-making about referral and all communication with women is open and transparent, irrespective of the reason for the referral or the nature of the agency the woman is being referred to. Findings from this study indicated that midwives more often referred women to mental health services and child protection services (82% and 63% respectively) compared to public health nurses (64% and 51% respectively). A much smaller percentage of practice nurses reported referring women to mental health services (27%) and child protection services (10%). In terms of skills in undertaking referrals to primary care (GP/PHN), social work, drug and alcohol services, perinatal mental health services and mental health services, both PHNs and midwives rated their skills above the midpoint of the scale. In comparison, the practice nurses did not perceive themselves to be skilled in any area except making a referral to a GP/PHN. In terms of referral to child protection services, PHNs' rating was 3.82, compared to 2.5 for midwives and 1.98 for practice nurses, suggesting that referral to child protection services is an area of challenge for the latter groups.

In the context of working collaboratively with mental health services and other support services, participants in the study all prioritised the need for clear referral pathways or 'escalation plans', better cross-disciplinary and cross-agency communication, as well as giving PHNs the autonomy to refer directly to mental health services, or allow women to self-refer. Without these, the participants were of the view that women would 'fall between the cracks' and not receive the right support in a timely and efficient manner.

Provision of support and information to partners and family

For many women, their partner or family member is their main support during their pregnancy and afterwards. They may be the first person to notice a change in the woman, or may be the person who accesses help and support if required. Providing support and education to the partner and family members in a collaborative manner is therefore essential for a good outcome (Higgins 2012; Stein *et al.* 2014). Without information, partners or family members may not recognise the need for help or may assume incorrectly that what the woman is experiencing is merely the stress of motherhood or adjustment to a new life situation (Letourneau 2013; Boots Family Trust Alliance 2013). Despite this, the provision of information on PMH to women's partners and family was practised by just 60% of PHNs, 40% of midwives and 17% of practice nurses. This may be due to a perceived lack of skills in this area as PHNs and midwives rated all items in relation to providing support to the woman's partner and family around the midpoint of the scale

(midpoint=3), with the practice nurses rating their skills in partner/family support between 1.9-2.2 on the scale. All three groups also prioritised education on family support, including acquiring skills to communicate with family members around mental health.

Knowledge and skills in relation to perinatal mental health

In relation to knowledge of perinatal mental health issues, whilst all groups reported some knowledge on depression, anxiety, risk factors, screening tools and the impact of PMHPs on mother and baby, other areas, such as personality disorders, obsessive compulsive or ritualistic behaviour, eating disorders, self-injury/suicide in the perinatal period, bipolar affective disorder, drug use in pregnancy and breastfeeding, and legal aspects were all rated much lower on the scale provided, with the practice nurses rating their knowledge on all items much lower than both the midwives and PHNs. This lack of knowledge is not surprising given that a large cohort of participants report not receiving education in the area of perinatal mental health. In addition, the higher reported knowledge on depression and anxiety is also a reflection of the emphasis within policy and practice guidelines, as the majority of documents submitted and analysed were focused on depression and screening for depression, with some briefly mentioning anxiety and psychosis. The emphasis on perinatal depression is also reflected in the international literature, with the majority of studies into practice or educational interventions, whether they were for midwives (Gerrard *et al.* 1993; Ross-Davie *et al*. 2007; Jardri *et al.* 2010), practice nurses (Gray *et al.* 2014; Bogossian *et al*. 2017) or PHNs (Almond and Lathlean 2011; Jomeen *et al*. 2013; Beauchamp 2014) focusing on postnatal depression and the EPDS or Whooley questions.

Notwithstanding the importance of postnatal depression, if practitioners are to provide comprehensive care, they need to be versed in other mental health issues, such as psychosis, bipolar disorders, depression during pregnancy, eating disorders, suicide, obsessive compulsive or ritualistic behaviour and the use of psychotropic medication. The low self-reported knowledge on legal aspects of caring for women experiencing mental health problems is concerning given that women may be transferred from a maternity or community context to an approved mental health centre under the Mental Health Act 2001. The lack of emphasis on this aspect of care was also reflected in the fact that only one policy document received addressed this issue.

The perceived deficits in knowledge were also reflected in the participants' self-rating of skill and confidence in relation to perinatal mental healthcare. Whilst PHNs rated their skill (M=5.24) and confidence (M=5.24) higher than the midwives (M=4.46; M= 4.35 respectively) and the practice nurses (M=3.17; M=3.15 respectively), all three groups rated their skill and confidence below the midpoint of the 10 point scale. In keeping with the findings on knowledge, all three groups had higher self-reported skills in opening a discussion on, or developing a plan of care with women in relation to depression and anxiety, compared to the other items listed.

The low self-reported knowledge and skills among all three groups of participants is not unique to the Irish context. Poor knowledge in relation to perinatal mental health is reflected within the international literature, with PHNs (McConnell *et al.* 2005; Brown and Bacigalupo 2006; Almond and Lathlean 2011; Agapidaki *et al*. 2014), PNs (Crosland and Kai 1998; Gray *et al*. 2009; Hardy 2014) and midwives (Stewart and Henshaw 2002; Ross-Davie *et al.* 2006; Skocir and Hundley 2006; Mivsek *et al.* 2008; Mollart *et al.* 2009; McCauley *et al.* 2011) all reporting receiving inadequate education on perinatal mental health. Practice nurses in Crosland and Kai's (1998) study were of their view that their general nurse training did not equip them to deal with mental health problems, with half (52%, n=231) reporting never having received education in the area of mental health, let alone perinatal mental health. Similarly, practice nurses in Gray *et al.*'s (2014) and Hardy's (2014) studies also reported receiving little or no mental health education

in the previous five years, for those who did attend education the focus was on depression and anxiety. Equally, PHNs reported a lack of knowledge on how to differentiate between distress that would resolve with support and distress that needed specialist intervention (McConnell *et al.* 2005; Almond and Lathlean 2011; Agapidaki *et al.* 2014), with some relying on self-directed study, searching the internet and reading community journals to access information (Brown and Bacigalupo 2006). Research involving midwives also portrays a similar picture with many reporting a lack of knowledge and skills to effectively and comprehensively assess and support women's mental health (Stewart and Henshaw 2002; Ross-Davie *et al.* 2006; Skocir and Hundley 2006; Mivsek *et al.* 2008; McCauley *et al*. 2011). Whilst these deficits in knowledge and skills can have seriously negative consequences for women, including relapse of existing mental health problems, development of new problems and in the extreme case maternal suicide (Oates & Cantwell 2011), it is heartening that there was an overwhelming desire among participants for further education in the area of perinatal mental health, including the provision of opportunities to improve their communication skills and to work with both women and their family members.

