# The experiences of women who have accessed a perinatal and infant mental health service: A qualitative investigation.

# Abstract

**Background**: Client feedback is an essential part of service evaluation and can aid both the development and delivery of client-centred services. The current study is an investigation into the experiences of women who have accessed a perinatal infant mental health (PIMH) service. The purpose of the service is to support vulnerable women to connect with and care for their infant, however it is not well understood how effectively the service supports the needs of the consumers. **Method**: One-hundred and seventy-six women, discharged from the service within the past 36 months were invited to participate in the study. Forty of the discharged consumers were able to participate in a semi-structured telephone interview. Interviews were transcribed verbatim and interpreted using thematic analysis. **Results:** One superordinate theme, the service as a “Lifesaver” and four subordinate themes describing the way in which the service met the needs of the participants were identified. More specifically, the themes included supportive counselling, trauma counselling, specialist interventions and assertive outreach. Overall, it was found that trusting therapeutic relationships with a regular clinician facilitated a safe environment conducive to counselling, which allowed for reflections on trauma, mental health and parenting. **Implications:** Findings from this study highlight the positive impact of PIMH services on consumers with a particular emphasis on the importance of the consumer-clinician relationship. Importantly, it was also found that dealing with past trauma was critically important for the women to enable them to move on with their lives as mothers.

**Background**

For many women the perinatal period is a time of great vulnerability with an increased need for emotional and social support (beyondblue, 2010; Doucet, Letourneau, & Blackmore, 2012; Myors, Johnson, Cleary, & Schmied, 2015; Myors, Schmied, Johnson, & Cleary, 2014b). The perinatal period refers to the period immediately before and after birth, and it is increasingly recognised that a woman’s vulnerability to psychosocial distress and mental illness is heightened in the perinatal period (beyondblue, 2010; Dennis, 2005; Fisher, Feekery, & Rowe, 2003; Khan, 2015). Perinatal mental health problems are reported to affect up to 20 per cent of women (Bauer, Parsonage, Knapp, Lemmi, & Adelaja, 2014; Khan, 2015). In Australia it is estimated that nine per cent of women have pre-natal depression and as many as 16 per cent of women develop postnatal depression (beyondblue, 2010). Across Australia and the United Kingdom perinatal mental health concerns are the leading causes of maternal death, with 50 per cent of deaths the result of suicide (beyondblue, 2010; Khan, 2015; NSW Department of Health, 2009). Yet, less than 50 per cent of women at risk of poor perinatal mental health receive adequate care (beyondblue, 2010; Khan, 2015; NSW Department of Health, 2009). The vulnerability to psychosocial distress and mental illness during the perinatal period is higher for women with a history of mental illness, substance use disorder, childhood abuse and domestic violence (Doucet et al., 2012; Hall & van Teijlingen, 2006; Khan, 2015).

Women who present with these vulnerabilities during the perinatal period may need additional support to strengthen their parenting capacity and to facilitate secure infant attachment (Fisher et al., 2003; Lavi, Gard, Hagan, Van Horn, & Lieberman, 2015; Rothera & Oates, 2008). The importance of secure infant attachment for a child’s development is well established in the literature, with significant evidence demonstrating that insecure infant attachment is a risk factor for negative outcomes (Coates, 2010a; Hoffman, Marvin, Cooper, & Powell, 2006; Jonas et al., 2015; Kenny, Conroy, Pariante, Seneviratne, & Pawlby, 2013; Lavi et al., 2015; Loman & Gunnar, 2010). Insecure infant attachment can disrupt the development of neural mechanisms critical to emotional regulation and social functioning, (Curley & Champagne, 2015 ; Kundakovic & Champagne, 2015; Numan & Young, 2016) which has been linked to an increased vulnerability to psychosocial stressors (Loman & Gunnar, 2010), mental illness (Curley & Champagne, 2015 ) and relationships difficulties (Kundakovic & Champagne, 2015). Moreover, it is estimated that up to 70 per cent of the cost of poor perinatal health to the public health system is caused by the physical and psychological health impact on the infant (Bauer et al., 2014).

Increasingly, perinatal infant mental health is recognised as a public health concern, and researchers, policy makers, service users and health professionals have highlighted the need for improved care in this area (Bauer et al., 2014; beyondblue, 2010; Myors et al., 2015). In Australia, the recognition of the significance of the perinatal period for a child’s development and health as well as mothers’ wellbeing has led to the establishment of specialist perinatal and infant mental health (PIMH) services to enhance the health and wellbeing of children and their families (NSW Department of Health, 2009). PIMH services focus on mothers with a current mental illness impacting on their level of functioning with additional vulnerabilities such as a history of unresolved grief and loss issues, unresolved relationship issues with family of origin and unresolved trauma. The initiative aims to increase the resources and outcomes available for vulnerable families by promoting continuity of family care throughout perinatal and early childhood periods. More specifically, these services utilise a prevention and early intervention framework to provide holistic psychosocial and mental health care interventions to women to enable mothers to build strong and adaptive relationships with their infants.

