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Healthcare professionals' perspectives on identifying and managing perinatal anxiety:

a qualitative study

Abstract

Background
Perinatal mental health problems are those that occur during pregnancy or up to 12 months postpartum, and affect up to 20% of women. Perinatal anxiety (PNA) is at least as common as depression during the perinatal phase and can adversely impact on both mother and child. Despite this, research into anxiety has received less attention than depression. The National Institute for Health and Care Excellence guidance on perinatal mental health has identified PNA as a research priority.

Aim
To explore the perspectives and experiences of healthcare professionals (HCPs) in the identification and management of PNA.

Design and setting
This was a qualitative study in primary and secondary care set in the West Midlands from February 2017 to December 2017.

Method
Semi-structured interviews (n = 23) with a range of HCPs. Iterative approach to data generation and analysis, using principles of constant comparison. Patient and Public Involvement and Engagement (PPIE) group was involved throughout the study.

Results
Twenty-three HCPs interviewed: 10 GPs, seven midwives, five health visitors, and one obstetrician. Four themes were uncovered: PNA as an 'unfamiliar concept'; reliance on clinical intuition and not clinical tools; fragmentation of care; and opportunities to improve care.

Conclusion
Awareness and understanding of PNA among HCPs is variable, with debate over what is 'normal' anxiety in pregnancy. HCPs suggested that PNA can be challenging to identify, with mixed views on the use and value of case-finding tools. Opportunistic identification was noted to be significant to aid diagnosis. Care for women diagnosed with PNA was reported to be fragmented and interprofessional communication poor. Potential solutions to improve care were identified.

Keywords
general practice; perinatal anxiety; perinatal mental health; pregnancy; qualitative research.

INTRODUCTION

Perinatal mental health (PMH) problems are those that occur during pregnancy or up to 1 year after birth.[1] In the UK, patients are registered with GPs who they can consult throughout the perinatal period and who will invite women for a 6–8-week postnatal check. Women will also have appointments with midwives (MWs) for routine antenatal care, obstetricians (Obs) for more complex antenatal care, and see health visitors (HVs) postnatally.

During the perinatal period, the most common mental health problems are depression and anxiety disorders, which include generalised anxiety disorder (GAD), obsessive compulsive disorder, panic, social anxiety,[1] and post-traumatic stress disorder.[2] Perinatal depression is reported to affect around 13% of women[3] and some evidence suggests that rates of perinatal anxiety (PNA) may be higher at around 22%.[4] Anxiety is often comorbid with depression, for example, 66% of women with postpartum major depression also had an anxiety disorder.[5] Women who have experienced previous problems with anxiety may be more at risk of PNA.[6]

PMH problems may negatively impact on pregnancy and neonatal outcomes,[7] postnatal mental health,[8] parenting behaviours, and the child's emotional, social, and behavioural development[9] such as attachment disorders.[10] A Swedish study identified an association between antenatal anxiety disorders with increased frequency of visits to obstetric clinics, caesarean delivery, and epidural analgesia.[11] Despite such reported increases in the use of healthcare services, women with PMH disorders are less likely to receive treatment for these in comparison with mental health problems experienced outside of the perinatal period.[12] Barriers to detecting PMH problems exist at individual (for example, patient and practitioner) and systemic levels.[13] Under half of women with mental health problems may have these problems identified in hospital antenatal clinics[14] and only 10–15% who have a PMH

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How this fits in

Perinatal anxiety (PNA) is a common problem that has implications for mother, baby, and wider society, and it has been demonstrated that early detection and appropriate interventions could improve clinical outcomes. There is currently a limited evidence base from which to draw appropriate identification and management options; this article reports the perspectives of healthcare professionals (HCPs) on current practice, and the barriers and facilitators to identification and management of women with PNA. The study found that PNA is an unfamiliar concept to many HCPs, the use of case-finding tools to aid diagnosis and management varies, and that HCPs feel the management of PNA can be fragmented. This study makes specific recommendations around the importance of raising awareness of PNA among HCPs, and of making every patient contact count.

problem detected receive treatment during pregnancy.[3,15,16] Pregnant women report reluctance to self-refer or disclose mental health problems, due to feelings of stigma, or indicate having a lack of time to receive treatment.[17] Healthcare professionals (HCPs) report insufficient time to case-find for post-natal depression[18] and MWs, HVs, and Obs have reported limited knowledge and awareness of PMH problems.[19] Case-finding for anxiety disorders has not received the same attention as for depression during pregnancy and the post-natal period.[20] National Institute for Health and Care Excellence (NICE) clinical guideline CG192 recommends specific case-finding questions (Box 1) to be used at the pregnancy booking appointment for every woman.[2,21,22]