Barriers to addressing perinatal mental health

Whilst there was variation between the numbers of PHNs, midwives and practice nurses in relation to the degree that the barriers listed impacted on their willingness to discuss perinatal mental health issues with women, organisational barriers were identified as having the most negative impact. With the exception of the midwives (76%), just half of the participants indicated that a specialist perinatal service (PHNs 52%; PNs 40%), policies and guidelines on perinatal mental health (PHNs 42%; MWs 41%; PNs6%) or care pathways (PHNs 56%; MWs40%; PNs 25%) were available. Consequently, nearly 60% of participants in all three cohorts noted that the lack of clear care pathways and lack of available perinatal mental health services were significant barriers to discussing mental health issues, with between 20-50% indicating that a lack of knowledge on how to access mental health services or supports was a barrier to them discussing mental health issues with women. Not surprisingly, in the priorities for change, all cohorts identified an urgent need for care pathways, policies and standard operating procedures to guide their practice, alongside an increase in the number and type of perinatal mental health services available to women. The negative impact of an absence of perinatal services (Brown and Bacigalupo 2006; Chew-graham *et al.* 2008; Jomeen *et al.* 2013; Agapidaki *et al.* 2014;) and organisational care pathways/guidelines (Jomeen *et al.* 2013; Rollans *et al.* 2013a) is evidenced within the literature, with some practitioners being of the view that there is little point in identifying women who are at risk of experiencing mental distress because of limited services or referral options available (Almond and Lathlean 2011; Jomeen *et al.* 2013). Whilst the majority of practitioners in the studies reviewed were happy to undertake the role of supporting women in the absence of services, PHNs in Rush's (2012) study expressed a reluctance to provide care to women with postnatal depression for fear that, in the absence of services, women would come to develop an overreliance on them.

Similar to other studies, lack of time and heavy workload were also identified as significant organisational barriers to effective care (Ross-Davie *et al.* 2006; Elliott *et al.* 2007; Lees *et al.* 2009; Mollart *et al.* 2009; McLachlan *et al.* 2011; Stewart-Moore *et al.* 2012; Obando Medina *et al.* 2014). Given the current staff shortages, the increasing caseload of midwives and nurses, and that, unlike other countries the PHNs in Ireland provides a cradle to grave service, it is not surprising that workload and time is an issue for all.

Practitioner-related barriers were the next significant group, with between 50-65% of participants reporting a lack of knowledge of mental health issues as negatively impacting on their ability to discuss issues with women, with a significant number feeling they did not have sufficient

knowledge to respond to women if they disclosed a mental health issue. A lack of knowledge around culture and mental health was also identified as a barrier to supporting women from different backgrounds. This perceived lack of knowledge in relation to cultural issues is of increased significance given that in 2013 '15.5% of births in Ireland were to women from EU countries outside of Ireland, and a further 6.6% were born to women from non-EU countries' (Department of Health 2016: 39). Lack of knowledge and skills was also identified within the international literature as a factor hampering practitioners' ability to offer psychological and mental healthcare to women (Ross-Davie *et al.* 2006; Elliott *et al.* 2007; Baldwin and Griffiths 2009; Glavin *et al.* 2010; Almond and Lathlean 2011; Jones *et al.* 2012; Jomeen *et al.* 2013). Participants in some of these studies expressed concerns about their lack of knowledge on cultural difference and nuances around mental health, and were concerned about language barriers and the lack of translated scales and literature (Baldwin and Griffiths 2009; Glavin *et al.* 2010; Almond and Lathlean 2011; Jomeen *et al.* 2013). They also raised concerns about the appropriateness of applying westernised psychiatric constructs to non-western cultures and using screening tools that were not culturally specific (Baldwin and Griffiths 2009; Glavin *et al.* 2010; Almond and Lathlean 2011; Jomeen *et al.* 2013). In one study, PHNs also reported reluctance around using interpreters for fear that information would not be interpreted correctly (Almond and Lathlean 2011). There was also a tendency in education programmes offered to PHNs to exclude culturally effective methods for detecting and dealing with postnatal depression in women from ethnic minority groups (Almond and Lathlean 2011). Interestingly, in the context of this study, the policy/guideline documentation reviewed made little or no reference to cultural competence in relation to perinatal mental healthcare. Neither did the information made available to women acknowledge variations in cultural interpretations of perinatal distress or indeed the language used to describe it.

Within the literature, a number of women-centred factors are identified as inhibiting discussion on mental health issues, including women's desire to present an image that all is 'going well' (Tammentie *et al.* 2013), fear of being judged (Aston *et al.* 2015) and fear of consequences from social services, such as loss of custody (Brown and Bacigalupo 2006). Consequently, in some studies practitioners 'cloaked' the psychosocial assessment in the baby check by introducing the discussion with euphemisms such as doing 'paper work' (McConnell *et al.* 2005; Rollans *et al.* 2013b) or by avoiding the term depression and, instead, opting to comment on how distress is part of the 'normal' and 'expected experience' (McConnell *et al.* 2005). Within this current study, similar issues emerged. Depending on the cohort, between 25-40% reported fears around women getting offended, misinterpreting their questions as a judgement of their mothering capacity and uncertainty about whether women wanted to be asked about mental health issues, as barriers to discussion. In addition, a small cohort of participants (midwives and PHNs in particular) reported fears around stigmatising women by documenting mental health issues and fears that if women were referred to a GP they would only receive medication. Practitioner assumptions around GPs prescribing and adopting an over medicalised approach towards the care of women was also reported by McConnell *et al.* (2005) and Chew-Graham *et al.* (2008), with both suggesting the need for ongoing education to challenge practitioners' assumptions and personal prejudices.

Education and training

The importance of education in the area of perinatal mental health is central to all policies in the area, with the national maternity strategy identifying the need for all health care professionals involved in antenatal and postnatal care, to be trained 'to identify women at risk of developing or experiencing emotional or mental health difficulties, including an exacerbation of previous mental health issues, in the perinatal period' (Department of Health 2016: 66). Despite this, approximately 40% of PHNs and midwives, and 80% of practice nurses, in the current study,

reported that they did not receive education in the area. In addition, participants reported that the availability of in-service education was low, with 41% of PHNs and midwives and only 4% of practice nurses indicating that their service provided in-service education. In the absence of in-service education, the primary source of learning for those who received education was as part of their nursing/midwifery training, which given the age profile and length of time participants reported working in their current role is possibly some time ago and out-dated. Therefore, it is not surprising that, similar to other studies, participants requested further education in the area (McConnell *et al.* 2005; Brown and Bacigalupo 2006; Skoðr and Hundley 2006; Mivsek *et al.* 2008; Almond and Lathlean 2011; Agapidaki *et al*. 2014). The educational priorities identified by participants in this study included acquiring knowledge about the continuum of perinatal mental health problems, incidence and risk factors as well as broader topics such as bonding and attachment, and cultural and legal issues. In addition, participants prioritised communication skills training, including opening a discussion on perinatal mental health, conducting a mental health assessment, and the use of screening tools as well as communication and counselling skills to support partners/ family members. In light of the findings of this study, there is a need to have specific focus on opening discussions on sensitive subjects, such as psychosis, thoughts of self-harm, IPV and sexual abuse. Whilst these areas are challenging, all practitioners need to have the confidence and skills to include them, if only to give women permission to talk and let them know that there are people there who are willing to listen and help at any stage in the healthcare journey. The importance of education is evidenced in this study, as findings suggest that those with PMH education had higher confidence and skill than those without any PMH education, and they also had higher scores on knowledge items compared to those without PMH education, and the differences were statistically significant.