This paper outlines the findings of a qualitative evaluation of the Gosford PIMH service in New South Wales, Australia. The Gosford PIMH service is a non-acute mental health service governed by The Central Coast Local Health District (CCLHD), Children and Young People’s Mental Health. Women are referred to the service following psychosocial screening at maternity booking-in if they are identified as at-risk of developing mental health problems or poor mother-infant attachment. To improve the health outcomes for mothers and children, the PIMH service provides a wide range of interventions in the perinatal period up to the infant’s first birthday. Interventions include but are not limited to psycho-education, risk management, preparation for birth in the context of managing mental health symptoms, support for transition to parenting, the promotion of a secure parent-infant attachment, support and strengthening of family relationships, enhancement of protective factors, a number of parenting intervention as clinically indicated including Circle of Security and referral to other appropriate services.

The Gosford PIMH service has a strong commitment to service evaluation and improvement and, consistent with the development of recovery-oriented services (Commonwealth of Australia, 2013; Department of Health and Ageing, 2013), considers gaining feedback from clients as critical to service improvement. Client feedback is recommended as an essential component of service evaluation and improvement (Lammers, 2003) and integral to the development of successful recovery-oriented services (Commonwealth of Australia, 2013; Department of Health and Ageing, 2013). However, the way in which PIMH services support women is not well understood, in particular from the perspective of consumers. To address this omission in the literature and inform the ongoing development of PIMH services, the current study aimed to examine the experiences and perspectives of consumers by undertaking semi-structured flexible telephone interviews with recently discharged clients of the service. A qualitative inductive approach was adopted to capture the participants’ personal account of the experience of treatment received from the service and data analysis was informed by principles of grounded theory (Charmaz, 2006; Corbin & Strauss, 2014). As such, this study explored consumers’ perspectives of: a) the role of the clinician; b) benefits to the consumer; c) needs of the consumer; and d) suggestions of improvements of services.

**Methodology**

Ethics approval for this study was received by the University of Newcastle Ethics Committee, Hunter New England Local Health District Human Research Ethics Committee and the Research Manager, CCLHD.

# Procedure

A purposive sample of 176 women discharged from the PIMH team at Gosford, New South Wales between August 2011 and June 2015 were invited to participate in the study. Only discharged clients with a long-term engagement with the service (> 100 days) were invited. Potential participants were identified from an existing PIMH client database that captures client details and demographical information. The average duration of care for clients who were invited to participate was nine months.

An invitation to participate and a consent form was posted to potential participants. In this invitation, potential participants were informed that they would be contacted within two weeks by a student researcher inviting them to participate in a service evaluation study. It was stressed in this correspondence that their decision to participate or not participate would not in any way impact on their relationship with the service, and that if they did not wish to participate the researchers would not contact them again. The information statement also included an opt-out form which they could complete and return if they did not wish to be contacted at all.

Out of the 176 invitations posted, 14 were returned to sender because of inaccurate addresses; these were excluded from the sample and not contacted. For the remaining 162, two weeks following this mail out, a follow up call was made to ask the consumers if they wished to participate. The potential participants were told about the purpose of the study and what would be involved in their participation, and given the opportunity to ask questions. If they wanted to participate a suitable time was arranged for the student researcher to call them. A total of 43 women w contacted over the phone, of which 40 agreed to be interviewed, and three women declined to participate. . The remaining 119 could not be contacted within three attempts (n=98) or the number we had on file had been disconnected (n=21).

The semi-structured interviews were conducted by a research student (the second author), supervised by the service researcher (first author). Interview questions included questions such as “*Did the service meet your needs? How so, how so not?*” and *“How could we improve the service?”* The interviews were between five to twenty-five minutes in length. The researchers do not have a clinical relationship with any of the participants, and there were no conflicts of interests to be managed. Consent was obtained at the time of the interview and audio recorded. Pseudonyms have been used in the reporting of results.

