Midwives' Knowledge of Perinatal Depression and Their Role in Supporting Pregnant and Postnatal Women Experiencing Depression: An Appreciative Inquiry

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A thesis submitted in accordance with the requirements for admission to the degree of

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CERTIFICATE OF ORIGINAL AUTHORSHIP

I certify that the work in this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

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I had always had in my mind that when I retired from full time employment (as Coordinator of the ACE Service, a service which supported women with perinatal depression) that I would do my master's degree in midwifery, but the presenting question was where to start. How could I make known to the wider world what a wonderful service the ACE Service had been? While talking with my midwifery colleagues it was suggested that I contact Maralyn Foureur at University of Technology of Sydney (UTS) with whom I had worked with many years ago, and so started my journey as a research student.

So many people have been amazingly supportive over the last four years. The UTS staff have been happy to answer my endless questions, offer advice, and make suggestions about how I could do things differently without ever making me feel I was 'a lost cause'. Librarians have given up their time doing literature searches and encouraged me to use Endnote. Special mention and a big thank you to Priya in admin who has always been patient, friendly, helpful and thankfully able to answer my questions. I valued the opportunity to form friendships with other students and hear their stories, those from other countries who have left family and friends to come to Australia to further their education. The fortnightly Friday morning support group allowed us to discuss our research and share our ups and downs as well as helpful ideas for completing the various tasks. We picked up tips from each other and had many laughs together. Thank you, Claire, for your fine formatting and for your assistance in preparing the final draft.

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ABSTRACT

Background and Aim: Perinatal depression (PND) affects around 20% of childbearing women with significant impacts on ongoing maternal mental health and developmental consequences for their infants. This research aimed to make visible the confidence, knowledge and skills of midwives in identifying and supporting women with PND through the lens of Appreciative Inquiry (AI). Appreciative Inquiry was chosen as the most appropriate approach for this research as AI starts from a positive perspective, identifying what is working well rather than what is wrong or not working well.

Methods: The study used an exploratory, qualitative design with in-depth, semi-structured interviews. Twelve midwives from three hospitals in one local health district in New South Wales consented to participate. Three phases of the AI 4D cycle (Discovery, Dream and Design) were used to frame the interviews and orient thematic analysis of the transcribed interview data. Due to limitations of the exploratory study design, the Destiny Phase was not completed.

Findings: Analysis of the AI Discovery phase revealed five themes: *personal motivation*, *models of care*, *clinical practice*, *education of midwives and education of women*. It was evident that participants were personally highly motivated to work with women with mental health issues and were empathic, non-judgmental and avoided stigmatizing women.

In the Dreaming phase, which asks midwives to respond to the 'miracle' question, four themes were identified: *mother-baby PND services*, *continuity of midwifery care*, *community-based care*, *midwives to be valued and supported*. Midwives dreamed of additional resources to be provided for women in the local area such as an inpatient mother-baby unit facilitating women with PND making it possible for mothers and babies to stay together. Midwives considered continuity of care as meeting women's needs appropriately as this model of care facilitated more time to spend with women. Services based in the community were viewed by midwives as ideal. They dreamed of a system that respected midwives for their valuable contribution to women's mental and physical health.

In the Design phase where participants were asked to think about what aspects of their dreams could be realized, two themes emerged: *supporting midwives* as valued providers of care for women with PND and *promoting continuity of care* since this evidence-based model is best for

women and families and allows for a seamless transition to community-based services. A synthesis of the themes occurred in a Taxonomy of Skills and Attributes identified in the literature that was also evidenced throughout the participant interviews.

Conclusion: The midwives in this study demonstrated that they were highly skilled in caring for women with PND and made recommendations for changes in clinical practice to facilitate and recognize the important contribution they can make.

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CHAPTER 1: INTRODUCTION AND BACKGROUND

Introduction

This chapter provides an introduction and background to the thesis and a justification for the focus of the research project. I provide details of my interest in caring for women experiencing perinatal depression (PND) and midwives' role in providing skilled support for these women and families, an interest that has arisen over my many years of clinical midwifery practice in this area. A brief overview of the project is provided to orient the reader to the study design and data gathering technique, followed by the presentation of a detailed background to the significant issue of perinatal depression (PND) and its impact on women and their families. The chapter begins with a clarification of terms used and describes the aims and objectives of the research.

Clarification of terms

The two key terms used throughout this thesis are "perinatal depression" (PND) and "Appreciative Inquiry" (AI). The following section provides a definition for each term.

Perinatal depression

Perinatal depression is defined as encompassing '…the period from conception to the end of the first postnatal year' (Austin et al., 2013, p1). Depression occurring in the perinatal period does not have its own category in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), rather it is referred to as a major depressive disorder with peripartum onset, defined as '…the most recent episode occurring during pregnancy as well as in the four weeks following delivery' (Serge et al., 2013, p5). Although, the DSM-5 has been acknowledged, it has not been incorporated into the diagnostic tools described in this document.

Appreciative inquiry

Appreciative inquiry has been described as a comparatively new and innovative approach to organizational learning, organizational change and research (Trajkovski et al., 2013) which is underpinned by the 4D cycle (Cooperrider and Whitney, 1999). As indicated in Figure 1, the 4D cycle is made up of four phases: discovery (the best of what is or has been), dreaming (what might be), designing (what should be) and destiny (what will be) (Carter, 2006). Appreciative inquiry encourages a shift from a problem orientation to a positive theory of inquiry (Koster & Kemelin 2009). A more simplified description of AI proposes that its forte lies in identifying 'what

works well' (Carter, 2006).

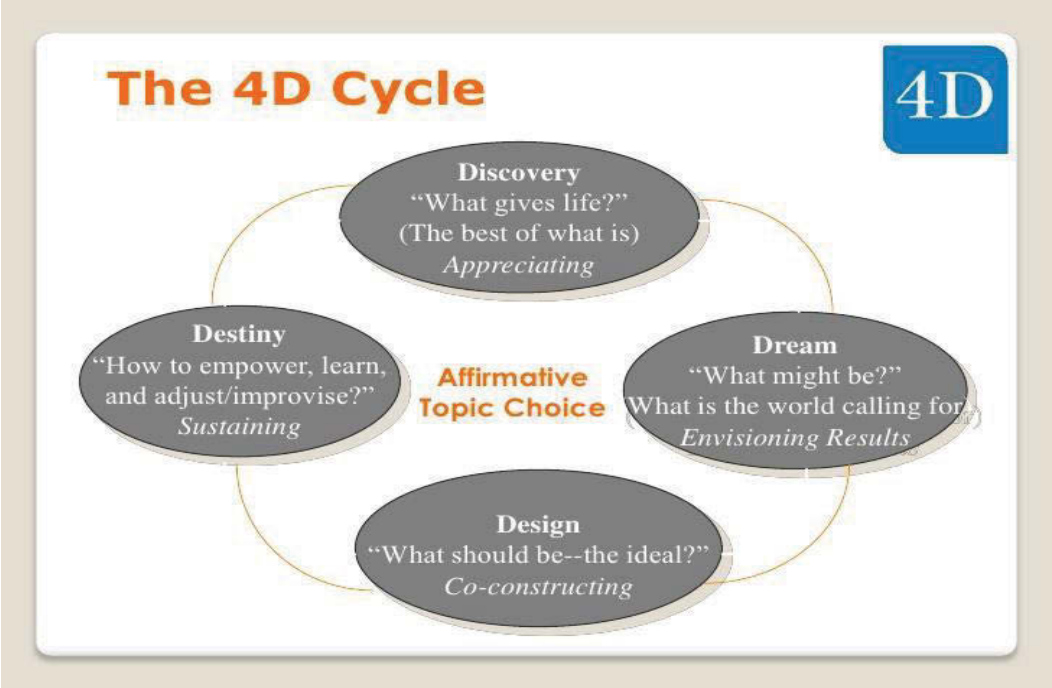


Figure 1: The Appreciative Inquiry 4D cycle *(Source: Mercedes, V., 2011, accessed at https://www.slideshare.net/mercedesviola/appreciative-inquiry-9165675 on 01/04/2018).*

Research Aim

This research aimed to investigate and make visible the confidence, knowledge and skills of midwives in identifying and supporting women with PND using the lens of Appreciative Inquiry (AI) (Cooperrider & Whitney 1999).

Research Questions

There were two inter-related research questions:

1. What knowledge and skill do midwives bring to caring for women with PND?
2. How does this specialized knowledge and skill inform midwives' role in supporting women with PND?

Research Objectives

1. To interview a purposive sample of midwives to explore their understanding, knowledge and skills pertaining to women with PND, using an AI lens (Cooperrider & Whitney, 1999).
2. To explore midwives' opportunities to practice and expand evidence-based care for women with PND.

3. To inform the enhancement of PND education for midwives.

Overview of the project

The project used an explorative qualitative design with in-depth, semi-structured interviews employed as the data gathering technique to explore midwives' confidence, knowledge and skills when caring for women with PND. The AI 4D cycle was used to frame the interviews and to orient analysis of the transcribed interview data. Twelve midwives from three hospitals within a large regional local health district (LHD) volunteered to be interviewed for the project. To protect the anonymity of the participants, the LHD and hospitals involved are not named in the thesis and pseudonyms are used for each participant.

Background

Following recommendations from the Commonwealth Government of Australia, the National Perinatal Mental Health Action Plan (2010) states that all pregnant and postnatal women undergo a psychosocial assessment including use of the Edinburgh Depression Scale (EDS). Therefore, women attending public hospitals in NSW are screened when booking into hospital, thus enabling the identification of those women who may have PND or be at risk of developing PND[1] (McAuley et al, 2011). Since the introduction of the structured antenatal psychosocial assessment, however, health concerns have been identified for midwives themselves including the potential for vicarious trauma, work related stress, compassion fatigue and burnout (Mollart et al., 2013). It has been proposed that adequate psychosocial assessment skills-training as well as ongoing clinical supervision from the mental health sector be made available to midwives carrying out psychosocial assessments (Marie-Paul Austin 2008). More recently, Sidebotham et al., (2017) have established that midwives are able to provide clinical supervision if appropriately educated.

Previously it was not considered an integral part of the midwife's role or responsibility to provide PND support to women, as it was not deemed within their scope of practice (Schmied et al., 2013). This situation appears to be changing since the current Australian Mental Health Guidelines (COPE 2017) includes midwives in the list of health professionals with responsibility for screening and psychosocial assessment to identify women who may be in need of PND support.

[1] While the focus of this research is on PND, I acknowledge that screening at the time of booking for maternity care in NSW is a broad psychosocial assessment that goes beyond the assessment of risk of PND to cover risk related to anxiety, previous history of depression, and past and current domestic violence or sexual abuse

This recognizes that midwives are frequently the primary contact for women in the perinatal period with many women developing a safe and confiding relationship with their midwife/s (Schmied et al, 2013). It is apparent that full advantage is not always taken of this unique relationship since midwifery consultations "… may be too short to allow for a dialogue about sensitive, personal questions, which would indicate maternal distress" (Seimyr et al., 2013, p.129).

Other researchers have identified that pregnant women are more likely to accept mental health support from a midwife (Small et al., 2014). Several studies concur: midwives are ideally placed to provide ongoing perinatal mental health support to women (Marnes and Hall 2013; Myors, 2013; Johnson and Galal, 2014; Austin, 2013; Homer et al., 2009), although few studies have focused on how the effects of midwifery interventions may reduce the incidence of PND (Seimyr et al., 2013).

Traditionally, many researchers in perinatal mental health have focused on identifying the knowledge and skill deficits of healthcare workers and the skill deficits and lack of confidence of midwives and their need for continuing education in PND (Jones et al., 2012; McCauley et al., 2011; Brown et al., 2009). My clinical experience suggests that many midwives exhibit excellent PND skills but are unaware of the contribution they can make to the support of women experiencing PND. Therefore, assisting midwives to gain insight into their skills and abilities in this area may allow for optimal support to be provided to women.

My interest in this area

My clinical experience includes 15 years as the Clinical Midwifery Consultant/Co-Ordinator of the Assessment Care and Evaluation Service (known as the ACE Service) at a major teaching hospital in regional NSW. The service supported 300 women a year who experienced PND or were at risk of developing PND. The team was made up of two clinical midwifery specialists, a social worker, a visiting psychiatrist (4 hours per week) and me. Team meetings and supervision were held weekly with the visiting psychiatrist. Each woman referred to the Service was allocated a team member to act as a case manager to oversee her mental health care during pregnancy and for six months postpartum. The hypothesis underpinning this initiative was that seeing the same midwife on a regular basis enabled a trusting and confiding relationship to develop between the woman and midwife. From the team's perspective, providing continuity of care ensured that no woman was 'lost' in the system and timely and appropriate referrals to further supports were seamlessly realized.

During my time as coordinator of the Service, I presented at local, state, national and international conferences. In 2007 the ACE Service was awarded a $10,000 scholarship by the NSW Department of Health (Nursing and Midwifery Office (NAMO) scholarship) to evaluate the care provided to the ACE Service clients. The findings from this review of services found women were happy with the service provided and valued home visits. The Edinburgh Depression Scale (EDS) used at a postnatal home visit with each woman often recorded an improvement in scores compared with the initial EDS score recorded at the time of joining the ACE Service. This was not formally studied, however. The main limitation to the review was the difference in the time periods that the women had been clients with the ACE Service, as this may have influenced the varying results of the EDS.