Limitations

The results of this study need to be interpreted in light of the following limitations:

- Nurses' and midwives' practices and behaviours are self-reported, therefore it is impossible to determine whether the behaviour is the same and/or different in actual practice.
- There is potential for a response bias with those more positively disposed to perinatal mental healthcare more likely to have completed the survey.
- In the absence of a national database there is no way of knowing how many participants received the surveys and how representative the sample is of the national numbers.
- There is also no way of knowing how representative the documentation received is of the overall documentation on perinatal mental health within services.
- The estimated response rate for PHNs (13.6%), midwives (27.7%) and practice nurses (10.3%) could be considered low, although this is not unusual in survey research.

Recommendations

The following recommendations are proposed:

Recommendations for policy

- National guidelines are required to inform the development of evidence-based policies and strategies for perinatal mental health at organisational and clinical practice levels.

Recommendations for practice

- A HSE wide approach is taken to the development of care pathways on perinatal mental health.

- Managers within local services need to review their policies on perinatal mental health to ensure that they address the full range of mental health issues experienced by women in the perinatal period. are recovery-oriented and culturally sensitive.
- A coherent approach to the development of documentation, including screening and other assessment documentation is required.
- The HSE needs to support the development of evidence-based information on perinatal mental health issues for women, their partners and families. This information needs to address the full range of perinatal mental health issues and be made available in both print and online media and in different languages.
- Perinatal mental health education is incorporated into all programmes offered to pregnant women and addresses the full range of mental health issues.

Recommendations for education

- Education programmes in the area of perinatal mental health should be developed and delivered to all relevant health practitioners to enable them to develop skills to screen, assess and support women who are at risk of, or experience mental health problems in the perinatal period. This education needs to address the full range of mental health issues, with reference to cultural differences and with a specific focus on improving practitioners' skills in opening a discussion on sensitive subjects, responding to women's fears and anxieties, discussing referral pathways, and skills to communicate and support partners and family members.
- Existing education programmes should be reviewed to ensure that they are addressing the core knowledge and skills required to provide care to women and are addressing cultural competence in relation to perinatal mental health.
- In line with collaborative principles, women and family/carer input should be incorporated into such training.

Recommendations for research

- Further study be undertaken to explore the working patterns and relationships between practice nurses, PHNs and midwives in order to identify possible overlaps and gaps in service provision, and to support integration and ensure the most efficient use of midwifery and nursing resources.

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APPENDICES

Appendices

Appendix I: Steering committee membership

Anne Brennan	Interim Director, Nursing & Midwifery Planning and Development, HSE Dublin North (Joined 2017)
Mary Brosnan	Director of Midwifery and Nursing, National Maternity Hospital
Susanna Byrne	Director, Nursing & Midwifery Planning and Development, Dublin South, Kildare and Wicklow
Margaret Carroll	Associate Professor of Midwifery, School of Nursing and Midwifery, Trinity College Dublin
Triona Cowman	Director of the Centre of Midwifery Education (CME), Coombe Women's and Infant's University Hospital
Eithne Cusack	Former Interim Area Director, Nursing & Midwifery Planning & Development, HSE Dublin North East (Until July 2016)
Emma Fleming	NMPD Officer, Nursing & Midwifery Planning and Development, HSE Dublin North (Joined 2016)
Ailish Gill	E-learning project worker, School of Nursing and Midwifery, Trinity College Dublin
Prof. Agnes Higgins	Professor in Mental Health, School of Nursing and Midwifery, Trinity College Dublin
Patricia Hughes	Former Director of Midwifery and Nursing, Coombe Women's and Infant's University Hospital (Until Oct 2016)
Rita Lawlor	Professional Development Coordinator for Practice Nurses, HSE Dublin Mid-Leinster
James Lynch	Former Interim Director, Nursing & Midwifery Planning and Development, HSE Dublin North – Chair until February 2017
Anne MacIntyre	Director of Midwifery and Nursing, Coombe Women's and Infant's University Hospital (Joined 2016)
Deirdre Madden	Registered Advanced Nurse Practitioner Perinatal Mental Health, National Maternity Hospital (Joined 2016)
Dr. Mark Monahan	Assistant Professor Mental Health Nursing, School of Nursing and Midwifery, Trinity College Dublin
Margaret Philbin	Director of Midwifery and Nursing, Rotunda Hospital
Virginia Pye	National Lead for Public Health Nursing/Office of the Nursing and Midwifery Services Director (ONMSD)/Clinical Strategy and Programmes Division, HSE
Liz Roche	Area Director, Nursing and Midwifery Planning and Development, Dublin Mid-Leinster (Chair from Feb. 2017)
Prof. John Sheehan	UCD Associate Clinical Professor, UCD School of Medicine, Consultant in Perinatal Psychiatry, Rotunda hospital
Sheila Sugrue	National Lead Midwife, Office of the Nursing & Midwifery Services Director, HSE

Appendix 2: Public health nurses

Appendix 2a: Knowledge of perinatal mental health (n=138)

How would you rate your knowledge (1-5) on:	Mean	SD
Perinatal depression (antenatal and postnatal depression)	3.56	.83
Impact of maternal mental health problems on mothering	3.33	.98
Perinatal anxiety (antenatal and postnatal anxiety)	3.19	.97
Risk factors for developing mental health problems in the perinatal period	3.15	.94
Services available to support women with perinatal mental health issues	3.10	1.01
Screening tools for perinatal mental health problems	3.01	1.17
Impact of maternal mental health problems on the foetus/baby	3.01	1.03
Obsessive thinking related to perinatal mental health	2.38	1.02
Alcohol misuse in the perinatal period	2.38	1.00
Psychosis in the perinatal period	2.35	1.04
Post-traumatic stress disorder	2.22	.98
Substance misuse in the perinatal period	2.21	1.00
Legal aspects of caring for women experiencing mental health problems, and their babies	2.08	.97
Drug use in pregnancy and breastfeeding	2.07	.96
Bipolar affective disorder	2.02	.95
Self-injury/suicide in perinatal period	2.01	.98
Eating disorders and pregnancy	1.98	.97
Obsessive compulsive or ritualistic behaviour	1.88	.90
Personality disorders	1.83	.83