# Epistemology

Data collection was informed by principles of Grounded theory. Grounded theory facilitates the development of a theoretical framework from the data as opposed to examining a previously existing theory (Corbin & Strauss, 2014; Creswell, 2013; Lewis, 2015). Since there is no existing theory on the experiences of women who access the perinatal mental health services the current study is discovery-orientated, aiming to build a theory from the experiences of the discharged clients. Qualitative interviewing (Malagon-Maldonado, 2013) was utilized to gather data for analysis from the discharged consumers concerning their perceptions of the PIMH service. As recommended by Grounded Theory (Corbin & Strauss, 2014; Creswell, 2013; Lewis, 2015) the interview questions were open, semi-structured and flexible. Interviews began with broad, open-ended questions informed by the research topic to encourage the participants to discuss topics that were important to them (Bryant & Charmaz, 2007). Whilst the conversation was conducted with purpose, there was an emphasis on actively listening to the participant and engaging with natural curiosity. In doing so, the researcher listened for opportunities to prompt and probe an area that was identified as important. As the researchers’ understanding of the women’s experiences increased, areas of salience were identified and explored. Consequently, data collected in the initial interviews informed future data collection by generating areas to be explored further (Bryant & Charmaz, 2007; Lewis, 2015; Malagon-Maldonado, 2013).

# Analysis

The interviews were transcribed in their entirety. The researcher who conducted the interviews transcribed the data, which is a procedure recommended to improve the accuracy of the transcript (Davidman & Greil, 2007; MacLean, Meyer, & Estable, 2004). Coding was the first step in interpreting the data. Transcripts were read with purpose to capture words and phrases that represented important content for understanding the overall experience of the participants (Basit, 2003; Harper & Thompson, 2011; Saldana, 2009). Since the experiences and perception of women who have accessed PIMH services are not well understood, codes were determined by the data instead of fitting to a predetermined theory. As data were collected, read, reread and coded the researchers gained insight into what constituted salient information (Bryant & Charmaz, 2007; Harper & Thompson, 2011; Kenny & Fourie, 2014). Codes that shared characteristics were categorized together (Burnard, 1991). Once categories had been formed, the researchers reviewed and removed categories that were irrelevant to the research question (Creswell, 2013; Malagon-Maldonado, 2013; Thomas, 2006). The creation and refinement of categories lead to the process of theoretical coding where the categories were considered in relation to each other (Bryant & Charmaz, 2007; Saldana, 2009). A thematic map was used as a visual tool for determining potential themes and subthemes (Bernard, 2003). Reliability and validity of the qualitative analysis was ensured by a transparent process of independent coding by the first and second author.

# Findings

Analysis of the interviews resulted in one superordinate theme: a *Lifesaver, reflecting the women’s overall view of the personal impact the service had on them during a critical period in their parenting journey*. In addition four subordinate themes more specifically described how the service met the needs of the participants namely *Supportive counselling*, *Trauma counselling*, *Specialist interventions* and *Assertive outreach*. Participants described the PIMH service as a “lifesaver” that supported them to deal with past trauma and grow their competence as a mother. Consistent with the entry criteria of the service, participants explained that at the time of their engagement with the service they were very vulnerable and in need of the supports offered by the service. Many participants described the service as critical in facilitating a change in themselves from a victim of traumatic life experiences to a mother better able to cope with the demands of parenthood. Participants commented that one of the most important impacts of the service is that it helped them “*deal with the past*”.

Many described the service as a “*lifesaver*”, in the literal sense of the word.

*Look, it was basically a lifesaver for me. At the time I had sort of had very severe prenatal anxiety when I started with the team. Especially before my baby was born and after, just until things settled down for me. I had a lot going on at the time and without their support, I don’t know how I would have you know really coped.* (Hannah)

A number of participants commented that not only did the service impact positively on their own wellbeing and ability to cope, it also had positive outcomes for their children. .

*If they* [PIMH] *hadn’t stepped in and given me counselling and shown me how things could be better, I would have just continued down the same path. I would have been unhappy and had unhappy children.* (Amy)

Further analysis of the findings identified a number of different ways in which the service supported these women in their change journey, namely: *supportive counselling*, *trauma counselling*, *specialist interventions* for mental health and parenting skills and *assertive outreach*.

# Supportive Counselling: Providing a safe space

Supportive counselling was a key service strength identified by participants as critical to their engagement with the clinician and an overall positive experience with the service. Specifically, a non-judgemental, respectful and empathetic clinician approach was highlighted as instrumental to participants’ positive experience of the service. Participants commented that *“*[The clinician] *would listen but he wouldn’t pass judgment”, “I felt listened to and respected, “I received support at a time of isolation”* and *“I was supported to work through things myself”.*

Participants described the relationship they formed with their clinician as “*exactly what was needed”*, and fundamental to facilitating the personal changes they made. They explained that the clinicians’ patience, consistency and care, within the context of professional boundaries and objectivity, provided a safe space to address some of their issues and negative thinking and coping patterns. While many participants explained that their clinician “*became part of the family*”, “*was always available*”, “*was like a friend*”, they stressed that despite the safety and comfort of this relationship, the clinicians remained professional and maintained clear boundaries.