In 2010, at the request of the Chief Executive Officer (CEO) of the local health district, I reviewed the perinatal depression services in the local government areas (LGA) across public and private sectors. Interviews were conducted, and telephone calls made with key informants across government and non-government organizations (NGOs) and information was obtained from telephone hot-lines including Lifeline and Beyond Blue. General practitioners (GPs) were asked to complete a questionnaire on how the ACE Service met their needs. Many negative responses from the GPs focused on the difficulty of getting women into the Service, as women did not always meet the criteria for acceptance. The private sector was frustrated by the non-availability of the ACE Service to private patients and generally, the telephone hot-lines were poorly informed about the services available in the region. The NGO's and public sectors regarded the ACE Service as reliable and co-operative. Recommendations arising from my review at that time included establishing an inpatient unit and a PND support hotline and making available PND education for health professionals. Unfortunately, the CEO who had requested the review moved on to another region before implementing any of the recommended changes. To the best of my knowledge, few of the recommendations have been acted upon. The ACE Service was closed in 2012 and limited home visiting support to women with mental health issues is now provided, for up to 6 weeks postpartum, by the midwifery-led Family Care Service.

My reflections on the ACE Service and the role of the ACE midwives in the provision of very competent and supportive care for women at risk of, or experiencing PND, has led to my continuing interest in this area. Therefore, my motivation for undertaking this study is to contribute further knowledge in the sphere of perinatal depression. It aims to help midwives identify their existing knowledge and skills and the many opportunities they have in everyday

interactions in a clinical practice setting to make a positive difference to the wellbeing of to the wellbeing of mothers and babies.

In the following section I provide further contextual information that contributes to the background to my study. I present epidemiological data and research evidence relevant to the understanding of PND, keeping in mind that antenatal depression and postnatal depression are described by the one term, perinatal depression.

Screening and prevalence of perinatal depression

Approximately 300,000 women give birth annually in Australia and a significant number of these will experience depression, anxiety and other mental health problems (Schmied et al., 2013). Over the last 25 years the reported rate of depressive symptoms in the first postnatal year has remained consistent between 10-20% of childbearing women (Schmied et al., 2013). In an earlier paper by McCauley et al. (2011), however, these same statistics are also quoted for postnatal depression, possibly because it is not made clear whether these figures include pre-existing mental illness as well as postnatal depression.

Perinatal mental health disorders are commonly identified using screening tools such as the Beck Inventory of Depression (Beck et al., 1961), the Antenatal and Postnatal Risk Questionnaire (Austin M-P et al., 2011), Patient Health Questionnaire-9 (PHQ-9) (Spizer et al., 1999) and the EDS (previously called the Edinburgh Postnatal Depression Scale) (Cox et al., 1987). In Australia, as well as internationally, the EDS, a ten-item self-report questionnaire, is the tool most commonly used to assess women for depression during the perinatal period. An EDS score of at 13-15 indicates at least probable "minor depression" while scores of 15 or higher indicate a probable "major depression" (Matthey et al 2006). It must be remembered that the EDS is a screening tool that indicates the possible presence of depression, but it is not a diagnostic tool (Galvin and Warren, 2013). Furthermore, findings indicate there is no evidence that using the EDS as a screening tool leads to improved maternal mental health (Austin, 2008; Hewitt and Gilbody, 2009; Alderice et al., 2013).

An Australian survey of postnatal women completing the EDS (n=12,361) identified that the point prevalence of participants scoring more than 12 varied from 5.6% to 10.2% depending on the state or territory in which they were screened and whether they were recruited from the public or private sector (Buist et al, 2008). An earlier and larger Australian study including 52,000 rural and regionally based women from public and private health sectors and Aboriginal and

Torres Strait Islander women, as well as women from a non-English speaking background, found that 9% of women experienced depression in the antenatal period and 16% in the postnatal period (Buist and Bilszta, 2006). Similar results have been noted by international studies with different population groups (Le Strat et al., 2011; Claridge, 2014).

Antenatal depression is as common as postnatal depression (O'Hara and Swain 1996; Milgrom et al., 2008; Leach et al 2014; Sidebottom et al., 2014) with McCauley and colleagues suggesting that between 15-25% of women develop a mental health problem during pregnancy and the first postnatal year (McCauley et al., 2011). Estimates of the prevalence of PND vary considerably (Austin & Priest 2005). Variations in scores may occur due to the particular questionnaire used, the time in the woman's pregnancy/postpartum period it is completed, differing cut-off scores for diagnostic criteria for the questionnaire, and the self-report format of questionnaires since some women lack understanding of written English and not all women answer questionnaires accurately (Rollans et al., 2013).

The importance of a woman's physical and mental health, however, should be central to every aspect of maternity care, as the following section indicates. PND has potentially serious consequences for the newborn and young child (Murray et al., 2003; Sharp et al., 1995; Murray & Cooper 1997; Alderice, McNeill & Lynn, 2012; Jones, Creedy et al., 2012a; Rollans, Schmied et al., 2013; Hauck et al., 2013; Murray, Cooper & Fearnon, 2014).

Midwives' psychosocial assessment of all women at the first antenatal visit

In recognition of the importance of women's physical and mental health, the Safe Start Initiative was mandated in NSW in 2010 (Ministry of Health NSW 2010). This initiative was based on recognition that the early years of a child's life are:

> …critical for the development of vital physical, cognitive and emotional competencies… through a process of dynamic interaction with their environment. A range of bio-psychosocial factors can contribute to health problems and disorders for mothers and infants (p.3)

Therefore, the Safe Start Initiative required midwives in public hospital maternity services to undertake a psychosocial assessment process as part of the first booking-in visit for every pregnant woman. This involves a set of questions covering seven key variables as well screening

for depression (Table1).

Table 1: Perinatal psychosocial assessment *(Source: Ministry of Health, NSW SAFE START Guidelines GL2010_004 p 8)*

1	Lack of social or emotional support
2	Recent stressors in the last year
3	Low self-esteem including self-confidence, high anxiety and perfectionist traits
4	History of anxiety, depression and other mental health problems
5	Couple relationship problems
6	Adverse childhood experience
7	Domestic violence
8	Edinburgh Postnatal Depression Scale (later the Edinburgh Depression Scale)

It was recommended as of the utmost importance that appropriate referral systems be put in place prior to the psychosocial assessment in order to allow for the ongoing care of women identified as needing extra support (Austin et al., 2013). All women attending the antenatal clinic for their visit are seen by a midwife and discussion takes place about what is involved in the psychosocial assessment, with reassurance given to the woman that it is part of routine care and the results of the screening test will generally remain confidential. A woman may decline to participate, and the midwife should gently try to tease out why the woman is refusing participation, whilst reassuring the woman that her decision not to participate will not affect her ongoing midwifery care. At the first visit the woman is also asked to complete the EDS (initially called the EPDS). The woman is made aware that details of the visit are documented in her notes and if issues are identified the woman is referred to the appropriate support. Midwives were provided with additional training in conducting the assessment and it is now included in curricula for preparation for registration. The psychosocial assessment is now an embedded aspect of midwives' role in maternity care along with screening and referral of pregnant women to additional support and resources as needed. A psychosocial assessment is also undertaken postnatally, by the Child and Family Health nurse (C&FHN) at the first visit of the mother and her infant. The postnatal psychosocial assessment incorporates "…emotional health, psychosocial risk assessment and identification of mental health symptoms" (Briggs, 2013) which is in line with the midwives' first visit assessment during pregnancy. In addition, the

comprehensive nursing assessment undertaken by the C&FHN includes support with feeding and settling problems.

The impact of PND on maternal and infant wellbeing

For over 20 years researchers have recognized that a mother's antenatal and/or postnatal depression can be detrimental to the development of her baby physically, emotionally and cognitively. This growing body of evidence justifies continuing research into PND (Madlala and Kassier, 2017; Kendig, 2017).

Postnatal depression can affect a woman's ability to care for her baby, impede her social interactions, and hamper the child's cognitive and emotional development (Murray, et al, 2003; Sharp, et al., 1995; Murray & Cooper, 1997). It has also been found that the mother's mood during pregnancy may influence the physical and mental development of the baby in utero (Austin et al., 2008) with potential long-term consequences for at least the next two generations (Austin et al., 2013; Schmied et al., 2013; Howard et al., 2014; Stein et al., 2014; Thombs et al., 2014). Studies have also revealed that pregnancy complications such as decreased uterine blood flow, pregnancy-induced hypertension, pre-eclampsia and preterm births are associated with untreated antenatal depression (Bonari et al., 2004; Strass et al., 2008; Dennis et al., 2007; Stein et al., 2014).

Given the potential for disturbing and distressing consequences of PND, it has been acknowledged that enquiry about past and present mental health issues at the first antenatal visit is important for all health professionals to undertake (COPE, 2017). Furthermore such enquiries are associated with help-seeking throughout the perinatal period (Reilly, et al., 2014).

Justification for PND Research

It is important that the issue of recognition and treatment of women experiencing PND or at risk of developing PND is addressed if there is to be a reduction in the long-term effects PND may have on women, their children and families. As midwives interact with almost every childbearing woman at some stage, antenatally, intrapartum and/or postnatally, they are ideally placed to provide ongoing support for women in the perinatal period. The research described in this thesis will contribute to our understanding of the role midwives can play in providing support for women with PND.

Summary of Chapter 1

This opening chapter has provided a background to the thesis, detailing my interest in this important aspect of midwifery practice. The brief overview of literature describing the potentially serious consequences of PND on the woman, the child and the family provides a strong justification for undertaking this study. The chapter has described the research aim, questions and objectives of the study. The next section presents the structure of the thesis and an overview of each of the thesis chapters.

Overview of the thesis chapters

In **Chapter 2** I present an integrative review of the literature asking, "What knowledge and skill do midwives bring to caring for women with PND?" In order to synthesize the literature it has been divided into six main themes. The first theme: '*Lack of evidence that screening is useful*', reveals there is little current evidence available to indicate that screening makes any difference to PND outcomes despite the national and international guidelines recommending antenatal screening. Theme two examines *'What interventions decrease the risk of PND?'* and considers whether these are appropriate interventions for midwives to provide. Theme three, *'New models of midwifery care may be beneficial',* reveals how new models of midwifery care, which include continuity of care or relationship-based care, may make a difference to the detection and management of women with PND. Theme four *'What do women and families/research say they need?',* explores what women and families consider they need from the health system and their care providers in order to detect and manage PND. Theme five explores the predominant message from the literature that reveals midwives consider they have few skills in this area. The final theme, theme six, *'What skills are needed?'* is presented as a taxonomy of skills and attributes identified in the literature as essential for the effective detection and management of women with PND or at risk of developing PND.

The study design and methods are detailed in **Chapter 3**. This chapter also provides a more in-depth examination of the AI approach to the design of the study, the conduct of the interviews and thematic analysis of the transcripts obtained from a diverse range of midwives from three maternity hospitals in one region of NSW. This chapter reveals how the AI approach was used to guide the interviews into exploring the 4D AI cycle of Discovery, Dream and Design and describes how the final AI phase of Destiny was beyond the scope of this study. The chapter also reveals how the typology of skills and attributes identified in the review of the literature was used to inform analysis of the data.

Chapter 4 presents the findings of the thematic analysis of the interview transcripts. Results are presented in relation to three of the four AI 4-D cycle categories - Discovery, Dreaming and Design. The final category, Destiny, was not completed as this would have required an Action Research component in order to implement the Designed future for midwives in caring for women with PND, and that was not within the scope of this study. Findings in relation to each of the three categories are presented as themes with supporting quotes from participants. In the Discovery phase five themes emerged: personal motivation, models of care, clinical practice, education of midwives and education of women. The four Dreaming themes included mother-baby PND services with subthemes of a Mother-baby inpatient unit, midwifery-led PND service and a 24-hour telephone helpline; continuity of midwifery care to enable more time to spend with women; care in the community; and a dream for midwives to be valued and well supported in order to provide the best care possible. The Design themes were supporting midwives and promoting continuity of care.

In **Chapter 5** the findings of the study are discussed in relation to the taxonomy of skills and attributes identified in the review of the literature and they reveal the previously hidden skill-base of the midwives in caring for women with PND. These findings challenge the large volume of literature that claims midwives have a large skill deficit in this area and require more education and training in order to be able to provide effective care for women with PND.

This chapter concludes the study by presenting the recommendations for policy and practice arising from the study as well as exploring the limitations of the study design and therefore the conclusions that can be drawn. The important recommendations are that women with mental health issues are provided with continuity of midwifery care throughout pregnancy and childbirth and the early postpartum period and a seamless transition to care in the community from child and family health services. Where serious mental health issues are identified, women should be provided with adequate resources such as an inpatient mother-baby mental health unit so that families are not separated (which adds to distress). This is a policy issue for the attention of the Ministry of Health. Future research in this area would require a randomized controlled trial of continuity of midwifery care for women with mental health issues in order to determine whether there is a positive impact on outcomes.