Significant research on perinatal depression exists, including aetiology and prevalence and incidence data,[3,23] trials of interventions,[24] and of the perspectives of women and HCPs.[19,25,26] However, at the commencement of this study in February 2017 there was no published literature that discussed the perspectives of GPs around PNA in the UK,[27] compared perspectives of multiple HCPs around PNA, or reviewed care delivery across the entire perinatal period.[28,29] The NHS *Five Year Forward View for Mental Health Report*[30] recommends the provision of additional specialist and community perinatal mental health support across England by 2020/2021. The development and implementation of evidence-based pathways that promote holistic care and integrated services for PMH are highlighted as important. NICE guidelines recommended the need for further research to develop psychological interventions to identify and treat moderate to severe anxiety disorders in pregnancy.[2] Before interventions can be developed, it is important to understand the factors influencing current practice. This study aimed to explore the perspectives of GPs, Obs, MWs, and HVs on the barriers and facilitators to the identification and management of PNA.

Box 1. Case-finding questions for perinatal mental health problems (extracted from the NICE clinical guideline [CG192])[2]

The following questions are recommended by NICE for use at the booking visit for each pregnant woman:

• Whooley questions[21]

1. During the past month, have you often been bothered by feeling down, depressed, or hopeless?
2. During the past month, have you often been bothered by having little interest in or pleasure doing things?

• Two-item Generalised Anxiety Disorder Scale (GAD-2)[22]

1. Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge?
2. Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?

METHOD

Study design and setting

This study utilised qualitative methods involving semi-structured interviews, predominantly face-to-face but some conducted by telephone. This allowed participants to express their individual views and facilitated in-depth comparison between the interviewees. The study took place across Staffordshire and Shropshire in primary and secondary care. A Patient and Public Involvement and Engagement (PPIE) group was involved throughout development of the study and contributed to the study protocol and data analysis process.

The 'Consolidated criteria for reporting qualitative research' checklist (COREQ) was used as a tool to ensure data trustworthiness.[31]

Sampling and recruitment

A purposive sampling strategy[32] aimed to recruit different HCPs (GPs, Obs, MWs, and HVs) involved in delivering care to women experiencing PMH problems. Inclusion criteria included HCPs who were currently employed in the West Midlands. Multiple NHS sites were engaged to support recruitment, including: Shropshire Community Health Trust, University Hospitals of North Midlands, Shrewsbury and Telford NHS Trust, and Royal Wolverhampton Trust. GPs were recruited with the support of West Midlands Clinical Research Network (CRN) and personal contacts. Information packs, including a participant information sheet and a consent to contact form, were distributed

Table 1. GP participants

	Sex	Ethnicity	GP role	Years as a GP	Type of practice (as stated by individual)
GP001	Female	White British	GP partner	15–20	Semi-rural
GP002	Female	White British	Salaried GP	<5	Suburban
GP003	Male	White British	GP partner	15–20	Semi-rural
GP004	Female	White British	Salaried GP	10–15	Semi-rural
GP005	Male	White British	GP partner	25–30	Suburban
GP006	Female	White Polish	GP partner	10–15	Semi-rural
GP007	Male	White British	Salaried GP	25–30	Suburban
GP008	Male	White British	GP partner	10–15	Rural
GP009	Male	Indian	GP partner	10–15	Semi-rural
GP010	Female	White British	Salaried GP	<5	Suburban

Table 2. Midwife participants

	Sex	Age, years	Specialist role/interest	Years as a midwife	Interview type
MW001	Female	50	Patient information	13	Face-to-face
MW002	Female	51	Research/clinical midwife	25	Face-to-face
MW003	Female	33	Clinical midwife	13	Face-to-face
MW004	Female	34	Antenatal and postnatal care	8	Face-to-face
MW005	Female	59	Community/public health midwife	12	Telephone
MW006	Female	59	Community midwife	9	Telephone
MW007	Female	53	Mental health	27	Face-to-face

Table 3. Health visitor participants

	Sex	Age, years	Years as a health visitor	Type of area worked in	Type of interview
HV001	Female	22	4	Children's centre attached to primary school	Telephone
HV002	Female	62	30	Children's centre attached to primary school	Telephone
HV003	Female	38	6	Community health centre	Telephone
HV004	Female	58	29	Community health centre	Telephone
HV005	Female	52	12	Community health centre	Telephone

to potential participants. The research team arranged interviews with HCPs who returned 'consent to contact' forms or contacted the team directly. GPs received financial reimbursement of their time according to BMA rates.