Similarly, participants reported that the clinicians counselled in a professional manner, and they saw this as valuable. Participants indicated that the counselling provided a balance between respectful listening, empathy and encouragement to work towards their goals. Karen described the value of an empathetic, professional clinician:

*My clinician was very constant. She took time to care and I felt that she was empathetic. Like some carers share too much and they are too attached to think critically and connect you with different things. What I like about [the clinician] was that she was empathetic but at the same time thinking how can I connect her with resources. She was processing, not just doing.*

Participants explained that the safety of that relationship provided a safe space to critically examine some of their patterns, “*reflect on their experiences and choices*” and “*collect their thoughts”*. The support they received instilled them with the ability and confidence to think critically about their situation and work towards their own solutions. Amy described how the supportive counselling empowered her to make her own decisions:

*They never told me what I should do. All they did was open my mind to what was happening to me by allowing that sort of behaviour [domestic violence] to continue in my life. I was empowered to make my own decision to move on*.

Furthermore, participants reported that their experience with the service has given them increased confidence to seek assistance when needed. Participants credited the clinician with their increase in their help seeking behaviours for instance, .

*Now I question, I reach out to people and ask should I be doing this? Should I being doing that? I think it gave me the confidence to keep asking people now that he is three and a half.* (Lynette)

*I did get braver, like when I went to see [my clinician] he would say ask some questions and that empowered me myself. Without him I don’t think I would have had the confidence to ask those questions… By the time I actually have my baby I knew a lot more… I actually stand up for myself and say this is what I want and be quite firm about it.* (Jordan)

***Trauma counselling: Dealing with the past***

The sense of safety and support provided by the service allowed participants to start to address the impacts of past trauma. Participants stressed that the service was critical in helping them deal with past trauma and that dealing with trauma was a catalyst for positive changes in their life. Participants reported that after dealing with past trauma they felt better prepared to deal with the stress of being a mother. Judy described dealing with childhood trauma as “*clearing her plate*” for the new stresses of pregnancy and parenthood. As demonstrated by the comments below, participants described both the necessity and the difficulty when dealing with the past:

*It* [dealing with the past] *was the catalyst for a massive change in my life, leaving a relationship I wasn’t happy in and moving on with my children. Finding somewhere to live with my children and financial pathways so that we could move on with our lives.*  (Amy)

*I guess the last thing I wanted to deal with was all my past when I was going through pregnancy. But I knew I had to. Should have been dealt with it beforehand I guess. So*  *I guess it was bad timing but good timing if that makes sense?* (Chloe)

As highlighted by the comments below, counselling was instrumental in overcoming or making sense of the impacts of traumatic childhood experiences:

*I’ve had in a way a pretty traumatic past so it was being able to talk to somebody and for them actually understand and not criticize me was the support I needed.* (Kristi)

*I had some anxiety and concerns about becoming a first time mother just because of how I was brought up. They were really good with counselling me through how I would deal with those situations and what was the best way to deal with it for me.* (Zea)

Participants explained that being supported to reflect on their childhood experiences and the impact of past events on their emotions and ability to cope gave them insight into their current behaviours for example, “*There was a lot of helping me to understand why I was reacting the way I was”* (Chanan)*.* In addition, many participants reported that they had not spoken about the trauma prior to engaging with the PIMH service, and that while addressing their traumatic histories was “*difficult”* and “*caused pain*”, it was critical to becoming more emotionally available and present for their child/children.

*It was good but it was really difficult. Talking about my childhood and beliefs I had that I wasn’t going to be a good mother due to that way I was raised by my mother and my father… I had that insecurity a lot.* [The clinician] *was good to help me see that I didn’t have to be like my parents, I didn’t have to continue the cycle.* (Nicole)

# Specialist Interventions: Coping with Mental Health Issues and Parenting

According to participants, the PIMHS clinicians provided mental health interventions that assisted them to cope with, and improve their mental illness symptoms. Participants described various techniques taught by the clinicians, which were effective at improving their mental health.

*It wasn’t just having someone to talk to. She really went, what I thought was, over and above to help reduce the stress that I was having that was causing the anxiety.* (Alyce)

*Offering techniques for anxiety and offering links and ideas where we could go to reduce my anxiety, so I could focus on my baby.* (Namoi)

Specifically, a number of participants mentioned the benefits of grounding techniques that reduced their stress during labour.