CHAPTER 2: LITERATURE REVIEW

In order to investigate the breadth of studies that have explored the role of midwives in working with women experiencing PND, I undertook a structured search of the literature and present an integrative review of relevant material. This chapter reveals the breadth of literature identified across a wide range of countries and across several decades of inquiry. For ease of reading, the literature has been grouped according to six themes. The chapter begins with an explanation of why an integrative review was considered the most appropriate, followed by a description of the search strategy which ultimately identified 58 relevant studies for inclusion.

The integrative review

There are many types of literature reviews available for the researcher to provide an informative account of current knowledge in the field of interest (Whittemore and Knafl, 2005). These include systematic reviews and meta-analyses, narrative reviews, qualitative reviews, meta-synthesis of qualitative studies and integrative reviews. Arguably the integrative review allows for the inclusion of diverse study designs and methodologies that can broadly be grouped into categories such as experimental and non-experimental or qualitative and quantitative approaches to inquiry, as well as including theoretical insights about phenomena. An integrative review can inform research as well as influence clinical practice and policy. The integrative review was considered the most appropriate for this study since the breadth of literature identified included much more than randomized controlled trials and systematic reviews of trials. Strategies for enhancing the rigor of the integrative review have been recommended and were carefully considered in the approach taken in this study. These strategies include a clear identification of the problem being addressed by the review and the purpose of the literature review, a well-defined literature search strategy, extraction of specific methodological features of included literature in order to evaluate the overall quality of each study, and a carefully articulated data analysis stage that provides "…a unified and integrated conclusion about the research problem" (Whittemore and Knafl, 2005, p550).

The research problem was articulated in the preceding chapter. The following sections detail the search strategy and description of the methodological features of included literature as well as a synthesis of the literature.

The search strategy

The literature search was conducted using the search terms 'antenatal depression', 'postnatal depression', 'perinatal depression', 'perinatal mental health', 'midwife' and 'midwives' and drew on the databases of Science Citation Index, Social Sciences Citation Index, Medline, Science Direct and CINAHL. The search was limited to English language articles published between 1995 and 2018. The search located 120 articles and a further 10 (including PND guidelines and unpublished thesis documents) were identified from other sources such as Google Scholar and the reference lists of relevant articles. After removal of duplicates (5) and a review of the titles and abstracts of each remaining article, 67 were excluded according to the inclusion/exclusion criteria.

The inclusion criteria were: Articles generally concerned with midwives and perinatal depression, Articles concerning midwives' knowledge of perinatal depression, Articles concerning guidelines and psychosocial assessment in the antenatal period, Pregnancy and women's mental health, Research-based articles.

As described in the Prisma Flow Diagram (Figure 3 Located in Appendix 1), this resulted in a total of 58 articles considered eligible for full review. Table 7 (located in Appendix 2) provides a summary of each article included in this review of the literature.

An overview of the 58 studies revealed both qualitative and quantitative studies. Twenty eight were from Australia (Alderdice, McNeill, Lynn, 2013; Armstrong, & Small, 2007; Armstrong, & Small 2010; Austin, 2004; Austin, Priest et al., 2008; Austin, Reilly et al., 2013; Austin, 2014; Biliszta, et al., 2010; Centre of Perinatal Excellence (COPE) 2017); Fenwick, Gamble et al. 2013; Fisher et al., 2012; Hauck et al 2015; Highet et al., 2014; Homer et al., 2009; Johnson and Galal 2014; Jones, Creedy et al. 2012; McCauley et al. 2011; McLachlan et al., 2011; Marnes et al., 2013; Mollart et al., 2013; Myors et al., 2013; Myors, Cleary et al., 2015; Myors, Schmied et al., 2014; Reilly, Black et al., 2017; Reilly, Harris et al., 2014; Rollans et al., 2013; Schmied et al., 2013; Sidebotham et al., 2015). Twelve were from the UK (Clark et al., 2014; Jarrett, 2014; McLoughlin 2013; Ross-Davie et al., 2013; Brown et al., 2009; Hewitt & Gilbody et al 2009; Bick 2003; Dennis, Ross et al., 2010; Henderson et al., Jomeen et al., 2018; Martin et al 2017; Phillips 2013; Williams et al., 2016). Four were from Canada (Thombs et al., 2014; Strass and Billay 2008; Lusskin et al., 2007; Legere, Wallace et al., 2017) while two were from America (Dennis, Dowswell, 2013; Serge et al., 2011), six from Ireland (Alderice et al., 2013; Higgins et al., 2016; Higgins et al 2012; Madden, Sliney et al., 2017; Noonan et al., 2017; Noonan et al., 2018), two from South Africa

(Mathibe-Neke et al., 2014; Madala and Kassier 2018), one each from Norway and Ireland (Glavin and Leahy-Warren, 2013), Italy and Pittsburgh (Banti, et al 2011), Nigeria (Gureje et al., 2015), France (Jardi et al., 2010), Turkey (Kurtcu and Golbasi 2014) and Sweden (Seimyr, Welles-Nysttrom et al., 2013). Several papers were systematic reviews. Three papers were narrative reviews or syntheses of the literature; studies also included randomized controlled trials, surveys, interviews, focus groups and one ethnographic study.

Theming the Literature

As previously described, due to the range of methodological approaches and variety of research methods used in the body of literature identified, it was considered that an integrative review would be the best way to synthesize the findings into a coherent whole and explore what aspects of the reviewed literature could be applied to midwifery practice.

Therefore, a thematic analysis of the literature was undertaken, and this identified six major themes. Developing the themes from the literature used a process like that employed in qualitative data analysis processes as described in Tesch's eight steps for thematic data analysis (Tesch, (1990) in Creswell, 2003; pp191-192). The literature was read and re-read several times to discern the key concepts and meaning from each paper. Similar concepts and topics were clustered together and refined until six themes were apparent. The first theme: *lack of evidence that screening is useful* includes literature from Australia as well as international studies. These studies reveal that while national and international guidelines recommend antenatal screening of women for perinatal depression, there is little current evidence to indicate that screening makes any difference to PND outcomes. Theme two: *what interventions decrease risk of PND?* considers the evidence regarding which interventions appear to be effective in reducing the risk of PND and considers whether these are appropriate interventions for midwives to provide. Theme three: *new models of midwifery care may be beneficial* identifies how new models of midwifery care which include continuity of care or relationship-based care, may make a difference to the detection and management of women with PND. Theme four: *what do women and families/research say they need* explores what women and families consider they need from the health system and their care providers in order to detect and manage PND. Theme five: *midwives identify lack of skills* explores the predominant literature that reveals midwives consider they have few skills in this area and require more targeted education in order to develop their confidence in managing women with PND. Theme six is particularly of relevance for this thesis since it is *what skills are needed?* The literature has clearly articulated the many skills needed in the repertoire of health care providers, including midwives, for PND identification,

intervention and support needs to be well met. These are presented as a taxonomy of skills and attributes. I begin the chapter by presenting the evidence in relation to theme one.

THEME 1: LACK OF EVIDENCE THAT SCREENING IS USEFUL

Owing to the frequent contact pregnant women and mothers and babies have with health services, primary prevention and early intervention have been recognized as valuable approaches to caring for women 'at risk' (Austin, 2003).

> [A] *combined approach to psychosocial screening using the midwife's antenatal interview which assesses drug and alcohol use, domestic violence and obstetric history with an Antenatal Psychosocial Risk Questionnaire (Austin 2003) and the Edinburgh Depression Scale (EDS) (which measures how symptomatic the woman has been in the last week) allows identification of individual or combinations of risk factors which may guide the primary caregiver into choosing specific intervention pathways* (Austin 2003, p.3)

This has been the inspiration for guidelines for antenatal PND risk screening for over a decade. However, whether the establishment of longer-term interventions for mothers and infants has a lasting impact on maternal and infant outcomes is yet to be established; interventions need to be well-validated, acceptable to staff and consumers, accessible and cost-effective (Austin 2003).

A Cochrane systematic review of antenatal psychosocial assessment tools for reducing perinatal mental health illness during pregnancy did not support the use of mental health screening tools antenatally (Austin, Middleton, Priest et al., 2008). Despite this finding, in 2008 the Commonwealth Government of Australia National Perinatal Mental Health Action Plan (NPMHAP) recommended that all pregnant and postnatal women undergo a psychosocial assessment including completion of the EDS. Antenatal psychosocial assessment remains controversial even though it is a public health policy initiative undertaken within maternity hospitals throughout Australia, albeit without support for a well-defined tool or method for identifying women at risk of mental health problems (Austin, et al., 2009). There is inadequate evidence available regarding false positive and false negative outcomes of psychosocial assessments. Equally, limited detailed data exists about uptake of referrals to mental health services or specialized programs (Lumley, et al., 2003). Given the lack of clear evidence that depression screening benefits women, some authors caution that consideration should be given to the possibility of adverse consequences of screening (Jofferes et al., 2018; Thombs et al.,

2014). Others assert that routinely enquiring about a woman's past and present mental health history during the perinatal period has a positive impact on women's help-seeking behaviour, even though a history of mental health problems is a risk factor for poorer mental health outcomes (Myers et al., 2013; Reilly et al., 2014). One Australian study (Reilly et al., 2014) demonstrated that an enquiry about past and present mental health issues by a professional is associated with help-seeking throughout the perinatal period. These results are not necessarily indicative that all women who are depressed will go on to receive extensive intervention and in relation to those women who do receive intervention, further research is required on short term and long-term maternal health outcomes (Reilly et al., 2014). The American College of Obstetricians and Gynecologists (2015) reported that there is limited evidence that screening and treating women who have PND improves their outcomes.

In Australia the National Perinatal Mental Health Action Plan (NPMHAP) recommends that psychosocial assessments be carried out by midwives at the first booking-in visit to the maternity service (Austin et al., 2004; McCauley et al., 2011). Universal psychosocial assessment has been recommended as a part of routine antenatal care by other authorities (Carroll et al., 2005; Minnaar & Boodking, 2009). Limited referral pathways exist, however, for women who identify with a psychosocial issue – a major gap in the system. Little is known about psychosocial assessment in the private sector or in hospitals with fewer than 1000 births annually (Fisher, Chatham et al., 2012). Austin (2004; 2014) recommends that before psychosocial screening is put in place adequate resources must be available to address the psychosocial morbidity that will be detected. A small qualitative study conducted in rural Victoria revealed a well-established universal screening system was not effective in detecting probable depression in women. These authors concluded that the detection of maternal depression requires more than administration of a screening tool at one point in time (Armstrong & Small, 2010). As one woman in the study commented:

> *Sometimes you feel more like a number, like you don't matter. If they could have just taken five minutes to chat with me one-on-one that would help. Asking for help is the hardest thing to do (Armstrong & Small, 2010, P.8).*

These authors also caution that before universal screening of women for postnatal depression can be recommended, better evidence needs to be provided of its feasibility and acceptability, alongside convincing evidence that screening leads to improved outcomes for women. The findings of this study may have been influenced by the study location where participants were

part of small communities which may have influenced their willingness to reveal vulnerabilities.

An important systematic review of 32 systematic reviews of interventions to improve maternal mental health that could be coordinated by midwives, found no specific role was identified for midwives in the literature (Alderice et al., 2013). This lack of acknowledgement that this period is when women have the most intensive contact with midwives is concerning as this represents a missed opportunity for identification of women with PND and appropriate referral and support. The interventions included non-pharmacological/psycho-social/psychological interventions such as mind-body therapies, acupuncture, acupressure, yoga, relaxation and meditation in conjunction with standard pregnancy care (Beddoe and Lee, 2008). Alderice et al (2013) concluded that it is premature to introduce any of the identified interventions.

The most recent iteration of Australian guidelines for screening and management of women with PND was published in 2017 (Centre of Perinatal Excellence (COPE), 2017). These guidelines support the implementation of Australia's National Perinatal Depression Initiative through provision of several strategies including provision of online resources, national data analytics, increasing community awareness, involving support services for women and families in need, and research and advocacy. Despite the lack of evidence that antenatal screening of women is efficacious, the guidelines continue to promote it and have simply added this activity to the role of the midwife. Interestingly, it is apparent from some studies that the National Perinatal Depression Initiative (NPDI) is not implemented in all Australian maternity units, for instance hospitals with fewer than a thousand births annually, and little is known about screening practices in the private hospital system (Fisher et al., 2012).

Referral and supports for women identified through screening are still sparse. No studies have provided evidence of the cost effectiveness of screening and the addition of this activity to the role of the midwife in antenatal care provision (Hewitt and Gilbody, 2009). One Australian study suggests that the use of psychosocial prevention strategies targeted at women with high EDS scores may be more cost-effective than a mass screening program (Boyce 2003). This finding is supported by a Canadian study that found targeting interventions at women identified with risk factors may be preferable (Lusskin et al., 2007). These authors suggest that the lack of evidence for improved outcomes from screening programs may be due to the small sample sizes of some studies and their limited focus on specific socio-economic classes or ethno-racial populations. Their findings have not been consistently reproducible.