Data collection

An interview topic guide, developed from the literature review and thorough discussion with the PPIE group, was used to generate data. This was modified as data collection and analysis proceeded, to include emerging themes to be checked in subsequent interviews in an iterative process.[33] Mean interview length was 41 minutes 46 seconds and total accumulated interview time was 15 hours 19 minutes.

The interviews were conducted by two authors, both of whom have training in qualitative methods. All GP interviews were face-to-face; MW and HV interviews were a mixture of face-to-face and telephone interviews. Prior to agreeing to take part, participants were given an information sheet outlining the study objectives. Interviews were digitally recorded with consent, and transcribed and anonymised prior to analysis using a unique participant identifier.

Data collection concluded when data saturation was achieved[34] in GP, HV, and MW datasets, when no new themes emerged from the data that prompted new theoretical or clinical insights. One obstetrician agreed to be interviewed, which was insufficient to generate saturation within the subgroup, and so these data were not included in the overall analysis.

Data analysis

Coding was guided by principles of constant comparison.[35,36] All transcripts were read by at least two authors. All authors were involved in coding data from interviews. Initial codes were refined within the team until key themes were identified. Emerging themes were discussed with the PPIE group throughout the data analysis process. Any variations in coding were discussed and agreed upon within research team meetings.

RESULTS

Recruitment was challenging with only one obstetrician interviewed. A total of 23 HCPs working in the West Midlands were interviewed. Participant demographics are shown in Tables 1–3.

The data were organised within four main themes: PNA as an unfamiliar concept; reliance on intuition in the identification of PNA as opposed to case-finding tools; fragmentation of care; and opportunities to improve care.

Illustrative data are presented to support analysis with unique participant identifiers to indicate HCP-type. These themes are outlined in Figure 1.

Perinatal anxiety as an unfamiliar concept

Some HCPs were not aware of PNA as a specific diagnosis and were uncertain that PNA existed as a distinct clinical entity:

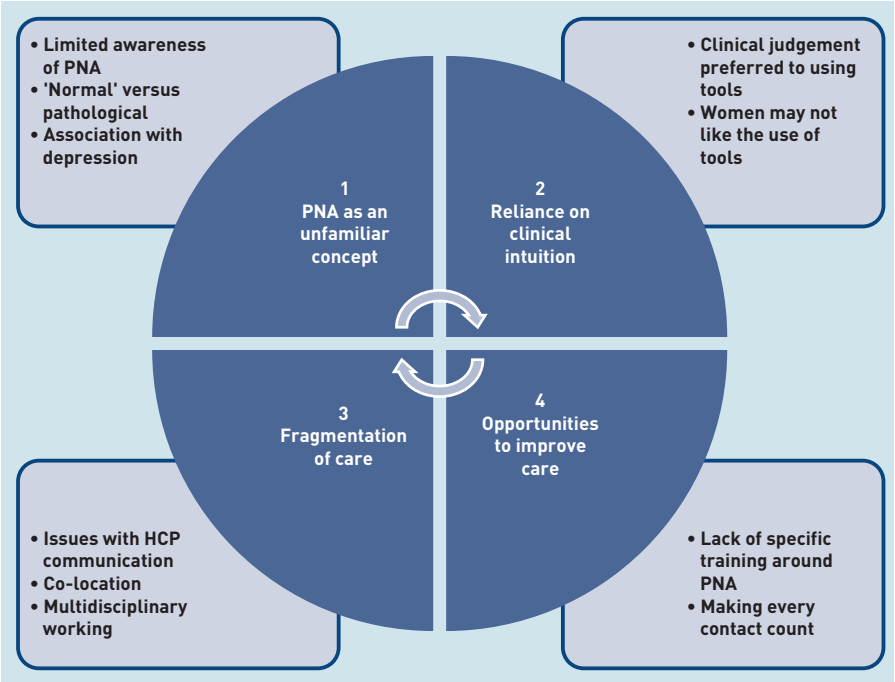

Figure 1. Data analysis themes.
HCP = healthcare professional. PNA = perinatal anxiety.