*She taught me grounding techniques, because I would get lots of thoughts. Actually that helped me with labour, counting five things in the room, helped me keep on task instead of just of racing off and thinking about other things.* (Zea)

*She did everything she could to get me over the fear of giving birth. She helped me get a birth plan ready and everything. Just took the stress and everything off my plate.* (Nicole)

Participants also highlighted how much they gained from the parenting interventions. Participants reported that the knowledge shared by the clinicians around parenting skills and the mother-infant relationship was valuable in supporting them to better cope with parenthood. Specifically, some participants highlighted the benefit Circle of Security, a program designed to improve the mother- infant attachment that some clients are offered.

*I mean I still have the Circle of Security on my fridge. That was two and half years ago now. You just look at it when you’re going to the fridge and it gets you back into that mindset. How you need to remember that little kids they understand things differently to how adults do.* (Lynette)

*When I did the Circle of Security I learnt a lot of stuff about how I am as a mother which helped me physically raise my children in a better light. Not that I was a bad mum, it just helped me understand what they are going through as children.* (Amanda)

# Assertive Outreach: Meeting my Needs

Another important service characteristic that participants considered important was service flexibility. ,. Most participants stressed that if it was not for clinicians’ flexibility and willingness to see them in their own home at a time convenient to them, they would not have engaged in the way that they did.

*There wasn’t any wait time or anything like that. They would work around me if I had really bad morning sickness. I would ring that morning and say I wasn’t able to make it and then they would just reschedule me in and it wouldn’t be a two week wait it would be like the next day. They could work around me it was great.* (Zea)

In particular, as demonstrated by the comments below, the women highlighted the value of an outreach service in providing them with the care they needed.

*It’s impossible to go anywhere with a little person and they worked around you.* [The clinician] *would stand in the kitchen and talk to me and he would just follow me around the house so I could get bubs changed.* (Melissa)

*I got quite depressed and so he was coming to visit the house. I got a visit about once a fortnight which was good. Like I wasn’t expecting that many visits. But it was, it was what I needed.* (Lynette)

*I’m a recovering acrophobia so I don’t like to go out. Nothing was too hard for*  *them. They even came to my house.* (Judy)

# Discussion

This study investigated a PIMH service from the perspective of women who had engaged with the service within the last four years. The findings indicate participants overall had a positive experience with the service and that the support provided facilitated positive changes which empowered them to feel confident about managing motherhood. Trusting therapeutic relationships was a key factor in creating an environment where participants’ needs could be met. Moreover, data suggest that for many participants, dealing with past trauma was critical to the consumers as it enabled them to move on with their lives and to prioritise the relationship with their infant.

For participants, supportive counselling within the context of a trusting therapeutic relationship facilitated highly valued changes. This is consistent with a body of literature indicating that active listening, without judgement and with a good understanding of individual needs, is essential to trusting therapeutic relationships (Corr & Fisher, 2015; Hesselink & Harting, 2011; Myors et al., 2015; Myors, Schmied, Johnson, & Cleary, 2014a; Sword, Busser, Ganann, McMillan, & Swinton, 2008). In this study, participants, who had such relationships with their clinician, reported feeling more encouraged to share their experience, which then empowered them to create their own meaning for their life. In addition, Corr et al., (2015) argue that mothers who have a trusting relationship with their clinician are more open to adopting proposed parenting strategies, than mothers in less trusting relationships with their clinicians (Corr & Fisher, 2015). Such a consumer-centred counselling approach is closely aligned with principles of recovery orientated care, which prioritises the consumer as the expert in their own life and the importance of the consumer determining their treatment plan (Commonwealth of Australia, 2013; Department of Health and Ageing, 2013). Providing a safe space provided participants with an opportunity to develop their own recovery solutions and meanings.