THEME 2: WHAT INTERVENTIONS DECREASE RISK OF PND?

Several studies have sought to identify which interventions may decrease the risk of PND in different population groups. In 2010, Dennis, Ross et al. undertook a systematic review of non-pharmacological interventions for the treatment of PND. These interventions included diverse supportive interactions such as support groups, interpersonal psychotherapy and cognitive behavioral therapy and single versus multiple contact interventions. Their search located only one trial that was eligible for inclusion and since its methodological quality was not strong, they were ultimately unable to make any recommendations for any treatment option.

Subsequently Dennis and Doswell (2013) undertook a further systematic review using the argument that interventions that can treat PND may also be successful in preventing PND. This review located 28 Randomized Controlled Trials (RCT), including 17,000 women participants, with the goal of assessing the effect of diverse psychosocial interventions compared with usual care. This systematic review found that women who received psychosocial or psychological interventions were significantly less likely to develop postpartum depression compared with women who received standard care. Possible interventions included intensive professionally-based postpartum home visits, telephone-based peer support, interpersonal psychotherapy and multiple contact interventions. Importantly, identifying mothers 'at-risk' assisted in the prevention of PND, which suggests screening is beneficial (RR 0.66, 95% CI 0.50-0.88; eight trials, 1853 women). Potentially midwives could provide the psychosocial and some of the psychological interventions described in the various studies of this systematic review.

In France, midwives play a major role in PND screening, as they follow women throughout their stay in the maternity unit. A controlled study by Jardi et al (2010) hypothesized that bringing together the EDS with the midwives' subjective perception of women's poor emotional wellbeing would allow more efficiency in the very early screening for PND. Women considered 'at risk' by the midwife or with an EPDS result considered positive were offered an appointment with a psychiatrist working in the unit. Subsequent clinical assessment by midwives found the EDS had improved following confirmation of the diagnosis by the psychiatrist and the offer of appropriate treatment.

A recent and interesting literature review paper from South Africa has highlighted the potential role of breastfeeding in the prevention of PND (Madlala & Kassier, 2018). While cautioning that further research is needed regarding the relationship between breastfeeding, formula feeding

and PND, the authors offer several interesting threads of evidence from epidemiological and cohort studies that suggest a plausible pathway to prevention of PND. For example, skin-to-skin contact before breastfeeding initiation lowers maternal cortisol levels, and cortisol continues to be lower during ongoing breastfeeding. The link is that high cortisol levels are associated with PND (Handlin et al 2009). The authors reference a study by Yusuff (2016) that suggests breastfeeding for at least three months can reduce the prevalence of PND and another study by Watkins et al (2011) suggesting that early breastfeeding cessation results in a loss of maternal-infant bond, thereby increasing the risk for PND. This appears to be an important area for further research since the support of breastfeeding is an integral component of the role and skill base of the midwife.

A question explored by Australian researchers Reilly, Harris et al. (2014) is whether assessment of past or current mental health, received with or without referral for extra support, is correlated with help-seeking during pregnancy and the postpartum. A sub-sample of women drawn from the Australian Longitudinal Study on Women's Health who reported suffering significant emotional distress during pregnancy (N=398) and/or in the 12 months following birth (N=380) agreed to participate in the study. Multivariate analysis revealed that women who were not asked about their emotional health, or the women who were asked but were not referred for further support, were less likely to seek formal help during either pregnancy o r the postpartum period. It emerges that women who were not referred for formal help did seek considerable levels of consultation with family doctors, midwives and child health nurses without referrals. This study makes it clear that enquiry by a health professional about a woman's past or present mental health during the perinatal period is linked to health seeking behavior during that time. These authors also caution that the clinical and resource implications of these findings for the primary health care sector need to be taken into consideration before future routine perinatal depression screening or psychosocial assessment programs are introduced.

THEME 3: NEW MODELS OF MIDWIFERY CARE MAY BE BENEFICIAL

Much of the literature depicts supportive programs for women with perinatal depression provided by health workers from varied disciplines (Strass & Billay, 2008). A recent review of Australian and New Zealand longitudinal studies of maternal health, however, has proposed an important role for midwives in supporting women with perinatal mental health problems (Schmied, et al., 2013). Midwives can fulfil a crucial role in detecting women with PND (Johnson & Galal, 2014; Austin et al., 2013; Homer et al., 2009) although few studies have focused on how

the effects of midwifery interventions may reduce the incidence of PND (Seimyr, et al., 2013).

Many women build a safe and confiding relationship with their midwife/s and full advantage is not always taken of this unique relationship (Seimyr, et al., 2013). Pregnant women are more likely to accept mental health support from a midwife (Small, et al., 2014; Schmied, et al., 2013) but this is not currently considered an integral part of the midwife's role or responsibility (Schmied et al., 2013).

For myriad reasons, women are often reluctant to seek help from mental health services (Schmied, et al., 2013). For some it is the stigma of mental illness (Brown et al., 2009; McLoughlin, 2013), for others, the woman/family's belief systems (Evans, et al., 2012) and family attitudes towards mental health (Biliszta, et al., 2010). Simply accessing help may be too hard. Some women and families fear if they ask for mental health support the authorities may take away their baby and/or other children (McLoughlin et al., 2013). A greater understanding by health professionals of women's attitudes, belief systems and societal attitudes, may help to break down the barriers that contribute to women not acknowledging their illness and therefore not seeking help (Bilszta, et al., 2010). It is imperative that the issue of recognition and treatment of women experiencing PND or at risk of developing PND is addressed, if there is to be a reduction in the long-term effects PND may inflict on women, their children and families. An interesting cross-country (Italy and USA) naturalistic, longitudinal study recruited 1066 pregnant women at three months of pregnancy and followed them up until 12 months postpartum. Minor and major depression were assessed at different times during the pregnancy and in the postpartum period using the EPDS and the Structured Clinical Interview for the Diagnostic and Statistical Manual of Mental Disorders (4^{th} edition) (Banati 2011). The study found that symptoms of depression were not more common or severe after childbirth than during pregnancy. Postpartum prevalence figures were lower than those reported in the literature which suggests that casting a multi-professional network around women in need of support may be useful to reduce the effects of PND on the mother and her baby. Women will potentially benefit from midwives being an integral component of a multi-professional network providing support.

An early systematic review by Bick (2003) summarized strategies to reduce psychological morbidity in women and the outcomes of studies that evaluated interventions provided by midwives. Twelve studies were reviewed which showed significant benefits to postnatal psychological wellbeing following the introduction of new models of midwifery-led care. Educational interventions, including those tailored for women deemed more vulnerable to

depression, yielded limited evidence they would be beneficial. Bick (2003) proposed that further evidence is needed to inform how midwifery care can be provided to all women throughout their pregnancy to ensure early detection and management of postnatal psychological morbidity. Fifteen years on, it seems little progress has been made in expanding new models of midwifery care that could have made a difference to the mental health and wellbeing of a generation of new mothers.

A systematic review and a meta-analysis of ten trials and 18,738 participants explored whether non-pharmacological interventions delivered by non-mental health specialists play a role in treating common perinatal mental health disorders. Most of the included studies were of high quality and indicated that psychosocial interventions by non-specialists are beneficial (Clarke et al., 2014). Midwives could well be regarded as 'non-mental health specialists'. The PRIME study by Fenwick, Gamble et al. (2013) described a perinatal emotional support intervention provided by midwives. In this Australian RCT study, women identified as experiencing emotional distress after birth were randomized to receive the PRIME counselling intervention or a parenting support intervention. When interviewed at 12 months postpartum, a subset of PRIME women (16) reported 'getting in touch with their feelings' and 'moving on' as beneficial outcomes; 'promoting reflection' and 'feeling cared for' were phrases used by all participants regardless of group allocation. Two women stated there were some issues which remained unresolved while two other women stated that they did not find the program hugely helpful nor necessary. Some women needed additional follow-up and targeted assistance. Findings from this study support the importance of providing personalized postnatal care that addresses women's emotional health needs, but importantly also endorse a role for the midwife in the provision of this care.

THEME 4: WHAT DO WOMEN AND FAMILIES/RESEARCH SAY THEY NEED?

Several studies from Australia (Bilszta et al., 2010; Myors, Schmied et al., 2013; Rollans et al., 2013; Schmeid et al., 2013) and internationally (Glavin, Leahy-Warren 2013; Henderson et al., 2018) have explored women's experience of postnatal depression and explored whether women's beliefs and attitudes are barriers to seeking care. An early Australian qualitative study of 40 postnatal women with PND who were receiving community-based care found that there was a need for women themselves and their families to have a greater understanding and recognition of PND (Bilszta et al., 2010). The study found that health professionals also needed to be aware of the personal and societal attitudes impacting on women which may prevent them from acknowledging their distress and become barriers for women seeking care. It was unclear

how women's experiences of PND influenced their beliefs and attitudes and their choice to seek help. In a later systematic review of 48 longitudinal studies, the stigma associated with having a mental illness, coupled with a fear of losing their children, was also identified as a significant barrier to women seeking help from mental health services. This review aimed to describe factors that influence the perinatal mental health of Australian and New Zealand women (Schmeid et al., 2013). The two strongest predictors of depression and anxiety were a previous history of depression and poor partner relationship although, importantly, women's mood appeared to be better in the first year after birth when compared to the period of pregnancy and five years later. Women reported a high number of stressors in pregnancy and following birth and the rate of intimate partner violence was reported as 'worryingly high'.

In a qualitative study which was part of a larger mixed methods study reviewing two specialists Perinatal and Infant Mental Health (PIMH) services in New South Wales, Australia, eleven women who had accessed the service agreed to participate in either face-to-face interviews or telephone interview (Myors, Schmied et al., 2013). The over-arching theme from data collected was '*my special time'.* From this theme three sub-themes emerged: *it wasn't just a job; someone was out there for me;* and *swimming or stranded: feelings about leaving the service*. Overall women described being part of the service as positive and saw their relationship with the clinician as a key component of this. Highlights from the study emphasized the importance of the relational aspect of care and support expressed by women, findings that were echoed in the study by Rollans et al (2013). Rollans et al (2013) focused on exploring the meaning women attributed to the psychosocial assessment and depression screening and how those meanings influenced their responses to the questions. While studies have suggested that most women find routine antenatal psychosocial assessment and depression screening acceptable (Austin et al., 2007; Leigh & Milgram 2007), it has been acknowledged that women with an EDS over 13 were more likely to find the screening process uncomfortable. The findings from the interviews suggested that a woman's experience of assessment can be clearly influenced by the midwife or nurse's approach. The development of a mutual, trusting relationship with women and families is required which is about building strong relationships and being mindful that women are wary of criticism, interference or surveillance. Women felt intensely that they should be able to collaborate around how to record the information they provide in these sensitive interviews.

In a study from Norway and Ireland (Glavin, Leahy-Warren 2013), low professional support at birth was found to increase the risk of PND at 12 weeks postpartum. This study explored the concept of perinatal depression, prevalence and outcomes, similarities and differences in public

health and public nursing models in two countries where public health nurses' practice, delivering social support to new mothers. Promoting the role of the public health nurse in an integrated model of primary care for women with PND was strongly recommended (Glavin & Leahy-Warren 2013).

The final and most recent study in this theme describes the results of a national survey administered to randomly sampled UK women of whom 352 (7.7% of 4,578 responders) self-identified with mental health problems in pregnancy (Henderson et al., 2018). A consistent finding was that women with mental health problems were more likely to have a sense of not being treated as individuals, and doctors did not talk to them in a manner they could understand or listen to them. Women felt they were not respected or treated as individuals, nor were they likely to feel they had been involved in decision-making. This is despite the health system endeavouring to increase support for women by providing additional antenatal visits, and seeing the same, named midwife. Health care professionals may need additional education to effectively support women with mental health problems during the perinatal period. This is a common recommendation from many studies in this area and as such deserves a theme of its own as detailed in theme five below.

THEME 5: MIDWIVES IDENTIFY LACK OF SKILLS

Traditionally, many researchers in perinatal mental health have focused on the identification of knowledge and skill deficits of healthcare workers, particularly midwives (Brown et al., 2009; Jones et al., 2012; McCauley et al., 2011; Jomeen 2018; Legere et al., 2017). The aim of much of the research is to identify such deficits in order to propose solutions such as education, skill development and development of new referral pathways for women with PND. This deficit-based approach is pervasive throughout health services research, but little beneficial change has occurred therefore.

The role responsibilities of Australian midwives have continued to multiply in response to consumer needs, mandatory legislation and the introduction of psychosocial assessments for all women coming into the public maternity services (Mollart, et al., 2013; Jones, Creedy et al., 2012; McLoughlin 2011; Madden et al., 2017). In recognition of the potential personal mental health risks for health personnel, it has been proposed that adequate psychosocial assessment skills-training as well as ongoing clinical supervision from the mental health sector be made available to midwives carrying out psychosocial assessments (Marce International Society Position

Statement 2013).

Women presenting for their first antenatal visit may find themselves in a busy and fragmented clinic environment. Due to staffing structures, the midwife allocated to do the psychosocial assessment may only meet the woman on this one occasion where sensitive information needs to be obtained from the woman about her history and current circumstances. Gathering this information may prove stressful for both the woman and the midwife (Rollans et al., 2012).