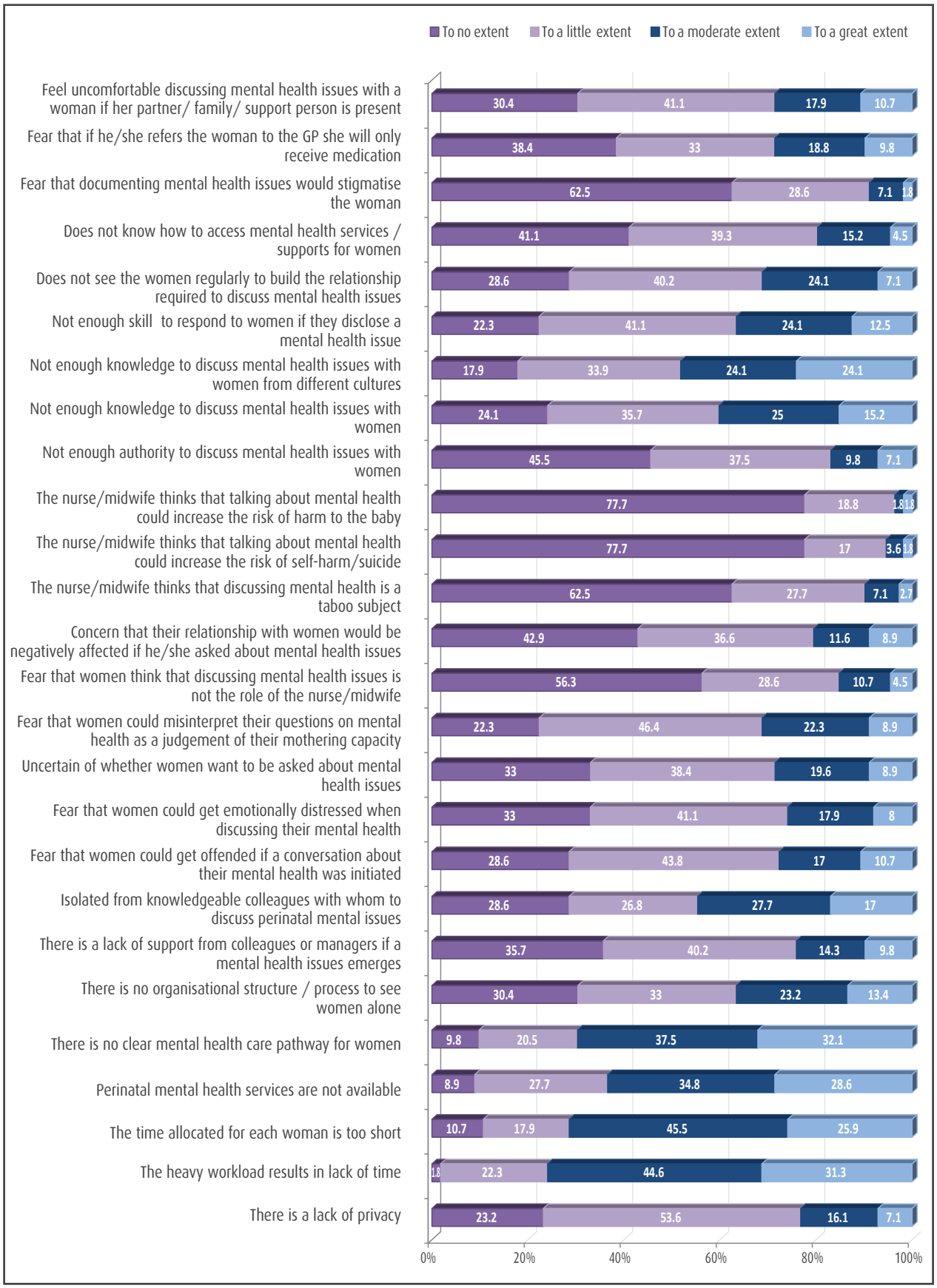
Appendix 2b: Skill ratings

	N	Mean	SD
Opening a discussion and asking women about:			
Mood	131	3.26	1.00
Anxiety	131	3.19	1.01
Self-injury or suicidal thoughts/behaviours	129	2.43	1.02
Alcohol and substance use	129	2.43	.87
Eating behaviours	129	2.22	.89
Psychosis	131	2.04	.99
Intimate partner violence	131	1.97	.91
Sexual abuse/sexual violence	131	1.89	.87
Providing support (informational, emotional, practical) to women who are:			
Traumatised by their birth experience	131	3.61	1.01
Emotionally distressed	131	3.37	.99
Concerned that they may develop mental health problems	131	3.24	.96
Concerned about taking psychotropic meds while pregnant or breastfeeding	131	2.66	1.03
Concerned about the hereditary nature of mental health problems	131	2.55	.99
Providing support to partners/ family members who are concerned about:			
The safety of the baby	131	3.19	.98
The woman's mental health	131	3.08	.96
Own mental health	131	3.08	.95
The woman's safety	131	3.04	.95
The impact of the woman's mental health on foetus/baby	131	2.98	.98
Developing a plan of care with women who:			
Are experiencing depression	131	2.96	1.04
Are experiencing severe anxiety	131	2.61	1.12
Have thoughts about harming their baby	131	2.44	1.18
Have thoughts about harming themselves	131	2.44	1.17
Have obsessive thinking	131	2.11	1.02
Are hearing voices	131	2.03	1.03
Are having strange or unusual thoughts (delusions)	131	2.03	1.04
Discussing with women the need to consult with and/or refer to:			
Primary care (GP/Public Health Nurse)	131	4.21	.88
Child Protection Services	131	3.82	.99
Social worker	131	3.64	1.01
Drug and alcohol Services	131	3.56	1.04
Perinatal Mental Health services (nurse/midwife/psychiatrist)	131	3.49	1.11
Mental Health services (nurse/psychiatrist/psychologist/counsellor)	131	3.08	1.05
Asking for advice or assistance on mental health issues from:			
Colleagues	131	4.20	.92
Managers	131	4.11	.97
Adult mental health services	131	3.62	1.15
Perinatal mental health services	131	3.55	1.22

Appendix 2c: Knowledge among those with and without some perinatal mental health education