It was found that participants believe that dealing with past trauma is critical to their recovery as it has a direct impact on their mental health and parenting capacity. Moreover, the trusting therapeutic relationship provided the safety needed to discuss trauma. Healing from the past allowed survivors of trauma to focus on other areas of their life (Bateman, Henderson, & Kezelman, 2013). For the majority of the participants this included prioritizing how they cared for their infant. The importance of perinatal services providing trauma counselling has not previously been acknowledged. Those women interviewed by Myors et al., (2014b) indicated they were willing to share personal memories with the clinician, they had not previously disclosed Similarly, women in the current study highlighted that they would not have been able to discuss the impact of trauma without the support provided by the clinician. Specifically, participants felt safe to discuss the impact of trauma within the context of the trusting therapeutic relationship. The collaboration between the PIMH clinician and client was recognized by participants as empowering, and allowed them to find their own solutions. Moreover, participants associated improvements to their wellbeing and parenting capacity with their trust in clinician who was concerned about their personal concerns, including past trauma. This results resonates with the key principles of trauma informed care (Bateman et al., 2013) including; safety, trustworthiness, choice, collaboration and empowerment. An essential component of recovery orientation is the provision of trauma-informed systems of care that recognises that the impact of trauma persists long after the trauma has ended, and acknowledges that wellbeing is determined by social and psychological factors in additional to biological ones (Coates, 2010a, 2010b; Mental Health Coordinating Council, 2013).

Participants highly valued the specialist knowledge of mental health and parenting skills of the PIMH clinician. Having access to this specialist knowledge allowed participants to collaborate with the PIMH clinician and work on multiple issues in a holistic manner. This is consistent with literature highlighting the need for perinatal services to provide interventions that address all aspects of the client’s circumstances (Doucet et al., 2012; Hall & van Teijlingen, 2006; Myors, Schmied, Johnson, & Cleary, 2013). The safe space provided by the supportive relationship empowered participants to engage in the learning process, who then were able to ask questions without fear of judgement. Women with psychosocial stress and symptoms of mental illness typically do not want to engage with multiple services or establish relationships with multiple clinicians (Fisher et al., 2003; Hall & van Teijlingen, 2006). Instead, “vulnerable” women require services that are able to address the complexity of their needs (Doucet et al., 2012; Hall & van Teijlingen, 2006; Rothera & Oates, 2008). Participants perceived the service as providing equal provision for each of their pre-existing conditions to form an integrated treatment plan, as recommend by recovery orientated practice (Commonwealth of Australia, 2013). Furthermore, the service was perceived to be flexible and equipt to address the individual needs of each consumer, which is a characteristic highly sought after by consumers (Fisher et al., 2003; Hall & van Teijlingen, 2006).

The interviews with women from the PIMH service suggests that providing an assertive outreach service helps women receive the care they need and helps to develop the therapeutic relationship. Both Myors et al. (2015) and the current study provide evidence that women with multiple risk factors for poor perinatal outcomes require an outreach service. In addition, providing outreach services has been recommended in state policy as a means of improving client engagement and accessibility of services (NSW Department of Health, 2009). Indeed, home visiting may improve the power imbalance between the therapist and consumer, which (when present) can be particularly damaging to victims of trauma (Bateman et al., 2013). The PIMH outreach service may assist the clinician to engage in a collaborative relationship by providing a context where the client feels comfortable and by being sensitive to the individual needs of consumers by removing obstacles that impact on engagement (Department of Health and Ageing, 2013).

# Implications and Recommendations

Although the importance of supporting the mother’s relationship with her infant is well documented within the literature little is known about perinatal mental health services that support women at risk of poor perinatal outcomes. The current study increased understanding of perinatal mental services in two ways; 1) by providing further evidence for the importance of client-centred specialised perinatal mental health services and 2) by adding new insights into service characteristics that are valued by the women. Firstly, consistent with literature, the longer-term intervention provided by PIMH services allows adequate time for the development of a trusting therapeutic relationship between the clinician and client.. Therefore, it is recommended that “vulnerable” women who access perinatal services be provided with a consistent clinician available across the 12-month perinatal period. In addition, according to those interviewed here, consumers may benefit from a holistic approach, with the clinician having specialist knowledge to address the women’s coexisting conditions. Secondly, the current study showed that participants require a safe space to discuss the impact of past trauma. Similarly, it has been found that women who are vulnerable to psychosocial stress during the perinatal period need a safe environment (Myors et al., 2015; Myors et al., 2014a).. Discussing the impact of the past provided participants with insight into their behaviour and promoted hope that their circumstances can improve. Consequently, principles of trauma-informed care might need to be considered in PIMH service evaluation, development and delivery.

There are a number of limitations to this study. Only participants who had engaged with the service for a minimum of 100 days were included in the study. Consumers who disengaged prior to 100 days may have had a negative experience which led them to disengage. Nonetheless, this study provides a unique insight into how the PIMH service supports some women who are at risk of poor perinatal outcomes by investigating the experience of the service from their perspective. To conclude, this study found that those women interviewed valued the PIMH service as it provided a trusting therapeutic relationship with a consistent clinician, which in-turn, provided an environment that enabled them to feel safe and engage in counselling. Moreover, it was found that past trauma hada crucial influence on participants’ wellbeing and parenting capacity, highlighting the importance of dealing with past trauma as a critical phase in recovery. After addressing past trauma with their clinician participants were able to focus on other important areas of their life, which included improving the relationship with their infant.Therefore, principles of trauma- informed practice may be an essential part of PIMH services delivering client-centred, recovery orientated care.