Since the introduction of the structured antenatal psychosocial assessment, health concerns have arisen in relation to midwives themselves including the potential for vicarious trauma, work-related stress, compassion fatigue and burnout (Mollart et al., 2013). Critically, a recent ethnographic study suggests that once midwives receive adequate training and support, they are capable of carrying out competent and caring psychosocial assessments (Schmied et al., 2013).

Studies exploring midwives' skills in identifying and supporting women with perinatal mental health issues have revealed midwives' lack of confidence, their feelings of discomfort and lack of safety when caring for women with mental illness, and their perceived need for further knowledge and skills around perinatal mental health topics (Brown et al 2009; McCauley et al., 2011; Jones et al., 2012; Hauck et al., 2015; Jarret 2014; Ross-Davie et al., 2013). It is generally agreed that midwives are willing to aid women with PND and they also acknowledge the importance of providing emotional support (Jones et al., 2012; Mathibe-Neke et al., 2014). Midwifery colleagues from the United Kingdom and Ireland share similar views to Australian midwives - a willingness to expand their perinatal mental health roles (Ross Davie et al., 2006; Hauck et al., 2015; Higgins et al., 2018), but a feeling that they lack the skills to sufficiently manage mental health disorders (Hauck et al., 2015; Higgins et al., 2012).

Finally, two studies from the same primary author provide complementary evidence of the skills and abilities of midwives in supporting women with perinatal mental health challenges. An integrative review undertaken by Noonan et al (2017) located 22 papers that found that midwives recognize that they have an integral role in perinatal mental health care provision, but that their willingness to offer emotional care to women is compromised by a perceived lack of confidence, competence and practical and emotional support skills (Jones et al., 2012a). Education and training have proven to be effective in developing midwives' confidence and competence to provide perinatal mental health (PMH) care (Forrest & Poat, 2005; Gunn et al. 2006; Elliott et al.,2007; Jardri et al., 2010; McLachlan et al., 2011; Warriner et al., 2011; King et

al., 2015). Hence, there needs to be an understanding of what effective PMH education is, which will prepare midwives to confidently provide optimal PMH care. Any education and training scheme must support the development of skills required for practice, including practical components which have been found to increase midwives' confidence in advising and caring for women with PMH problems (Gunn et al., 2006; Elliott et al., 2007; McLachlan et al., 2011; King et al., 2012). The literature asserts that assessment skills need to extend to suicide risk assessment (Lau et al., 2015a). Different study designs prevented commonalities between studies to be identified. In conclusion, the findings of this review are that midwives are restricted in their ability to provide PMH care for women due to their self-perceived limited knowledge and skill base, and a lack of referral options. They require ongoing educational organizational supports to optimize their role in perinatal mental health.

Noonan et al (2018) conducted a cross-sectional survey of 428 midwives working across seven maternity services in Ireland. The objectives of the survey were to explore midwives' knowledge and confidence in identifying and managing women with perinatal mental issues, midwives' attitudes towards women who experience severe mental illness, and midwives' perceived training needs. One hundred and fifty-seven midwives (36.7%) completed the survey. The findings from the study confirmed that midwives in this population have relatively high levels of knowledge in relation to depression and anxiety and positive attitudes towards women with severe mental illness. Nevertheless, it was apparent that cultural variations in the concept of mental health stigma exist meaning that it is important to examine attitudes to mental health among midwives in their context of care (Noonan et al., 2017; Gabbidon et al., 2006; Linden et al 2012). The preferred format for education was study days with only 6% identifying online delivery as their first choice. If midwives are to be effective in supporting women who experience PND and their families, it is imperative they have access to ongoing education and training, organizational support that recognizes the importance of PND, and time to address the issue. There must also be appropriate referral pathways with an array of options. Education needs to focus on developing midwives' cultural competence. The frequent response when reviewing midwives' comments remains the same: midwives require further education on perinatal mental health across all cultures, with a skill focus which explores attitudes, delivered in a study day format.

Importantly the skills needed to provide effective care for women at risk of or experiencing perinatal mental health challenges are well described in the literature which provides multiple descriptions of the skills, attributes and attitudes of care providers, including midwives, working

in this area. The following theme, theme six, is presented as a taxonomy arising from what was described in the literature.

THEME 6: WHAT SKILLS ARE NEEDED?

Theme six is presented as a table (Table 2) that provides a taxonomy of skills that have been identified in the literature as essential skills for health professionals providing care for women with or at risk of, perinatal mental health challenges. A taxonomy is defined as 'a system used for putting things into groups according to how they are similar: the study of how things can be divided into different types' (Merriam-Webster https://www.merriam-webster.com/dictionary. Viewed 17 March 2018)

Table 2 presents the taxonomy as a list of categories together with the source of the category and the description of the category as identified in the literature. The taxonomy consists of 17 related categories of skills and attributes required of health care workers and for this study, midwives working with women at risk of or experiencing PND.

Table 2: Taxonomy of skills and attributes needed by midwives working with women with PND as revealed in the literature

Midwife Skills & Attributes	Reference	Evidence from the literature
Develops trusting relationships	Armstrong & Small 2010, Australia	A trusting relationship with the nurse/midwife able to communicate her concern for the woman and offer support and referrals, if needed.
	Rollans et al. 2013, Australia	The development of a mutual, trusting relationship with women and families, building strong relationships and being mindful that women are wary of criticism, interference or surveillance.
	Myors, Schmied et al 2014, Australia	A trusting relationship between woman and clinician is an essential basis for therapeutic interventions and services.
	Phillips 2013, United Kingdom	Relationship building is critical
Empathy	Armstrong & Small 2010, Australia	Empathic health care workers are essential, encouraging women to disclose and discuss their emotional health issues
	Fenwick, Gamble et al 2013, Australia	PRIME study - women reported 'getting in touch with their feelings' and 'moving on', as beneficial outcomes; 'promoting reflection' and 'feeling cared for' were phrases used by all participants regardless of group allocation.

Midwife Skills & Attributes	Reference	Evidence from the literature
	Higgins et al 2012, Ireland	Midwives have been censured for failure to connect with the emotional and mental health aspect of their role and to respond to women's emotional needs in an informed, empathetic and timely manner
Communication skills	Armstrong & Small 2010, Australia	Able to communicate her concern for the woman and offer support and referrals if needed
	Henderson et al 2018, United Kingdom	Women with mental health problems were less likely to have a sense of being treated as individuals, doctors did not talk to them in a manner they could understand or listen to them, women felt they were not respected or treated as individuals, nor were they likely to feel they had been involved in decision-making
	Rollans et al. 2013, Australia	Assessment can be clearly influenced by the midwife or nurse's approach. The development of a mutual, trusting relationship with women and families is about building strong relationships and being mindful that women are wary of criticism, interference or surveillance
	McCauley et al 2011, Australia	Midwives rated communication skills, teamwork, rapport building and grief counselling as the four most important skills.
Respect - treats women as individuals	Henderson et al 2018, United Kingdom	Women with mental health problems were less likely to have a sense of being treated as individuals, doctors did not talk to them in manner they could understand or listen to them, women felt they were not respected, nor were they likely to feel they had been involved in decision-making
	Myors, Schmied et al 2013, Australia	Theme 1: *it wasn't just a job,* Theme 2: *someone was out there for me* Theme 3: *swimming or stranded: feelings about leaving the service* were identified.
Non-judgemental	Higgins et al 2012, Ireland	Women are fearful about disclosing distress as they do not want to be seen or judged as bad or unfit mothers.
Able to de-stigmatise PND	Bilszta et al 2010, Australia	Health professionals need to be aware of the personal and societal attitudes impacting on women which prevents them from acknowledging their distress and become barriers for women seeking care
	Schmeid et al 2013, Australia	Many women do not seek help from mental health services, possibly due to the stigma that is associated with having a mental health illness, coupled with the fear of losing their children. Midwives have an important role in the identification, support and referral of women experiencing mental health problems
	Phillips 2013, United Kingdom	Stress the importance of understanding cultural perceptions of motherhood and ethnicity issues as well as seeing the ways social factors can impact upon individuals and increase the women's susceptibility to mental illness

Midwife Skills & Attributes	Reference	Evidence from the literature
Able to offer home visits	Dennis & Doswell 2013, Canada	Intensive professionally-based postpartum home visits, telephone-based support (found to be beneficial)
	Jomeen 2018, United Kingdom	Lack of time in maternity settings and the absence of clearly defined or timely care pathways (opportunity to offer home visits makes the time available)
Knowledgeable re importance of breastfeeding support	Madlala & Kassier, 2018, South Africa	Evidence suggests that breastfeeding can prevent PND, therefore expectant mothers should be encouraged to breastfeed as it aids the mental well-being of the mother and child.
Asks about past or present mental health, encourages woman to reveal emotions	Reilly, Harris et al. 2014, Australia	Enquiry by a health professional about a woman's past or present mental health during the perinatal period is linked to health-seeking behaviour during that time.
	Seimyr et al 2013, Sweden	Prior mental health predicts PND
	Fenwick, Gamble et al 2013, Australia	PRIME women reported getting in touch with their feelings and moving on as beneficial outcomes, 'promoting reflection' and 'feeling cared for' were phrases used by all participants regardless of group allocation.
Sees PND screening as the midwife's role	Hauck et al 2015, Australia	Acceptance by midwives that it is their role to assess the mental health status of perinatal women.
	Mathibe-Neke et al 2014, South Africa	Midwives regard psychosocial assessment as an important aspect of caring for pregnant women and are willing to assess women psychosocially.
	Hauck et al 2015, Australia	Acceptance by midwives that it is their role to assess the mental health status of perinatal women.
	Kurtcu & Golbasi 2014, Turkey	Nurses and midwives recognize PPD as an important health problem and recognize their role in supporting women with PND
Acknowledges importance of self-determination of women	Myors, Schmied et al 2013, Australia	It is important to acknowledge that women need self-determination in all therapeutic processes which includes discharge if recovery and self-efficacy as a mother is to be gained
Knowledge of local referral networks	Johnson & Galal 2014, Australia	Understand that secure attachments often begin in the antenatal period and need to refer to Infant and child health services post birth
	Noonan, et al., 2017 Ireland	Without referral pathways and support services, education of midwives will have little value
Able to provide support throughout pregnancy/ birth/ postnatally and refer appropriately	Banati 2011, Italy & Pittsburgh	Casting a multi-professional network around women in need of support may be useful in reducing the effects of PND on the mother and her baby
	Clarke et al 2014, United Kingdom	Psychosocial interventions by non-specialists are beneficial
	Fenwick, Gamble et al 2013, Australia	Providing personalized postnatal care that addresses women's emotional health needs
	Glavin, Leahy-Warren 2013, Norway and Ireland	Mothers who received low levels of professional support at birth were 3.24 times more at risk of PND at 12 weeks, therefore, provision of professional support at birth is very important

Midwife Skills & Attributes	Reference	Evidence from the literature
	Homer et al 2009	Midwives and women pinpointed the significant essentials required of a midwife: being woman-centred, providing safe and supportive care, and working in collaboration with others as required.
	Bick 2003, UK	12 studies were reviewed that were able to show significant benefits to postnatal psychological well-being following the introduction of new models of midwifery-led care.
	Jones, Creedy et al 2012, Australia	Systematic issues (e.g. time constraints) encountered by midwives need to be addressed to support the delivery of effective emotional care to childbearing women.
Knowledge of PND and positive attitude towards women with PND	Noonan et al 2018, Ireland	High levels of knowledge in relation to depression and anxiety and positive attitudes towards women with severe mental illness –possessed by midwives in most recent study
Works in a coordinated primary care service	Armstrong & Small 2010, Australia	Working in a coordinated primary care service enables midwives to provide multiple and flexible opportunities for women to disclose and discuss their emotional health issues
Has clear guidelines and referral pathways	Austin M-P 2003, Australia	Mechanisms need to be in place for clear guidelines and referral pathways
	Austin et al 2013	Clinical Practice Guidelines for depression and related disorders in the perinatal period must recognize the difficulties of regional and rural areas and the neediness of indigenous and culturally and linguistically diverse families and support a holistic, woman-centered approach to providing psychosocial care in the perinatal period
	COPE 2017, Australia	Follow up may be improved by health professionals having access to timely and appropriate referral pathways
Able to refer women following high EDS screening score	Jardi 2010, France	This type of screening program is only of use if it ends in confirmation of the diagnosis and suitable treatment of the mother.

The 17 skills and attributes in Table 2 can be further divided into two main areas for consideration. The first considers behavioral skills and attributes: developing trusting relationships, empathy, communication skills, respect, treating women as individuals, non-judgmental, able to de-stigmatize PND, acknowledges the self-determination of women, knowledge of PND and positive attitude towards PND. The second describes system-related attributes including able to offer home visits, sees PND screening as the midwife's role, asks about past or present mental health and encourages the woman to reveal emotions, able to provide support throughout pregnancy, birth and postnatally and refer appropriately, works in a

coordinated primary care service, has clear guidelines and referral pathways, and able to refer women following a high EDS score.