Knowledge	Some Education in PMH						T-Test
	Yes			No			
	N	Mean	SD	N	Mean	SD	
Risk factors for developing mental health problems in the perinatal period	86	3.43	.83	52	2.69	.92	t(136)= 4.847, p<.001
Perinatal depression (antenatal and postnatal depression)	86	3.71	.76	52	3.31	.88	t(136)= 2.829, p<.01
Perinatal anxiety (antenatal and postnatal anxiety)	86	3.37	.91	52	2.88	1.00	t(136)= 2.937, p<.01
Obsessive thinking related to perinatal mental health	86	2.60	1.00	52	2.02	.96	t(136)= 3.389, p<.001
Screening tools for perinatal mental health problems	86	3.29	1.05	52	2.56	1.21	t(136)= 3.748, p<.001
Eating disorders and pregnancy	86	2.12	.99	52	1.75	.90	t(136)= 2.178, p<.05
Psychosis in the perinatal period	86	2.53	1.01	52	2.04	1.01	t(136)= 2.792 , p<.01
Bipolar affective disorder	86	2.16	.98	52	1.79	.87	t(136)= 2.265, p<.05
Post-traumatic stress disorder	86	2.36	1.05	52	1.98	.80	t(128.482)= 2.388, p<.005
Psychotropic drug use in pregnancy and breastfeeding	86	2.23	.94	52	1.81	.93	t(136)= 2.581, p<.05
Self-injury/suicide in perinatal period	86	2.20	1.02	52	1.69	.83	t(136)= 3.029, p<.01
Alcohol misuse in the perinatal period	86	2.53	.99	52	2.12	.96	t(136)= 2.436, p<.05
Substance misuse in the perinatal period	86	2.36	1.00	52	1.96	.95	t(136)= 2.307, p<.05
Personality Disorders	86	2.00	.87	52	1.56	.70	t(136)= 3.116, p<.01
Obsessive compulsive or ritualistic behaviour	86	2.14	.88	52	1.46	.75	t(136)= 4.612, p<.001
Impact of maternal mental health problems on the foetus/baby	86	3.21	.92	52	2.69	1.11	t(136)= 2.951, p<.01
Impact of maternal mental health problems on mothering	86	3.50	.88	52	3.06	1.09	t(136)= 2.613, p<.01
Services available to support women with perinatal mental health issues	86	3.31	.95	52	2.75	1.01	t(136)= 3.306, p<.001
Legal aspects of caring for women experiencing mental health problems, and their babies	86	2.26	.96	52	1.79	.94	t(136)= 2.797, p<.01

Appendix 2d: Barriers to discussing mental health issues



Appendix 3: Midwives

Appendix 3a: Participants working in multiple areas

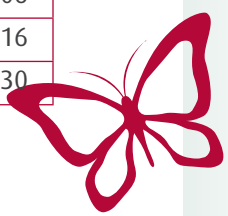
Multiple and Other areas	N	%
A & P care & Labour and delivery care	25	23.4
Antenatal and postnatal care (hospital)	13	12.1
Training/clinical placement co-ordination; Education	10	9.3
Management	10	9.3
Antenatal care & Labour and delivery care	9	8.4
Practice Development co-ordinator	6	5.6
Ultrasound Department	5	4.7
Antenatal care (hospital) & Early Pregnancy/Gynae unit	3	2.8
Bereavement support	3	2.8
Specialist/Consultant	2	1.9
A & P care & Labour and delivery care & Gynae/Pregnancy unit	2	1.9
Labour and delivery care; Emergency room	2	1.9
All areas	2	1.9
A & P care & Early discharge home postnatal services	1	.9
Postnatal care & Early discharge home postnatal services	1	.9
Labour & delivery care; Early discharge home; DOMINO	1	.9
Postnatal care-hospital based & Bereavement support	1	.9
NICU/SCBU care & Labour & Delivery Care	1	.9
Community Services and Early discharge home	1	.9
Antenatal outpatients	1	.9
Midwives clinic-hospital and outreach	1	.9
A & P care/Gynae unit	1	.9
Postnatal care (hospital) & Early Pregnancy/Gynae unit	1	.9
Community services; Labour and delivery; DOMINO	1	.9
Community services; DOMINO	1	.9
A & P care & Labour and delivery care; Community services	1	.9
Breastfeeding support	1	.9
Labour and delivery care; DOMINO	1	.9
Total	**107**	**100.0**

Appendix 3b: Knowledge of perinatal mental health

How would you rate your knowledge on:	N	Mean	SD
Perinatal depression (antenatal and postnatal depression)	449	3.29	.83
Perinatal anxiety (antenatal and postnatal anxiety)	449	3.13	.87
Risk factors for developing mental health problems in the perinatal period	451	3.07	.90
Services available to support women with perinatal mental health issues	454	2.92	1.02
Impact of maternal mental health problems on mothering	453	2.88	1.00
Impact of maternal mental health problems on the foetus/baby	452	2.58	1.00
Post-traumatic stress disorder	450	2.53	1.07
Substance misuse in the perinatal period	453	2.50	1.01
Obsessive thinking related to perinatal mental health	449	2.44	.97
Alcohol misuse in the perinatal period	453	2.44	1.01
Psychosis in the perinatal period	453	2.39	1.00
Bipolar affective disorder	449	2.23	.99
Psychotropic drug use in pregnancy and breastfeeding	453	2.21	1.02
Eating disorders and pregnancy	452	2.12	.93
Self-injury/suicide in perinatal period	453	2.08	.95
Screening tools for perinatal mental health problems	453	2.07	1.01
Legal aspects of caring for women experiencing mental health problems, and their babies	454	2.04	.91
Obsessive compulsive or ritualistic behaviour	451	2.02	.93
Personality disorders	450	2.01	.93