**References**

Basit, T. (2003). Manual or electronic? The role of coding in qualitative data analysis. *Educational research, 45*(2), 143-154.

Bateman, J., Henderson, C., & Kezelman, C. (2013). *Trauma informed care and practice: Towards a cultural shift in policy reform across mental ehalth and human servcies in Australia, A National Strategic Direction, Position Paper and Recommendations of the National Trauma-Informed Care and Practice Advisory Working Group*. Mental Health Coordinating Council.

Bauer, A., Parsonage, M., Knapp, M., Lemmi, V., & Adelaja, B. (2014). *The costs of perinatal mental health problems* London: Centre for Mental Health.

Bernard, R. (2003). Techniques to identify themes. *Field methods, 15*(1), 85-109.

beyondblue. (2010). *Perintal mental health national action plan* Retrieved from https://www.beyondblue.org.au/docs/default-source/8.-perinatal-documents/bw0125-report-beyondblues-perinatal-mental-health-(nap)-full-report.pdf?sfvrsn=2

Bryant, A., & Charmaz, K. (2007). Grounded theory methods and practices. In A. Bryant & K. Charmaz (Eds.), *The Sage handbook of grounded theory* (pp. 1-28). Los Angeles: Sage Publications.

Burnard, P. (1991). A method of analysing interview transcripts in qualitative research. *Nurse education today, 11*(6), 461-466.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative research* London Sage Publications

Coates, D. (2010a). Impact of childhood abuse: Biopsychosocial pathways through which adult mental health is compromised. *Australian Social Work, 63*(4), 391 — 403. doi:10.1080/0312407X.2010.508533

Coates, D. (2010b). Working with adult survivors of childhood abuse: A review of existing treatment models. *Psychotherapy in Australia, 17*(1).

Commonwealth of Australia. (2013). *A national framework for recovery-oriented mental health services - Policy and theory*. Australian Health Ministers Advisory Council.

Corbin, J., & Strauss, A. (2014). *Basics of qualitative research: Techniques and procedures for developing grounded theory.* (4th ed.). Thousand Oaks, CA: Sage Publications.

Corr, L. R., H., & Fisher, J. (2015). Mothers' perceptions of primary health-care providers: Thematic analysis of responses to open-ended survey questions. *Australian Journal of Primary Health, 21*, 58-65.

Creswell, J. W. (2013). *Research design: Qualitative, quantitative, and mixed methods approaches.* . California: Sage Publications.

Curley, J. P., & Champagne, F. A. (2015 ). Influence of maternal care on the developing brain: Mechanisms, temporal dynamics and sensitive periods. *Frontiers in Neuroendocrinology*.

Davidman, L., & Greil, A. L. (2007). Characters in search of a script: The exit narratives of formerly ultra-orthodox jews. *Journal for the Scientific Study of Religion, 46*(2), 201-216.

Dennis, C. L. (2005). Psychosocial and psychological interventions for prevention of postnatal depression: systematic review. *BMJ: British Medical Journal, 331*(7507), 15.

Department of Health and Ageing. (2013). A national framework for recovery- oriented mental health services: Guide for practitioners and providers. Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/67D17065514CF8E8CA257C1D00017A90/$File/recovgde.pdf

Doucet, S., Letourneau, N., & Blackmore, E. R. (2012). Support needs of mothers who experience postpartum psychosis and their partners. *Journal of Obstetric, Gynecologic, & Neonatal Nursing, 4*(2), 236-245.

Fisher, J., Feekery, C., & Rowe, H. (2003). Treatment of maternal mood disorder and infant behaviour disturbance in an Australian private mothercraft unit: A follow-up study. *Arch Womens Ment Health, 7*, 89-93.

Hall, J. L., & van Teijlingen, E. R. (2006). A qualitative study of an integrated maternity, drugs and social care service for drug-using women. *BMJ: British Medical Journal, 6*(1), 1.

Harper, D., & Thompson, A. R. (2011). *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners.* : John Wiley & Sons.

Hesselink, A. E., & Harting, J. (2011). Process evaluation of a multiple risk factor perinatal programme for a hard‐to‐reach minority group. *Journal of Advanced Nursing, 67*(9), 2026-2037.