Summary of Chapter 2

This chapter has presented a review of an extensive body of literature in the form of six themes. While the first theme revealed a lack of evidence on which to base recommendations for universal screening of all pregnant women for PND, this practice is the basis of Australian perinatal mental health guidelines and those of many other countries. Screening for PND is a key component of midwifery practice during pregnancy and the early postpartum period, sometimes with negative consequences for the midwives when they identify women at risk of PND and have no one to whom she can be referred. The second theme explored was what kind of PND interventions midwives could provide which are evidence-based including a range of psychosocial and psychological activities such as telephone counselling and cognitive behavior therapy amongst many others. Theme three revealed some evidence of the beneficial effect of continuity of midwifery care where women have an opportunity to see the same one or two midwives and develop relationships with their care providers. What women and families say they need in terms of support was identified in the literature reviewed in theme four. This theme included an acknowledgement that care providers who were most effective gave women the impression they were focused on the woman and this was not 'just a job'. Theme five considered the many studies that have explored midwives' perceived lack of skills in this area. The final theme was presented as a taxonomy of concepts and skills identified throughout the literature as essential skills for effective health care providers working with women at risk of PND or experiencing PND, a taxonomy that will be used during the analysis of the data collected through interviews with midwives for this study.

In the next chapter the detailed study design will be presented for an investigation of the skills and attributes that midwives have, that may be pertinent to the care and management of women experiencing or at risk of experiencing PND.

CHAPTER 3: STUDY DESIGN AND METHODS

This research aimed to identify and make known the confidence, knowledge, skills and abilities of midwives in supporting women with perinatal depression. An Appreciative Inquiry (AI) approach using several AI techniques guided the research and provided the approach for interviews with a purposive sample of midwives. The study design and methods are presented in this chapter in two sections. Section 1 presents a justification for the research approach, which utilized techniques from the AI 4D cycle. This section provides details of the 4D cycle and how this has been used generally in organizational change and more specifically in research. Section 2 describes the study design and methods including the method of participant recruitment, the conduct of individual in-depth interviews, the technique of data analysis using the process described by Tesch (1990), how trustworthiness and rigor were established, and the ethical considerations required to conduct the research appropriately.

Section One

Appreciative Inquiry

Appreciative Inquiry was chosen as the best approach to address the research questions in my study because it encourages contributors to bring forward their philosophies, dreams, knowledge and understandings of the subject under discussion (Bushe, 2011). The most important aspect of AI for this study is that AI starts from a positive perspective, identifying what is working well within an organization (or for an individual), rather than what is wrong or not working well (Trajkovski et al., 2013). A major theme within the review of the literature was the constant finding that midwives perceive they have few skills in this area. This finding may have been the result of the kinds of questions asked of midwives during interviews and in surveys. An AI positive approach to exploring this issue may be able to bring to light very different understandings of the skills and attributes midwives possess. Furthermore, AI has been described as a:

> *philosophy and method for promoting transformational change, shifting from a traditional problem-based orientation to a more strengths-based approach to change, focusing on affirmation, appreciation and positive dialog (sic)* (Trajkovski et al., 2013, p95).

AI offers a new process to the workforce, moving from traditional problem solving and progressing towards an openness and appreciation for health care professionals to adopt

innovative ideas and positive change in health care. AI can be a means to help bring about change in shaping the organization's most valuable asset, its people (Higgins 2017), since AI gives members of an organization the opportunity to have a voice in the change process (Trajovski et al., 2013). AI is seen as a model of research that 'aims to plant the seeds of social change' (Cojocaru, 2012, p.124).

Storytelling in Appreciative Inquiry

AI promotes the use of storytelling as a process of discovery (Michael, 2005). Participants in AI studies may be encouraged to tell their best stories when asked about their work and the work environment. Initial storytelling at interview is a significant innovation of AI and is thought to be crucial (Ludema, 2002; Khalsa, 2002; Cooperrider & Whitney, 1999). The story told, essentially may be a facilitator for change (Barrett & Fry 2005).

Previous Appreciative Inquiry research with nurses and midwives

This section presents just two examples of previous research with nurses or midwives using the AI approach. Researchers in Canada (Knibbs, et al. 2012) evaluated the use of AI in focus groups with public health nurses, managers and policy makers as part of a project to create policy proposals for developing public health nursing capacity. Centering on what worked well in the organizations, AI enabled the policy-makers to focus on the attributes that best supported public health nursing practice, which led to practical policy recommendations based on participants' experiences.

A qualitative descriptive study using AI focus groups to explore midwives' perceptions of their roles within the context of the new models of maternity care in Queensland, however, found a very different result (Sidebotham et al., 2015). Focus group questions were appropriately planned around the AI stages of Discovery, Dream, Design and Destiny with the Discovery stage focused on uncovering moments of excellence, core values, and best practice.

Participants were asked *What do you enjoy about being a midwife within this organization?* In the Dream stage participants were asked to envision positive possibilities with questions such as *If there were no barriers to your vision, what would make being a midwife in this organization perfect?* The third stage, the design stage, included inviting the midwives to envisage the structure, processes and relationships that would best support the dream.

Participants were then asked *What strategies could be put in place to make your vision for*

midwifery a reality? What would be needed at an organizational level to make it happen? and *What would be needed at an individual level to let the vision become a reality?* For the destiny stage participants were asked two specific questions: *What barriers might you face in striving to make these changes happen?* and *What strategies could you use to overcome them?*

The findings of this study indicated that even the iterative process of the AI 4D cycle was not enough to enable the participants to envision how they could make change to the systems and organizations within which they worked. In particular, the midwives felt powerless to effect change and many expressed feelings of job insecurity. "Even when prompted midwives could not conceptualize any circumstances in which they might create the opportunity to work in different ways within their current institution" (Sidebotham et al., p118).

While many studies using the AI approach achieve positive outcomes (Delgadillo et al., 2016; Hussein et al., 2014), the latter example provides a cautionary note in designing this study in that AI may not always produce the positive perspectives one is aiming to generate, despite carefully applying the method throughout the research process. As Trajkovsky and colleagues suggest, AI "… is a process which takes shape differently in different contexts or organizations" (Trajkovski et al., 2012, p1228).

Appreciative Inquiry: The 4D Cycle

In the following section details are provided of the Appreciative Inquiry 4D cycle that explains the four key aspects of the AI approach. The overarching concept of the AI approach is the positively framed interview where every question is positive in order to assist the participants to discover and articulate their personal and organizational values and dreams of how they wish to enhance their role in supporting women with PND. The conceptual model presented in Figure 1 reveals the sequential and iterative nature of inquiry in AI with Discovery, Dream, Design and Destiny phases within the process (Cooperrider & Whitney, 1999; Cooperrider, Whitney & Starvos, 2008). Each phase is described in the following section.

Discovery

The appreciative interview is at the heart of discovery and every question asked is positively framed. During an appreciative interview participants discover what gives life to their organization (Ludema et al., 2015, p6). The aim of the discovery phase is to probe, explore, ask *What do you enjoy most about your work? What do you like to do and what do you do well?* This discovery of information includes the strengths and skills the participant brings to their work

and what is it that gives life to the work and the organization they work within.

Dreaming

The aim of the Dreaming phase is to invite participants to think about things worth valuing. It sets in motion curiosity and inspires the envisioning mind (Trajkovski et al., 2015). During the dream phase, participants are invited to tell a story of what they want the future to be and from the story's insights can be gained about the strategic focus on *what might be.* When participants see the best of each other, they are willing to support each other in affirming ways and create better worlds. In terms of this research which is focused on interviewing midwives, this means they were asked to envision what their dream is for the future of the system in which they work and how it might enable them to provide appropriate support for women with PND.

Design

The aim of the Design phase is to "…have a vision for a better world, a powerful purpose or a compelling statement of strategic intent" (Cooperrider & Whitney, 1999 p9). During the Design phase participants are encouraged to confront the status quo as well as thinking about the accepted assumptions which govern their organization. Participants are encouraged to think about 'what should be' (Cooperrider & Whitney, 1999), 'creating an ideal organization … participants working together to design plans for the future' *(*Trajkovski et al., 2012*).*

Participants are invited to invent propositions and/or principles for action. For this research participants were invited to design a system where midwives could provide support for women with PND within their existing organization. Trajovski et al (2015) recommend that the Dreaming and Design phases occur at the same meeting. In my study design, all three phases happened in the one interview, potentially strengthening the participants' engagement with the process.

Destiny

The aim of the Destiny phase is to explore how to implement this dream and put the principles into action. This is meant to be:

> … *a reality-based process of looking at the opportunities for implementing the strategic design in reality…* (Cooperrider and Whitney, 2005, pp 34)

As previously described, this phase of the 4D cycle was not undertaken in this study as the Design for change envisioned by each midwife was not implemented in practice. To do this would have required a very different study design. This study used three of the AI techniques as a positive approach to inquiry during interviews with participants.

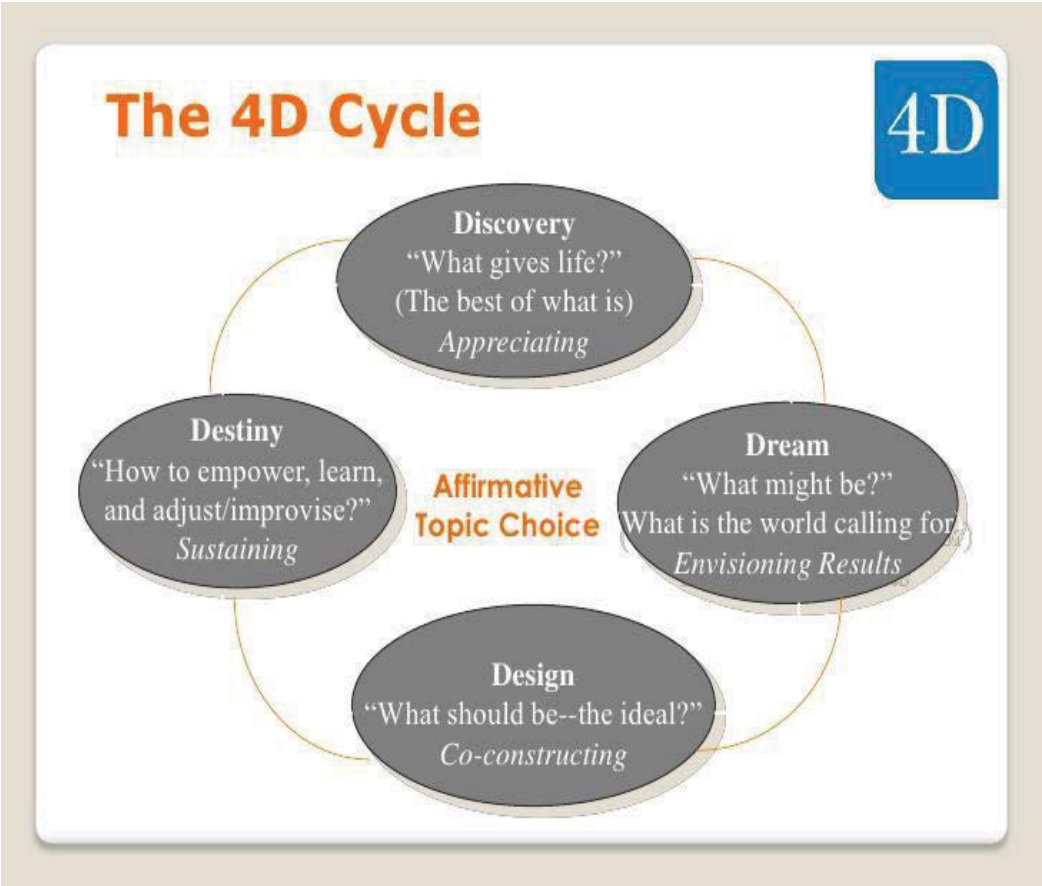


Figure 2 : The AI 4D cycle: The AI 4D cycle

(After Cooperrider and Whitney, 2005, p16. Image Source: Mercedes, V., 2011, accessed at https://www.slideshare.net/mercedesviola/appreciative-inquiry-9165675 viewed on 1 April 2018).

Affirmative Topic Choice

Cooperrider & Whitney (1999) advocated for AI to be more than a 4D cycle, but rather something deeper at the core (Cooperrider & Whitney, 1999). At the core of the 4D cycle is the 'affirmative topic choice' (Cooperrider & Whitney, 1999) which is considered to play a major role in the AI process (Cooperrider et al., 2008). In AI organizational research the organization would set the topic as "…an opportunity for members of an organization to set a strategic course for the future" (Cooperidder and Whitney 2005, p17). The 4D process is governed by the topics selected as they are the basis in discovery interviews, they inform the dreaming phase and can even help craft design propositions and actions in the destiny phase. For this study, the "affirmative topic choice" was set by me as the research focus of "midwives supporting women with PND" and "growth through PND education". These topics were derived from my many years of working in the area and my review of literature in Chapter 2, as well as discussions with my academic supervisors.