Appendix 3c: Skill ratings

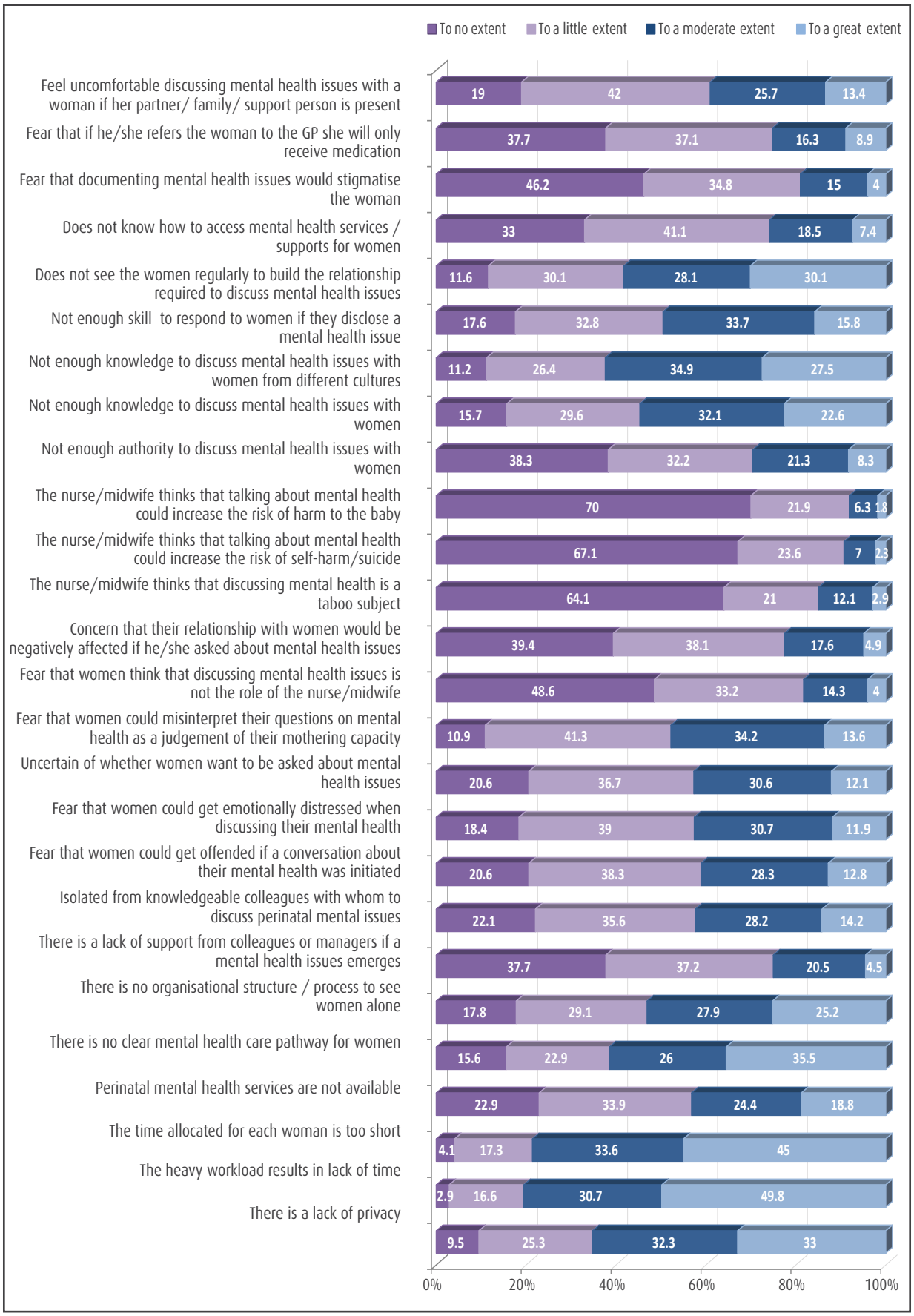
	N	Mean	SD
Opening a discussion and asking women about:			
Mood	450	3.14	1.04
Anxiety	450	3.08	.99
Alcohol and substance use	449	2.76	1.06
Self-injury or suicidal thoughts/behaviours	449	2.39	1.03
Eating behaviours	449	2.39	.99
Intimate partner violence	450	2.20	1.06
Psychosis	450	2.18	.96
Sexual abuse/sexual violence	450	2.14	1.03
Providing support (informational, emotional, practical) to women who are:			
Traumatised by their birth experience	450	3.47	.99
Emotionally distressed	450	3.21	.99
Concerned that they may develop mental health problems	451	3.03	1.01
Concerned about taking psychotropic medication while pregnant or breastfeeding	450	2.62	1.07
Concerned about the hereditary nature of mental health problems (for self or baby)	450	2.34	1.02
Providing support to partners/ family members who are concerned about:			
The safety of the baby	451	2.85	1.07
The woman's safety	452	2.77	1.04
The woman's mental health	452	2.68	1.07
Own mental health	449	2.65	1.12
The impact of the woman's mental health on foetus/baby	451	2.58	1.01
Developing a plan of care with women who:			
Are experiencing depression	451	2.50	1.08
Are experiencing severe anxiety	452	2.31	1.08
Have thoughts about harming themselves	451	2.03	1.04
Have thoughts about harming their baby	450	1.96	1.02
Have obsessive thinking	451	1.88	.98
Are hearing voices	450	1.76	.96
Are having strange or unusual thoughts (delusions)	451	1.73	.95
Discussing with women the need to consult with and/or refer to:			
Perinatal Mental Health services (nurse/midwife/psychiatrist)	449	3.43	1.02
Social worker	451	3.36	.88
Primary care (GP/Public Health Nurse)	445	3.36	1.11
Drug and alcohol Services	450	3.26	1.07
Mental Health services (nurse/psychiatrist/psychologist/counsellor)	448	2.99	1.14
Child Protection Services	447	2.50	1.13
Asking for advice or assistance on mental health issues from:			
Colleagues	448	3.96	.98
Managers	449	3.86	1.06
Perinatal mental health services	448	3.61	1.16
Adult mental health services	447	3.13	1.30



Appendix 3d: Knowledge among those with and without some perinatal mental health education

Knowledge	Some Education in PMH						T-Test
	Yes			No			
	N	Mean	SD	N	Mean	SD	
Risk factors for developing MHPin the perinatal period	284	3.28	.814	162	2.72	.929	t(300.132)= 6.7, p<.001
Perinatal depression (antenatal and postnatal)	282	3.41	.792	162	3.08	.863	t(442)= 4.06, p<.001
Perinatal anxiety (antenatal and postnatal)	282	3.26	.819	162	2.90	.927	t(442)= 4.259, p<.001
Obsessive thinking related to perinatal mental health	283	2.60	.968	161	2.16	.919	t(442)= 4.71, p<.001
Screening tools for mental health problems	285	2.31	1.025	162	1.64	.831	t(393.142)= 7.438, p<.001
Eating disorders and pregnancy	285	2.26	.950	161	1.88	.864	t(445)= 5.959, p<.001
Psychosis in the perinatal period	285	2.60	.979	162	2.03	.955	t(341.774)= 6.001, p<.001
Bipolar affective disorder	283	2.43	.992	160	1.86	.894	t(359.389)= 6.217, p<.001
Post-traumatic stress disorder	285	2.74	1.047	159	2.14	.999	t(442)= 5.808, p<.001
Psychotropic drug use in pregnancy/ breastfeeding	286	2.33	1.038	161	1.98	.958	t(354.369)= 3.569, p<.001
Self-injury/suicide in perinatal period	286	2.27	.952	161	1.75	.846	t(445)= 5.809, p<.001
Alcohol misuse in the perinatal period	286	2.56	1.006	161	2.24	.991	t(445)= 3.281, p<.001
Substance misuse in the perinatal period	286	2.61	1.002	161	2.30	.993	t(445)= 3.153, p<.05
Personality Disorders	283	2.18	.970	161	1.72	.776	t(393.988)= 5.427, p<.001
Obsessive compulsive or ritualistic behaviour	285	2.16	.971	160	1.76	.813	t(379.626)= 4.485, p<.001
Impact of maternal MHP on the foetus/baby	284	2.69	.993	162	2.39	.992	t(444)= 3.046, p<.05
Impact of MHP on mothering	285	3.00	.971	162	2.64	1.025	t(320.001)= 3.617, p<.001
Services available to support women with PMHP	286	3.09	1.003	162	2.60	.987	t(446)= 4.994, p<.001
Legal aspects of caring for women experiencing MHP, and their babies	286	2.15	.938	162	1.84	.833	t(446)= 3.507, p<.001