Hoffman, K., Marvin, R., Cooper, G., & Powell, B. (2006). Changing toddlers’ and preschoolers’ attachment classifications: The Circle of Security Intervention. *Journal of Consulting and Clinical Psychology, 74*, 1017-1026.

Jonas, W., Atkinson, L., Steiner, M., Meaney, M. J., Wazana, A., & Fleming, A. S. (2015). Breastfeeding and maternal sensitivity predict early infant temperament. *Acta Paediatrica, 104*(7), 678-686.

Kenny, M., Conroy, S., Pariante, C., Seneviratne, G., & Pawlby, S. (2013). Mother-infant interaction in mother and baby unit patients: Before and after treatment'. *Journal of Psychiatric Research, 47*(9), 1192-1198.

Kenny, M., & Fourie, M. K. (2014). Tracing the history of grounded theory methodology: From formation to fragmentation. *The Qualitative Report, 19*(52), 1-9.

Khan, L. (2015). *Falling through the gaps: Perinatal mental health and general practice* London Centre for mental health

Kundakovic, M., & Champagne, F. A. (2015). Early-life experience, epigenetics, and the developing brain. *Neuropsychopharmacology, 40*(1), 141-153.

Lammers, J., & Happell, B. (2003). Consumer participation in mental health services: Looking from a consumer perspective. .*Journal of psychiatric and mental health nursing,, 10*(4), 385-392.

Lavi, I., Gard, A. M., Hagan, M., Van Horn, P., & Lieberman, A. F. (2015). Child-parent psychotherapy examined in a perinatal sample: Depression, posttraumatic stress symptoms and child-rearing attitudes. *Journal of Social and Clinical Psychology, 34*(1), 64-82.

Lewis, S. (2015). Qualitative inquiry and research design: Choosing among five approaches. *Health Promotion Practice, 16*(4), 473-475.

Loman, M. M., & Gunnar, M. R. (2010). Early experience and the development of stress reactivity and regulation in children. *Neuroscience & Biobehavioral Reviews, 34*(6), 867-876.

MacLean, M., Meyer, M., & Estable, A. (2004). Improving accuracy of transcripts in qualitative research. *Qualitative Health Research, 14*(1), 113-123.

Malagon-Maldonado, G. (2013). Qualitative research in health design. *HERD, 7*(4), 120-134.

Mental Health Coordinating Council. (2013). *Trauma Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia: A National Strategic Direction. National Trauma-Informed Care and Practice Advisory Paper and Recommendations, Authors: Bateman, K & Henderso, C (MHCC), Kezelman, C (ASCA)*. Retrieved from Sydney: http://www.mhcc.org.au/media/32045/ticp\_awg\_position\_paper\_\_v\_44\_final\_\_\_07\_11\_13.pdf

Myors, K. A., Johnson, M., Cleary, M., & Schmied, V. (2015). Engaging women at risk for poor perinatal mental health outcomes: A mixed‐methods study. *International journal of mental health nursing, 24*(3), 241-252.

Myors, K. A., Schmied, V., Johnson, M., & Cleary, M. (2013). Collaboration and integrated services for perinatal mental health: an integrative review. . *Child and Adolescent Mental Health, 18*(1), 1-10.

Myors, K. A., Schmied, V., Johnson, M., & Cleary, M. (2014a). 'My special time’: Australian women's experiences of accessing a specialist perinatal and infant mental health service. *Health & Social Care in the Community, 22*(3), 268-277.

Myors, K. A., Schmied, V., Johnson, M., & Cleary, M. (2014b). Therapeutic interventions in perinatal and infant mental health services: A mixed methods inquiry. *Issues in mental health nursing, 35*(5), 372-385.

NSW Department of Health. (2009). *NSW Health/Families NSW Supporting Families Early Package – SAFE START Strategic Policy*. NSW Department of Health.

Numan, M., & Young, L. J. (2016). Neural mechanisms of mother–infant bonding and pair bonding: Similarities, differences, and broader implications. *Hormones and behavior, 77*, 98-112.

Rothera, I., & Oates, M. (2008). Managing perinatal mental health disorders effectively: Identifying the necessary components of service provision and delivery. *The Psychiatrist, 32*(4), 131-133.

Saldana, J. (2009). An introduction to codes and coding. *The coding manual for qualitative researchers*, 1-31.

Sword, W., Busser, D., Ganann, R., McMillan, T., & Swinton, M. (2008). Women's care-seeking experiences after referral for postpartum depression. *Qualitative Health Research, 18*(9), 1161-1173.

Thomas, D. R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation, 27*(2), 237-246.