'I mean it's a concept that I'm really not that much aware of either professionally or from reading.' (GP007, male [M], 25–30 years in role)

Anxiety was seen commonly as 'normal' or 'understandable', with HCPs suggesting that some anxiety during the perinatal period was to be expected:

'I was surprised about the amount of women that report they have anxiety when you ask them about it. Some of that is the normal anxiety, but I would say at least half of the women that I look after have some sort of anxiety.' (MW006, 9 years in role)

It was suggested by several HCPs that anxiety becomes *'pathological'* when symptoms began to affect a woman's everyday functioning. HCPs suggested that it can be challenging to differentiate between 'normal' and 'pathological' PNA:

'We do recognise that pregnant women can be more anxious, and it's trying to identify when that might be becoming more pathological rather than, sort of normal.' (GP003, M, 15–20 years in role)

Some respondents felt that normalising PNA could reassure women that they are not alone, but others were concerned that normalising symptoms could lead to women feeling unable to seek help and support. In addition, HCPs suggested that society's expectations to have a positive perinatal experience are unrealistic and creates pressures for women.

These pressures, combined with stigma around mental health, mean women may be reluctant to disclose symptoms of anxiety:

'I think there is, unfortunately, still a bit of a stigma around thinking, "If I share with my health visitor that I'm not coping and I'm experiencing low mood, then ..." It's quite an old-fashioned stigma but I do think it's still there.' (HV004, 29 years in role)

The association of anxiety symptoms associated with depression was discussed, with a range of opinions expressed.

Some HCPs acknowledged that they now view anxiety as a distinct diagnosis; others felt that the focus should be on depression and therefore they did not screen for anxiety symptoms:

'Postnatal depression is a term that we would more commonly use but obviously that doesn't necessarily encapsulate anxiety, and I think often anxiety seems to come hand in hand with a degree of depression. So maybe there needs to be a wider use of anxiety as a definition.' (GP008, M, 10–15 years in role)

Clinician intuition versus the use of case-finding tools

HCPs discussed the clinical tools and validated questionnaires they were aware of for the identification and assessment of PMH problems, suggesting that these were focused on depression, not on PNA. There was disagreement about how helpful clinical tools were.

GPs indicated that they did not commonly use tools to assess anxiety, but some remarked they would anticipate that their MW or HV colleagues might use the Edinburgh Postnatal Depression Scale (EPDS)[37] to identify both depression and anxiety. Several participants felt that their own clinical expertise and professional judgement were preferable to using tools:

'I personally don't [use diagnostic tools] *with postnatal women, I don't like mental health score cards and things where you have to get a number and then you are, then you're diagnosed as whatever. I think with experience and skill, you can pretty much pick it up yourself.'* (GP007, M, 25–30 years in role)

Several MWs and HVs also described including scores from assessment tools to

support referrals to specialist mental health services:

'I think it gives a bit of credibility. We used to find that we'd struggle to get people referred into the services … because we didn't use those and we'd be saying, oh this woman's a bit depressed …' (MW007, 27 years in role)

Some HCPs suggested that women expressed opinions about the tools, and reported a range of experiences in using them:

'Some women look at me and say, "I'm not using those, that's just really weird." Yet other families think well, actually that's a great introduction …' (HV001, 4 years in role)

One perceived limitation of using scoring tools to assess PNA was that a woman might consciously provide responses to generate a 'normal' score to avoid being identified as having a PMH problem:

'There are lots of tools we could be using but I think even with the tool, they can give the answers that they want to give really.' (HV002, 30 years in role)

Fragmentation of care

GPs reported that they rarely see pregnant women in the course of their daily work, as woman are seen by their MWs for the majority of their routine antenatal care:

'If it's a completely uneventful normal pregnancy then the contact may be minimal, depending on the needs in terms of the patient as well as the medical needs identified by midwife in the prenatal period.' (GP009, M, 10–15 years in role)

Some GPs reported that they felt routine antenatal care was not part of their role, that they had lost clinical skills, and that pregnant women should be managed wholly by the MW:

'I mean the reason we're de-skilled is because we don't do it anymore. But we don't get paid to do it and we don't have the time to do it. If we were to take on more of a role with antenatal care, then what would the midwives do?' (GP010, female [F], <5 years in role)

Most participants reported management of PNA to be fragmented, with poor communication between different HCPs:

'I think if we had a better way of communicating with our allied health professionals; with our MWs; with our GPs. If we had better communication which gave us a clearer picture of [a patient's] *history, then that would help.'* (HV005, 12 years in role)

HCPs discussed how the quantity and quality of information received from each other was highly variable:

'If the person who sends them to see me hasn't made it clear to the patient or to me why they have expressed such a concern, that's a shame. Just a loss of a link in the chain really.' (GP001, F, 15–20 years in role)

Many HCPs expressed frustration at the limited availability of specialist services to refer women with PNA to, especially the long waiting times for psychological support, leaving some HCPs reporting feelings of helplessness:

'With the midwife you're their advocate. You're supposed to be able to help and make it better for them and know where they can go to get some help. But it's just not there.' (MW005, 12 years in role)

Lack of integration of care was identified as a barrier to effective management of women with PNA, with some HCPs feeling that working in separate premises was a geographical barrier to an effective working relationship:

'When we used to be based in GP surgeries, we used to see more of the midwives because they'd be there doing the clinics.' (HV002, 30 years in role)

However, even when HCPs were located in the same building they acknowledged that interprofessional communication between HCPs could still be limited, despite working alongside each other:

'They [midwives] *just tend to come in and have their own clinic. I think that's running in parallel rather than you're working with them.'* (GP010, F, <5 years in role)

One HV reported they felt that being centrally located with other HV colleagues was beneficial as they could provide support to each other and respond to concerns raised by patients and other HCPs more quickly:

'So at least any concerns do get actioned quite quickly, whereas I suppose if you're based in a GP practice and you're maybe one or two health visitors, perhaps, or a couple that

work part time, you haven't always got the coverage.' (HV003, 6 years in role)

Some HCPs expressed concerns that they may be duplicating or overlapping work with their colleagues and commented that at some points it was not clear who should be delivering care:

'It depends, really, who's the best professional to deliver that intervention at the time, because, primarily, they come under the midwife's remit but obviously there's benefit to us being there.' (HV003, 6 years in role)

HCPs suggested that referral pathways and available referral services for specialist mental health support were often unclear. Several stated that it was only with experience that they began to understand the constantly changing clinical landscape and know where they could refer to appropriately, suggesting that if pathways were simplified it would be more straightforward to find appropriate support for patients:

'I think there's more services out there than we realised, I think that's a lot of my initial years took a lot of time to actually work out what was out there.' (MW007, 27 years in role)

Opportunities to improve care

Very few HCPs described having specific training around PNA, which they felt would be helpful. When asked about previous training, the majority of HCPs felt that education could have been more targeted towards PMH and described most of their personal learning around PMH occurring within ongoing continued professional development or through clinical or personal experiences:

'Not on anxiety specifically but I suppose you know anxiety, depression they often feel like they come hand in hand, maybe I'm wrong about that ... but I feel probably a lot of my experience has come either once I've become a qualified GP or once I've been training as an actual GP, seeing patients and learning from those interactions and reflecting on how that's gone. And then also my personal experiences with, you know, having children.' (GP008, M, 10-15 years in role)

Even where educational resources are available they may not be accessed. For example, although some GPs were aware of, and had used, the Royal College of General Practitioners' (RCGP) PMH toolkit,[38] several were unaware of it:

'The problem is there are so many different toolkits. I tend to just access them if and when I see a patient that I'm unsure about something or if I need to do some CPD [continued professional development].*'* (GP010, F, <5 years in role)

Although care overall appears to be fragmented, improved integration of services could be beneficial for patients. It was acknowledged that, in one locality, the PMH service is improving specifically because HCPs are working more closely together:

'The service that we work with, the perinatal [mental health] *service is just getting ... after all these years we're actually finally working together, and it's really exciting*