Appendix 3e: Barriers to discussing mental health issues



Appendix 4: Practice Nurses

Appendix 4a: Knowledge of perinatal mental health (n=146)

How would you rate your knowledge on:	Mean	SD
Perinatal depression (antenatal and postnatal depression)	2.72	1.04
Perinatal anxiety (antenatal and postnatal anxiety)	2.53	1.00
Risk factors for developing mental health problems in the perinatal period	2.39	1.04
Impact of maternal mental health problems on mothering	2.34	1.08
Impact of maternal mental health problems on the foetus/baby	2.08	1.03
Services available to support women with perinatal mental health issues	2.08	1.01
Obsessive thinking related to perinatal mental health	2.04	1.01
Alcohol misuse in the perinatal period	2.03	.93
Post-traumatic stress disorder	1.93	.97
Substance misuse in the perinatal period	1.92	.94
Bipolar affective disorder	1.84	.98
Obsessive compulsive or ritualistic behaviour	1.82	.97
Psychosis in the perinatal period	1.77	.94
Screening tools for perinatal mental health problems	1.76	1.00
Eating disorders and pregnancy	1.73	1.01
Self-injury/suicide in perinatal period	1.64	.85
Personality disorders	1.64	.86
Psychotropic drug use in pregnancy and breastfeeding	1.62	.87
Legal aspects of caring for women experiencing mental health problems, and their babies	1.49	.81

Appendix 4b: Skill ratings

	N	Mean	SD
Opening a discussion and asking women about:			
Mood	137	2.77	1.15
Anxiety	133	2.77	1.13
Alcohol and substance use	138	2.54	1.09
Eating behaviours	137	2.28	1.07
Self-injury or suicidal thoughts/behaviours	137	2.24	1.07
Sexual abuse/sexual violence	138	1.83	1.04
Intimate partner violence	138	1.79	1.04
Psychosis	137	1.77	.96
Providing support (informational, emotional, practical) to women who are:			
Emotionally distressed	138	2.67	1.15
Traumatised by their birth experience	138	2.56	1.13
Concerned that they may develop mental health problems	138	2.40	1.12
Concerned about the hereditary nature of mental health problems (for self or baby)	138	2.01	1.09
Concerned about taking psychotropic medication while pregnant or breastfeeding	138	1.99	1.07
Providing support to partners/ family members who are concerned about			
Own mental health	138	2.26	1.11
The safety of the baby	138	2.25	1.09
The woman's safety	138	2.22	1.08
The woman's mental health	138	2.10	1.02
The impact of the woman's mental health on foetus/baby	138	1.99	1.02
Developing a plan of care with women who:			
Are experiencing depression	138	1.87	1.05
Are experiencing severe anxiety	138	1.76	1.03
Have obsessive thinking	138	1.57	.97
Have thoughts about harming their baby	138	1.47	.87
Have thoughts about harming themselves	138	1.59	.93
Are having strange or unusual thoughts (delusions)	138	1.41	.86
Are hearing voices	138	1.41	.83
Discussing with women the need to consult with and/or refer to:			
Primary care (GP/Public Health Nurse)	138	3.23	1.37
Drug and alcohol Services	138	2.31	1.18
Perinatal Mental Health services (nurse/midwife/psychiatrist)	138	2.28	1.15
Mental Health services (nurse/psychiatrist/psychologist/counsellor)	138	2.20	1.14
Social worker	138	2.12	1.09
Child Protection Services	138	1.98	1.09
Asking for advice or assistance on mental health issues from:			
Colleagues	138	3.62	1.22
Managers	138	3.18	1.37
Adult mental health services	138	2.66	1.33
Perinatal mental health services	138	2.64	1.33

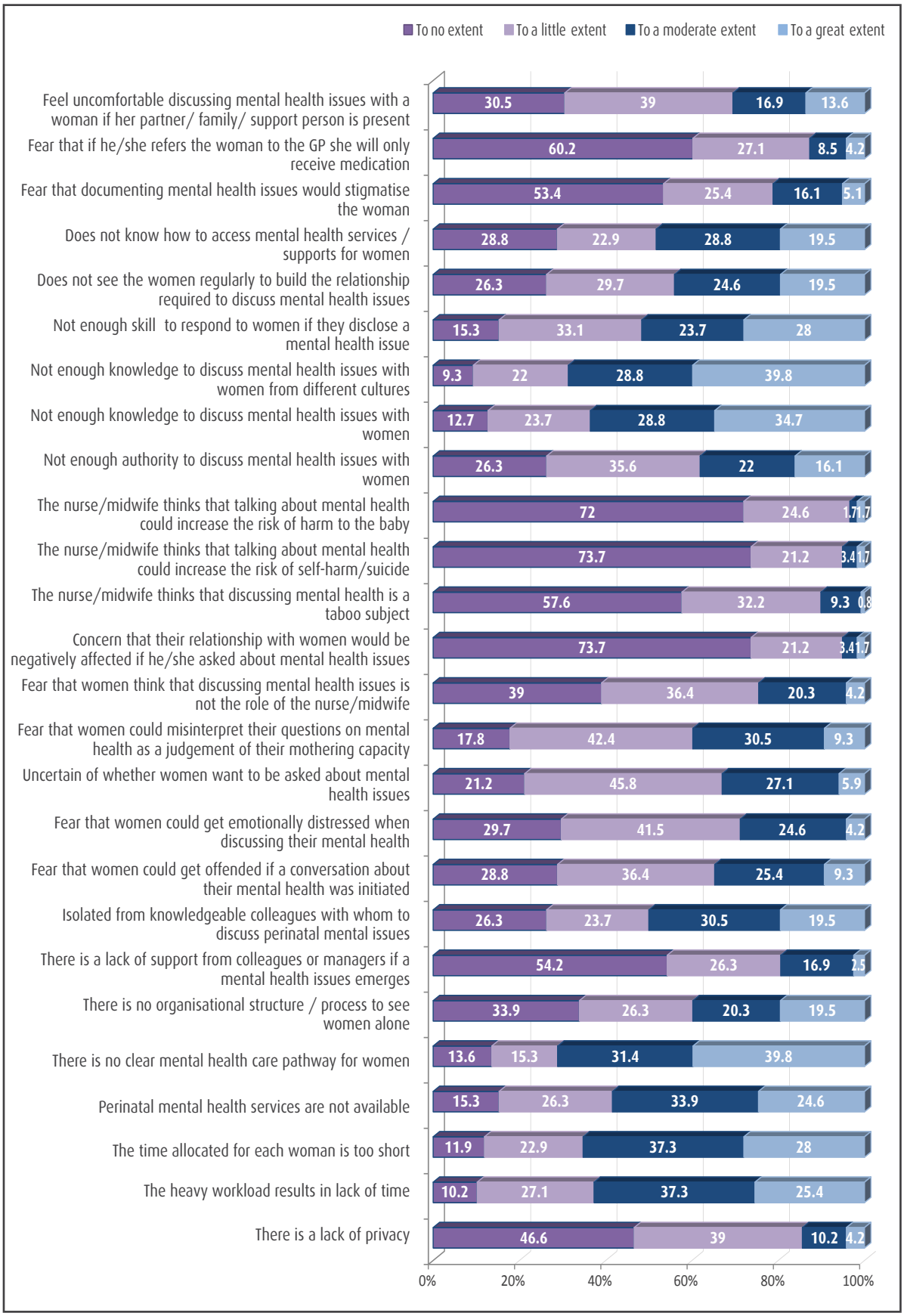
Appendix 4c: Knowledge among those with and without some perinatal mental health education