Appreciative Inquiry shares philosophical values with nursing and midwifery through focusing on individualized patient/woman-centered care and pursuing "…the uniqueness, wholeness and the essence of human life" (Trajkovski, 2013, p98). An important observation by Carter (2006) was that most of the significant and prominent nursing research which has influenced current practice began from a problem orientation and arguably the same orientation has occurred in midwifery research. The literature review in Chapter 2 presented several articles reflecting the problem orientation of much research in the area of perinatal depression and midwives' apparent lack of skills in this area. AI proposes a radical departure from this and instead proposes a positive approach that aims to identify the individual's existing skills and strengths on which to base further development to achieve successful change in practice (Trajkovski, 2013). AI, when adapted for use in research, reframes the research (Lavender & Chapple, 2004; Carter, 2006) which encourages a shift from a problem orientation to a positive theory of inquiry (Koster & Kemelin, 2009; Reed, 2007; Carter, 2006).

Further evidence provided in the review of the literature in Chapter 2 reveals that midwives perceive a need to further their knowledge and skills around perinatal mental health as they lack confidence in their ability to provide skilled support (McAuley et al., 2011; Jones et al., 2012; Hauck et al., 2015). Midwifery colleagues from the United Kingdom share similar views to Australian midwives, as they also express a willingness to expand their perinatal mental health roles (Ross Davie et al; Hauck et al., 2015) but feel they lack the skills to sufficiently manage mental health disorders (Hauck et al., 2015). Midwives need to be encouraged to investigate the options for change and to look beyond the difficulties and problems they work with daily (Richer et al., 2009). Midwives' perceptions that they are not capable of providing appropriate care to women with mental illness may affect their motivational performance and feelings of frustration (Bandura, 1986). If feedback from the women cared for is not forthcoming, midwives may see themselves as lacking in the ability to master the skills required for effective care.

Therefore, finding a new way to assist midwives to explore their skills (which they may not be fully aware of) could assist them to move away from feeling they are not adequately skilled to provide the kind of support that women with PND require. The 4D AI cycle during the research study interviews assisted in facilitating the participants through a process that helped them to uncover the unknown and to provide new insights into their capabilities rather than their perceived shortcomings in this area of practice.

Justification for the AI approach

In summary, supporters of AI have declared an AI approach enables understanding of both the positive and the negative experience, which may not occur if a problem-solving approach is used (Trajkovski et al., 2013). AI also offers a new process to the workforce, moving from traditional problem solving and towards an openness and appreciation of health care professionals to gain confidence in adopting innovative ideas, thereby bringing about positive change to health care delivery.

Since one of the main findings of the review of previous research in this area was a continuing focus on midwives' skill deficits and lack of confidence in supporting women with PND, an AI approach to inquiry would potentially uncover a different story. My extensive clinical experience in this area had led me to believe that midwives do indeed possess the knowledge and skills required to contribute to the identification of and intervention for women at risk or experiencing PND. My discovery of AI (through timely guidance from my supervisors), led me to appreciate the potential power of this research approach in helping midwives to understand the knowledge and skills they already possessed.

In the next section I provide details of how the AI approach was used in the design of the study to investigate:

1. What knowledge and skill do midwives bring to caring for women with PND?
2. How does this specialized knowledge and skill inform midwives' role in supporting women with PND?

Section Two

Study design and methods

This study uses a qualitative, descriptive design using an approach to inquiry described as the four-stage AI model. As described previously, three of the four iterative phases of the 4D cycle - *Discovery, Dreaming, Design* (Cooperrider & Whitney, 1999; Cooperrider, Whitney & Starvos, 2008) - were used to guide the data collection and analysis.

Study Setting

Midwives from three services within a large, regional Local Health District (LHD) were invited to participate in the research. These consisted of the main teaching hospital (MTH), an urban

general hospital (UGH) with a maternity section and a private maternity unit (PMU). To protect the anonymity of research participants in this study, the LHD and the maternity units will not be named.

Recruitment

Posters and flyers giving details of the study and expression of interest forms were distributed to all participating hospitals prior to the researcher attending in-service meetings with midwives at each location. At the meetings the purpose of the research was outlined and an invitation to participate was made through providing an information package (Appendix 4) and contact details of the researcher. Potential participants contacted the researcher to arrange the signing of a consent form and the time and location for interview.

Participants

A purposive sample of up to 20 midwives was sought, with at least five midwives from each of the three study locations, to ensure a range of experiences and views of screening, identification and caring for women with PND. Participants could be full-time or part-time, working in continuity of care models or standard models where they were working at least two 8hour shifts per week and have worked regularly in the last six months. Working regularly for at least two shifts per week would ensure that the participants were current practitioners who may have been exposed to women with PND.

Participants signed a consent form (Appendix 4) agreeing to participate in the study and to the digital recording of an in-depth interview. Interviews took place at the participants' hospitals, in a private environment such as an office as chosen by the participant and at a time convenient for each participant. Table 4 (in Chapter 4) provides the details of the participants alongside the results of the study.

Data Collection

Data were collected from each participant using semi-structured, in-depth, individual interviews conducted by the researcher. The interviews were digitally recorded and fully transcribed by the researcher. The aim was for recruitment and interviews to continue until data saturation occurred. Data saturation is a concept well accepted in qualitative research as described by Saunders et al. (2018). Data saturation occurs when no new insights are gained during qualitative data analysis that can contribute to the development and refinement of themes. Once this occurs it is reasonable to cease data collection. Data saturation was reached after 12 participants had

been interviewed and their data analysed. Each participant was given a copy of the transcript of their interview to check for accuracy, but only one change was required.

Method of In-depth interview

The interview goal was to collect stories from midwives who conduct screening and/or care for women with PND. The interview was semi-structured with trigger questions employed around the three of the four stages of AI: discovery, dream and design. The interview trigger questions are located in Appendix 3.

Each interview lasted up to an hour. Field notes were made following each interview to record reflections and note any particular issues that arose. These notes were used to provide an interview context and further insights during the data analysis phase. Midwives were asked to complete a short questionnaire at interview to provide details of educational qualifications, current midwifery role, years of midwifery experience and year of birth in order to provide a description of the participant characteristics.

Data Analysis

Appreciative inquiry was used as a theoretical lens to guide the thematic analysis of the interview transcripts. This means the analysis focused on identifying positive keywords or phrases that were coded and grouped into sub-themes and finally into major themes using the three phases of the 4D cycle as a guiding framework. Tesch (1990 in Creswell, 2003) proposes eight steps for thematic data analysis (see Table 3) and these were also used during the analysis process.

Table 3: Tesch's eight steps for thematic data analysis

(Tesch, (1990) in Creswell, 2003; pp191-192).

STEP	DESCRIPTION	DATA ANALYSIS
1	Get a sense of the whole.	Read all the transcripts carefully. Write down the ideas you get from the reading of the transcript
2	Pick one document – the most interesting one, the shortest or the one on top of the pile.	Go through it, asking yourself what it is about. Write down your thoughts in the margin.
3	After completing the above step, make a list of all the topics.	Cluster similar topics together. Form these topics into columns as major topics or unique or leftover topics.
4	Go back to the data with the list of topics.	Abbreviate the topics as codes and write the codes next to the appropriate segments of the text.
5	Find the most descriptive wording for the topics and turn it into categories.	Look for ways of reducing the categories by clustering together what belongs together.

STEP	DESCRIPTION	DATA ANALYSIS
6	Make the final decision on the abbreviations and categories	Arrange the categories alphabetically.
7	Assemble the data belonging together into groups.	Perform a preliminary analysis.
8	If needed, recode the existing data.	Recode.

According to Tesch (1990) the steps in thematic analysis of qualitative data include the following: the digital/audio files are transcribed verbatim by the researcher as it is important to listen to voice, tone, pauses, exclamations, laughter, crying and other responses observed (Burns & Grove 2003). Appropriate notes are made. Carefully reading and rereading all the transcripts enables a sense of meaning to be gained from the transcripts. Make notes of ideas that come to mind. Select a transcript and go through the transcript carefully, identifying what it is about, and write down thoughts, key words and phrases in the margin following this reading/re-reading process.

The next step was to arrange similar topics/key words/phrases into groups by forming columns labelled 'major topics', 'unique' or 'leftover topics. Abbreviating the topics into codes and writing the codes next to appropriate segments of text was then followed by checking if new categories or codes emerged. Clustering together the topics that belonged together helped to reduce the categories until a final decision was made on the abbreviation of each category.

When this was completed the categories were arranged alphabetically. Data belonging together were assembled into groups, followed by a preliminary analysis and, if needed, recoding took place (Tesch 1990). The records of raw data were notated and compared with audio files, and notes were kept in a memorandum setting out thoughts and ideas on the overall meaning of the interviews.

As the interviews had been guided by the AI 4D cycle, the analysis was similarly constructed to reflect the categories of Discovery, Dreaming and Design. The Destiny phase was not undertaken in this study as the Design for change envisioned by each midwife was not implemented in practice. Sections of transcripts and initial codes were shared with my supervisors to check that I was on track and again when clustering of common themes occurred. Discussion occurred until agreement was reached on the naming and content of the themes within each category of the 4D cycle.

Data saturation

As data saturation was a driving consideration in recruitment and interview, data analysis occurred quite close to each interview, with no new concepts or information appearing at the eleventh interview, with one more interview undertaken to ensure data saturation had indeed been reached.

Trustworthiness and rigor

Qualitative research requires rigor in the form of an accurate representation of participants' experiences (Silverman 2000). Therefore, it is imperative for research using qualitative methods that the quality and rigor of the study data are trustworthy; that is, the research needs to be plausible and of high quality, processes for which the researcher is responsible during the course of the research, rather than the reviewer or reader of the research following completion and publication. The four elements of trustworthiness are credibility, transferability, dependability and confirmability (Bryman, 2000; Morse et al., 2002; Lincoln and Guba, 1982).

Some argue that ***credibility*** is like internal validity, while others argue this concept is largely derived from the quantitative research paradigm and is of less use in qualitative studies (Morse et al., 2002). Credibility refers to the intended objectives of the research and how well the individual aspects of the study are designed to meet these objectives (Graneheim & Lundman, 2004). In this descriptive study design, credibility was established through recruiting a range of participants who offered a varied experience of the phenomena. In this study 12 midwives were recruited from a range of settings and with various forms of work and life experiences. These varied perspectives lent richness to the data. Credibility was also addressed through prolonged engagement with the participants and by expressing regard and respect for the participants (Denzin and Lincoln, 2000). In this study 'prolonged engagement' took the form of an initial meeting in the participant's hospital and a subsequent telephone conversation arranging a meeting time and place, at least a one-hour long interview with additional 'getting to know you' conversation and closure-time, plus a follow up conversation when the copy of the interview transcript was returned to the participants for confirmation of accuracy. In addition, following the AI 4D cycle provided a structure that kept the inquiry within specific bounds.

Transferability

Transferability parallels external validity, another concept derived from the quantitative paradigm, which is the extent to which the research findings can be generalized to other

situations and other participants. In qualitative research, transferability concerns the application of the research findings to other settings or situations and how this occurs (Merriam 1998). It is recommended that researchers use strategies to improve transferability, thus assisting those reading the research to take information from the specific study that may be relevant to their own situation. In this study the strategy involved placing the research findings within the context of current literature and clinical understandings within the *Discussion* chapter. Another strategy is to provide rich, thick descriptions of the contextual experiences of the participants, which allows potential users of the research to select what is relevant to their situation.

Dependability

Dependability is the third aspect of trustworthiness and is considered to have occurred when someone external to a study judges that the form of data collected (in this case one-to-one, in-depth interviews), the analysis process and findings are understood, consistent and dependable. An audit trail can assist this process and one is provided in Appendix 5 to illustrate the process of data analysis (Table 8). A further component of establishing dependability is the use of a set of trigger questions to guide each interview and to ensure questioning occurred in a similar way for each participant. The AI 4D cycle was again an aid in this process by providing a well-defined framework within which the questions occurred. The questions are listed in Appendix 3.

Confirmability

Confirmability concerns the extent to which the research and its findings are not influenced by the values and biases of the researcher, which requires a continuous process of reflection on the research (Denzin and Lincoln 2000). In part the researcher's values and biases are explored in the section on reflexivity, which is an integral part of the research process.

Reflexivity

Reflexivity is a process of scrutinizing oneself as researcher, and the research relationship, as these factors impact on the researchers' effect on the research and findings:

> *A researcher's background and position will affect what they choose to investigate, the angle of investigation, the methods judged most adequate for this purpose, the findings considered most appropriate, and the framing and communication of conclusions* (Malterud, 2001, pp. 483-4).

I approached the issue of reflexivity by exploring the views that I held around the research topic including my assumptions and preconceptions about the role of midwives in supporting women with PND. I reflected constantly on whether and how my views might be impacting on my

approach to the literature and my critique of the literature as well as how the interviews were conducted and particularly my interpretation of the findings. Emerging themes were verified through discussions with my academic supervisors and consensus agreement reached.

I was known to some of the participants and was aware that this could impact on the relationship dynamics, how the questions were framed and the participants' responses to questions. The AI 4D cycle was an important structure for me during the entire research process as it prevented me from straying too far from the research focus and kept bringing me back to the affirmative topic choice.