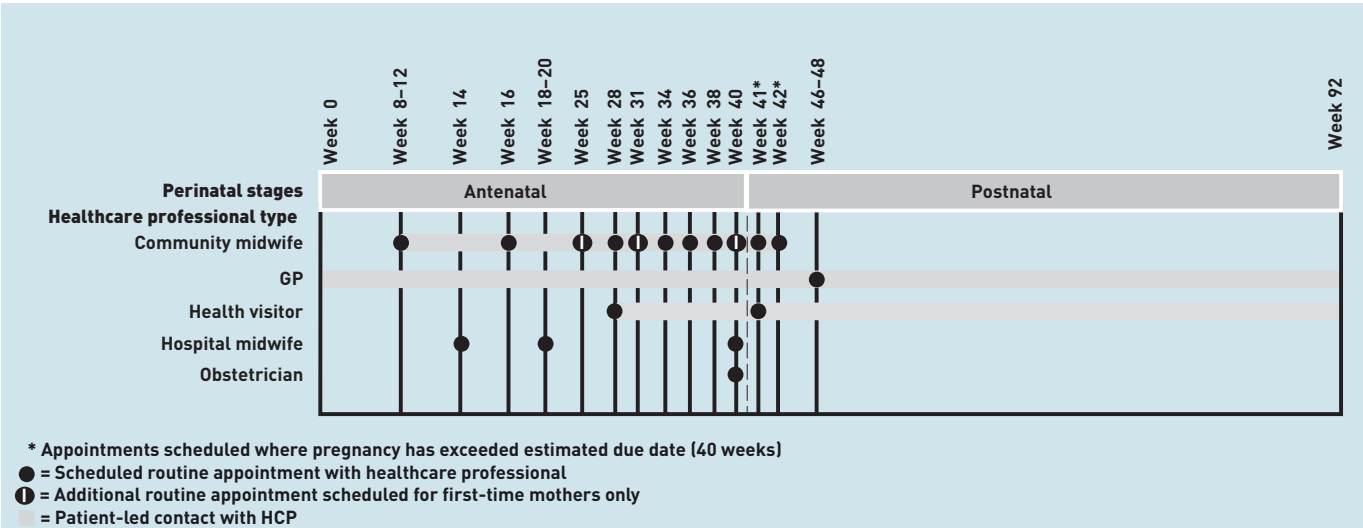

Figure 2. Opportunities to identify perinatal mental health problems during perinatal period.

at the moment that these things are changing.' (MV007, 27 years in role)

It was considered essential to make the most of scheduled contacts to opportunistically identify PNA. As noted earlier, GPs reported that they did not regularly see women in the perinatal period; however, they felt that it would be possible for them to identify PNA in consultations for other problems if they were alert to it. Additional opportunities to identify PNA were also identified by HVs during the postnatal period via walk-in clinics:

'It may be that that woman we see every week for breastfeeding support or indeed maternal mental health support, it maybe that she comes into clinic, to our open clinic every month to get her baby weighed, and I suppose it's that opportunistic contact that helps provide the bigger picture.' (HV001, 4 years in role)

Figure 2 summarises this data and maps the various contact opportunities the various HCPs have with women across the perinatal phase.

DISCUSSION

Summary

This is the first study to report the perspectives of a range of HCPs about the identification and management of PNA. HCPs were unsure whether PNA is a distinct clinical entity and found it difficult to differentiate from what they considered as 'normal' anxiety in pregnancy. The expectation of 'normal' levels of anxiety was reported, as HCPs acknowledged that they anticipated women would feel certain levels of anxiety. However, they recognised that so-called 'pathological anxiety' needed to be identified and managed rather than ignored or dismissed.

There were mixed views on the use and value of case-finding tools, with some HCPs expressing a preference to rely on their own clinical intuition, and reporting that they felt some women disliked tools being used.

Care for women identified with PNA was reported to be fragmented and interprofessional communication was seen as challenging. It was acknowledged that even when HCPs were co-located they may not work together in an interprofessional way, and relationships and work were described as often 'running in parallel'.

Some HVs indicated that being centrally located in a hub with other HVs, rather than with other members of the primary care team, helps them to respond more efficiently to women's concerns, but also suggested that this might compromise the opportunities for interprofessional working. HCPs suggested there was inadequate access to specialist services for women with PNA.

Strengths and limitations

This paper reports a qualitative study that explores the views and opinions of a variety of different HCPs. As different HCPs were interviewed (GPs, MWs, HVs) comparisons could be made between interviewees in the same profession and also between different HCP groups. Data collection concluded when data saturation was achieved[34] and analysis was conducted in a team comprising clinicians and researchers with different backgrounds (clinical and sociology of health), and with members of the PPIE team. This allowed for multiple perspectives on the data and increases the trustworthiness of analysis.[39]

A further strength in this study was the extensive contribution of the PPIE group. In addition to helping develop the study design, participant-facing documentation for ethical approvals, and interview topic guide, they also contributed their views on the analysis and advised on dissemination plans.