Knowledge	Some Education in PMH						T-Test
	Yes			No			
	N	Mean	SD	N	Mean	SD	
Risk factors for developing mental health problems in the perinatal period	33	3.42	.90	113	2.09	.87	t(144)= 7.683, p<.001
Perinatal depression (antenatal and postnatal depression)	33	3.67	.89	113	2.44	.91	t(144)= 6.858, p<.001
Perinatal anxiety (antenatal and postnatal anxiety)	33	3.52	.87	113	2.24	.85	t(144)= 7.561, p<.001
Obsessive thinking related to perinatal mental health	33	2.91	1.04	113	1.79	.85	t(144)= 6.325, p<.001
Screening tools for perinatal mental health problems	33	2.58	1.15	113	1.52	.81	t(41.854)= 4.929, p<.001
Eating disorders and pregnancy	33	2.55	1.23	113	1.49	.80	t(40.326)= 4.673, p<.001
Psychosis in the perinatal period	33	2.52	1.06	113	1.55	.78	t(42.503)= 4.851, p<.001
Bipolar affective disorder	33	2.39	1.03	113	1.67	.90	t(144)= 3.917, p<.001
Post-traumatic stress disorder	33	2.61	1.03	113	1.73	.87	t(144)= 4.868, p<.001
Psychotropic drug use in pregnancy and breastfeeding	33	2.36	1.03	113	1.40	.68	t(40.438)= 5.096, p<.001
Self-injury/suicide in perinatal period	33	2.33	1.02	113	1.43	.68	t(40.633)= 4.765, p<.001
Alcohol misuse in the perinatal period	33	2.73	1.01	113	1.82	.80	t(144)= 5.352, p<.001
Substance misuse in the perinatal period	33	2.70	1.05	113	1.70	.78	t(144)= 5.970, p<.001
Personality Disorders	33	2.09	.98	113	1.50	.78	t(144)= 3.575, p<.001
Obsessive compulsive or ritualistic behaviour	33	2.39	1.14	113	1.65	.84	t(42.682)= 3.488, p<.001
Impact of maternal mental health problems on the foetus/baby	33	3.00	1.06	113	1.81	.85	t(144)= 6.646, p<.001
Impact of maternal mental health problems on mothering	33	3.24	1.00	113	2.07	.96	t(144)= 6.104, p<.001
Services available to support women with perinatal mental health issues	33	2.73	.94	113	1.89	.95	t(144)= 4.446, p<.001
Legal aspects of caring for women experiencing mental health problems, and their babies	33	1.91	1.01	113	1.37	.70	t(41.263)= 2.861, p<.01

Appendix 4d: Knowledge among those dealing with women with perinatal mental health issues and those not

Knowledge	Deal with women with PMH issues						T-Test
	Yes			No			
	N	M	SD	N	M	SD	
Risk factors for developing MHP in the perinatal period	72	2.75	.95	74	2.04	1.01	t(144)= 4.372, p<.001
Perinatal depression (antenatal and postnatal depression)	72	3.13	.93	74	2.32	.98	t(144)= 5.050, p<.001
Perinatal anxiety (antenatal and postnatal anxiety)	72	2.86	.92	74	2.20	.98	t(144)= 4.177, p<.001
Obsessive thinking related to perinatal mental health	72	2.35	1.12	74	1.74	.79	t(128.089)= 3.759, p<.001
Screening tools for perinatal mental health problems	72	2.06	1.10	74	1.47	.80	t(144)= 3.673, p<.001
Eating disorders and pregnancy	72	2.04	1.09	74	1.42	.83	t(144)= 3.887, p<.001
Psychosis in the perinatal period	72	2.13	1.05	74	1.42	.66	t(119.410)= 4.854, p<.001
Bipolar affective disorder	72	2.14	1.05	74	1.54	.80	t(144)= 3.880, p<.001
Post-traumatic stress disorder	72	2.22	1.04	74	1.65	.82	t(144)= 3.714, p<.001
Psychotropic drug use in pregnancy and breastfeeding	72	1.89	1.01	74	1.35	.58	t(112.702)= 3.910, p<.001
Self-injury/suicide in perinatal period	72	1.99	.99	74	1.30	.52	t(106.578)= 5.268, p<.001
Alcohol misuse in the perinatal period	72	2.44	.99	74	1.62	.66	t(122.710)= 5.898, p<.001
Substance misuse in the perinatal period	72	2.32	.98	74	1.54	.73	t(144)= 5.483, p<.001
Personality Disorders	72	1.90	.95	74	1.38	.68	t(144)= 3.845, p<.001
Obsessive compulsive or ritualistic behaviour	72	2.11	1.09	74	1.53	.73	t(122.842)= 3.789, p<.001
Impact of maternal mental health problems on the foetus/ baby	72	2.49	1.07	74	1.69	.81	t(131.941)= 5.051, p<.001
Impact of maternal mental health problems on mothering	72	2.82	1.05	74	1.86	.90	t(144)= 5.906, p<.001
Services available to support women with perinatal mental health issues	72	2.46	.99	74	1.72	.88	t(144)= 4.775, p<.001
Legal aspects of caring for women experiencing MH problems, and their babies	72	1.71	.91	74	1.28	.63	t(126.042)= 3.266, p<.001

Appendix 4e: Barriers to discussing mental health issues



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