Recruitment was challenging, particularly among obstetricians. Although good levels of interest to participate in the study were expressed, it proved difficult to schedule interviews with obstetricians as participants, with *'pressure of clinical commitments'* and *'service restructuring'* given as barriers to participation.

This study was performed across the West Midlands and so the results may not be generalisable to other areas of the UK but could still have important implications for service provision more generally.

Comparison with existing literature

Previous studies have explored perspectives about PNA of single professions[28,29] and there is literature that discusses HVs' and MWs' perspectives in the assessment and diagnosis of postnatal depression,[26] but not in PNA. This study adds to the literature specifically around management of PNA in primary care, addressing the gap noted by Ford *et al*.[27] This study also adds to the current evidence base that there is significant 'normalising' of symptoms in the perinatal period by HCPs.

This study is the first to explore perspectives of the range of HCPs delivering perinatal care. Ashford *et al*[28] reported that some HVs are unaware of the

current NICE[2] recommendations that HCPs should administer the GAD-2 to a woman at the booking visit (for MWs) or first contact and at subsequent contacts throughout pregnancy and the postnatal period. In this study, HCPs expressed a variety of opinions with regards to tools used, with a range of clinical knowledge about which tools were recommended. HCPs expressed doubts that the recommended tools are clinically appropriate, echoing recent discussion about the suitability of both the EPDS and GAD-2 as case-finding tools in PNA.[40]

HCPs suggested that the pressure women face when becoming a mother could be a potential cause for PNA. This echoes Highet *et al*, who explored women's views of PNA and PND, and reported that women's PMH symptoms were associated with dissatisfaction about their perinatal experience.[41]

The fragmentation of care across the perinatal period echoes the discussion in a 2015 meta-synthesis, where fragmented health care has been reported to be commonplace, with regular occurrence of communication issues and organisational system failures, resulting in negative consequences for patients.[42] Lack of clarity regarding role boundaries and limited understanding of other HCPs' roles was a theme that demonstrates correlation with a previous study investigating GP and HV perspectives or postnatal depression.[25]

Opportunistic identification was identified as being crucial — especially for GPs who may not see patients regularly during the perinatal period and so have less time to build rapport. This supports the concept of making every encounter meaningful and making every opportunity to identify PMH problems count, as discussed in the RCGP report *Falling through the gaps*.[43] This concept can be broadened to include other HCPs such as HVs and MWs.

Implications for research and practice

From a clinical perspective, the profile of PNA needs to be raised in order to promote better understanding and awareness of PNA, and support appropriate identification and management. HCPs should also be aware that they need to remain alert to signs and symptoms that suggest PNA is present and acknowledge that women can provide answers to generate 'normal' scores when assessment tools are used if they do not wish to disclose anxiety symptoms. Improved written communication between HCPs could be beneficial and HCPs should be aware of negative implications to patients of not establishing effective working relationships and communication channels with other HCPs. It might be helpful to share resources between different HCPs, such as the RCGP PMH toolkit,[38] which contains information relevant to all HCPs working with women in the perinatal period.

Education around PNA appears to be limited and although educational resources are available they are not routinely accessed by many HCPs. Greater awareness of these tools would be beneficial to address training needs. A more integrated approach to patient care could be helpful and has been having a positive effect in one locality where it has been implemented. Opportunistic identification has been identified as crucial in appropriate diagnosis of PNA, with HCPs agreeing that overall MWs and HVs are more likely to identify PNA, as they have more time to build rapport with women at routine contacts throughout the perinatal period (Figure 2).

The Five Year Forward View for Mental Health Report emphasises that the integration of care between different HCPs involved in delivering perinatal care should be a priority.[30] PMH pathways need sufficient support and resources to enable them to be effective and appropriately integrated.[44,45] HCPs need to keep updated on new referral pathways and specialist services that are available so they can refer for specialist support appropriately. This study provides evidence for the need for improved interprofessional communication when managing women with PNA, to ensure services are responsive and integrated.

This study suggests that there are multiple practical methods of improving care for PNA, such as raising awareness of PNA among HCPs and the general public, making every patient contact count and working to improve the provision of integrated, individualised care.

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Ethical approval

Ethical approval for the study was obtained from the Keele University Ethical Review Panel (Ref: ERP2308), and the Health Research Authority granted approval to conduct the research in NHS settings (IRAS REF: 211285).

Provenance

Freely submitted; externally peer reviewed.

Competing interests

The authors have declared no competing interests.

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