Morse et al (2002) argue that "research is only as good as the investigator" (p17) by which they mean it is the researcher's skill, sensitivity, creativity, insight and flexibility during the evolving study that determines the validity of the study. The researcher needs to remain open to what is emerging during the interview process and the data analysis process and "…be willing to relinquish any ideas that are poorly supported" (Morse et al., 2002, p.18). I endeavored to remain open throughout the research process.

Ethical Issues

The Health Research Ethics Committee of the LHD 16/HNE/118 and the University of Technology Sydney, Human Research Ethics Committee LNRSSA/HNE/166 granted ethical approval. (Ethical approval documentation is found in Appendix 4). Ethical principles of informed consent were addressed by providing all participants with printed information about the study, with time to consider participation, prior to signing a consent form. Anonymity and confidentiality were assured with the following processes: interviews were digitally/audio recorded and de-identified, with each participant choosing a pseudonym. The record of each participant's name and their pseudonym is kept in a password-protected computer file, in a locked filing cabinet in a locked office in my home. At the completion of the project, the data will be stored in a University of Technology of Sydney secure archive. It is also the intention that no midwife will be identified in any publication or presentation arising from this research. Should any midwife participant have become distressed either through the interview or at the end of the interview, support was available through the Employee Assistance Program provided by the LHD. This was not required.

Summary of Chapter 3

This chapter has provided a justification for the use of the Appreciative Inquiry approach and the 4D cycle in this study. Previous research had often used a problem orientation to uncover evidence of the lack of knowledge, skills and confidence of midwives in the area of support for women with PND. AI provided an approach that would focus on the strengths and abilities of midwives, abilities they may not have been aware they possessed. Therefore, AI and the 4D cycle of AI were used to inform the design and conduct of this study. The methods of participant recruitment and data collection and analysis were described, as well as reflections on establishing the trustworthiness and rigor of the study. In the next chapter the results of the analysis of the interview transcripts is presented highlighting that the AI approach enabled the collection of rich descriptions of the knowledge and skills of the participants in identifying and caring for women at risk of or experiencing PND.

CHAPTER 4: FINDINGS

The findings of the study are presented in the following chapter. Following thematic analysis as described by Tesch (1990), the findings from conversational interviews with participants were divided into themes relating to three of the four phases of the AI 4D cycle: Discovery, Dreaming and Design. These themes are presented together with quotes from participants.

The second section of this chapter provides an analysis of the midwives' skills and attributes demonstrated in the transcripts of their interviews in relation to the taxonomy of skills and attributes identified in Table 2 in the review of the literature. The final section presents the analysis of two vignettes identified in the participant interviews that illustrate the knowledge, skills and attitudes of midwives in relation to working with women with or at risk of PND. The chapter begins with describing characteristics of the 12 midwife participants.

Participants

As Table 4 reveals, the 12 midwife participants worked in one of three hospitals within the LHD: two public hospitals and one private hospital. Most participants held a Bachelor of Midwifery qualification with five having a Graduate Diploma in Midwifery. Four participants worked full-time and eight were part-time ranging from 0.4 (2 days per week) to 0.8 (4 days per week). The participants had a range of years of experience from 18 months to 36 years. Six of the participants had worked less than 10 years in midwifery, three had worked between 11 and 15 years and the remaining three had worked in midwifery for more than 30 years. Four worked in a continuity of care model of practice (Midwifery Group Practice), which meant that they each had a caseload of 40 women per year for whom they were the primary midwife and for whom they provided continuity of care throughout pregnancy, the intrapartum and early postnatal periods. The participants ranged in age from the youngest at 30 to the oldest at 60 years with an average age of 43.3 years.

Table 4: Characteristics of the 12 participating midwives

Pseudonym	Age	Qualifications	Role & Location	Part-time / Full- time	Years of midwifery experience
Jemima	38	EN*, BN**, RM***	Midwifery Group Practice (MGP) (UGH)	Full time	9 years
Norah	35	EN, BN, BM****	MGP (UGH)	Full time	2 years
Marigold	44	RN#, FPA##, C& Fam Health+, LactCons++, PG Dip Mid+++	MGP (UGH)	Part time 0.8	15 years
Rosie	42	EN (18 years), BN, BM	MGP (UGH)	Part time 0.8	12 years
Louise	30	BN, BM, MMid*#	Postnatal ward midwife (UGH) Provides lectures on PND	Part time 0.4	7 years
Evelyn	44	BN, BM	Works across all areas of midwifery (UGH)	Part time 0.6	15 years
Grace	35	BM	Ward midwife (PMU)	Part time 0.8	2 years
Charlotte	38	BN, BM	Ward midwife (MTH)	Full time	18 months
Kaz	55	RN, RM, Lactation Consultant	Lactation Consultant, runs a group for new parents (PMU)	Part time 0.6	35 years
Sally	58	RN, RM, BN, C&Fam. Health, Neonatal Nursing Cert	Midwife antenatal clinic (MTH)	Part time 0.6	36 years
Spicer	60	RN, RM	Ward midwife, (PMU)	Full time	32 years
Rochelle	40	BM	Antenatal clinic (MTH)	Full time	2 years

*EN=enrolled nurse; **BN=Bachelor of Nursing, ***RM=Registered Midwife; ****BM= Bachelor of Midwifery; #RN=Registered Nurse, ##FPA=Family Planning certificate or diploma, +C&FamHealth=Child and Family Health certificate or diploma, +++ Post Graduate Diploma in Midwifery, ++ Lactation Consultant , UGH = Urban general hospital , MTH =Main teaching hospital , PMU= private maternity unit.

The following section describes the themes identified within the three phases of enquiry that guided the interviews with the midwives. In order to help them to relax and to begin the first of the 4D interviews, the participants were invited to share their stories about what motivated them to become midwives, and the most successful moments in their practice when working as a midwife generally and, with women at risk of or experiencing PND. The section begins with description of the five themes that emerged following analysis of the interview transcripts of the AI Discovery phase. The **Discovery** phase themes identified were *personal motivation, models of care, clinical practice, education of midwives and education of women*. In the dreaming phase participants were invited to reveal what they would like to see provided for women at risk of or experiencing PND. Analysis of responses to the 'miracle' question in the Dreaming phase of the interviews revealed four **Dreaming** phase themes: theme one was for *mother-baby PND services that included a mother-baby inpatient unit, midwifery-led PND service* and a *locally-based 24-*

hour telephone helpline. *Continuity of midwifery care* to enable more time to spend with women was the second theme to emerge. The third Dreaming theme was *care in the community*, and the fourth was a dream for *midwives to be valued and well supported* in order to provide the best care possible. When considering how the ideas of the Dreaming phase could be put into practice in their setting, the following **Design** themes emerged: s*upporting midwives* and *promoting continuity of care*. Without an associated action research project, it was not possible to actually put in place the Design developed by the midwives so the **Destiny** phase of the 4D cycle was not implemented.

The next stage of analysis considered the taxonomy of skills and attributes identified in the review of the literature (Table 7 in Appendix 2) and explored which if any of these were revealed in the analysis of interviews. Finally, two of the many vignettes described by participants during the interviews were selected as exemplars and analyzed to explore the knowledge of PND revealed in the stories from clinical practice. The Chapter begins with presenting the findings of the thematic analysis of the Discovery phase of the interviews.

Table 5: Themes arising from data analysis

AI PHASES	THEMES
Discovery	Personal motivation Models of care Clinical practice Education of midwives Education of women
Dreaming	Mother-baby PND services • Mother-baby inpatient unit • Midwifery-led PND service • Locally-based 24-hour telephone help line Continuity of midwifery care Care in the community
Design	Supporting midwives Promoting continuity of care
Destiny	Phase unable to be implemented within the constraints of this research study

Discovery

Theme 1 Discovery: Personal motivation

Many of the participants had personal experiences of mental ill health, either for themselves or in their own families. This appeared to influence their acceptance of mental health as an

important issue to address in their work and motivated them to develop relationships with women in their care that would provide an open and trusting space between them. These tendencies are illustrated in the following quotes. (All quotes are identified using pseudonyms followed by the page number/number of pages in the transcript). The theme begins with the words of Louise and Evelyn who had been midwives for seven and 15 years respectively:

> *My own personal experience motivates me and is important as early help has an impact…I like to be open about my own mental illness and I think it is important for society to be understanding and accepting of people with mental illness (Louise, p6/15)*
>
> *I do feel I have a calm way and that maybe because of my own mental health I develop rapport and ask the right questions (Evelyn, p3/12)*

It is apparent that Louise and Evelyn draw on their own personal experiences of mental illness in their work. For Louise this has provided her with both increased knowledge of the benefits of early help for women and a sense of social justice in wanting society to accept people with mental illness. Evelyn's experience of mental illness and her response acknowledges her skills of calmness, an ability to establish rapport with women and an ability to ask the right questions.

In the following quote Grace talks in more general terms about her personal experience and wanting to give back, to pass on to other women the support that she received when she had what is known as 'the postnatal blues':

> *I went into midwifery because of my own personal* [postnatal blues] *experience. It was time for me to pay back and pass that on to somebody else…I had a lovely midwife who walked through the door and sat down with me and said "I am going to nurse* [hold] *your baby while you pop in and have a shower" …she helped me to understand that how I was feeling was okay …and it was all normal...to this day I think I have gone into midwifery to help people like me (Grace, p6/19)*

Rochelle candidly revealed her family history of domestic violence that inspired her to work with women and families with similar backgrounds:

> *I come from a background of domestic violence: my father was violent. I have always had an interest in people from backgrounds like mine and how that affected their family and the way they parent (Rochelle p2/26)*

Her interest in the area of domestic violence extended to also wanting to understand how these experiences of violence *affect the family* and the impact this has on parenting ability.

Rochelle continued later to expand on her motivation to help women:

> *…how can I, as one person, help women from socioeconomic disadvantaged backgrounds be the best parents they can be? …um and that's the start isn't it, when they're pregnant, so if I can help them, then you know, if it's all just for one person, then it's all been worth it … (Rochelle p7/26).*

Rochelle in the above quote provides a rich acknowledgment of increasing her role as a midwife to more fully work within her scope of practice dealing with the psychosocial needs of parents, especially if they are from disadvantaged backgrounds. The potential outcome is to enable the parents to be the best parents they can be.

Charlotte, a relatively new midwife, and Sally, a midwife with over 30 years in clinical practice, have been motivated by different reasons. Charlotte's motivation has arisen through a clinical experience of caring for a family who had a stillbirth. That had a profound impact on her. The experience was distressing but the huge amount of support she felt from her midwifery colleagues helped her through the distress she felt so that she was better able to help the family in her care:

> *I learned something new* [caring for a family who had a stillbirth] *and it will stick with me forever (Charlotte, p30/37)*

Charlotte also found being a midwife in a small community very rewarding as she often met women and families whom she had cared for when going about her day-to-day activities:

> *It's rewarding…like you're making a difference in people's lives, like I have people come up to me in the shops and recognize me and be like "Oh, you delivered Declan two years ago". That sort of gratitude and that sort of thing is really, that's what kind of keeps you going, I think…Having that kind of feedback is great (Charlotte, p6/37)*

Although Sally uses different language, she reflects a similar feeling of honor to be working with women during childbirth and to be trusted with confidential and intimate information*:*

> *As a midwife I consider it is an honor that women are willing to share and trust me with their personal information (Sally, p3/7)*

Several participants also had a passionate interest in midwifery practice specifically and approached their practice as a process of engagement and relationship-building with women and their families. Many expressed a confident understanding of the importance of early mothering and the need to address PND as it could impact on the short and long-term wellbeing of infants.

Rosie described her midwifery as a life-long passion rather than just a career or job:

> *I had always wanted to be a midwife from the time I was three…I just wanted to help women have babies and that was always my focus. I think midwifery is not about having a career; it is about having a life-long passion and interest (Rosie, p4/24)*

A different idea was expressed by Norah, a midwifery group practice (MGP) midwife, who appeared to be motivated by a passion for learning. Working as an on-call MGP midwife also meant that her family would often have to cope with her sudden absences. She could be called to care for a woman in labor at any hour of the day or night so she wanted to acknowledge the support of her family in enabling her to work in what she described as an 'awesome' and 'amazing' profession:

> *The huge amount of study and the huge number of hours of work you do, totally immersing yourself into it and it was awesome and it was amazing. I do feel my family have given a lot to my profession as well (Norah, p6/24)*

Despite being in practice for more than 30 years, Spicer vividly recalled her time as a student nurse and her first exposure to pregnant women and their unborn babies. Spicer's motivation appears to be inspired by early experiences where she became 'enthralled' by being able to feel the baby moving inside the woman:

> *I used to regularly do clinics in the outpatient department* [while a student nurse]. *I used to be just enthralled by the pregnant women…I used to swap my clinic so that I could listen to what the obstetricians had to say…sometimes I would be able to touch their* [women's] *tummy, you know it was a wonderful experience just to be able to see the babies moving. (Spicer p4/26)*

Marigold was extremely articulate when speaking about her role as positively influencing longer-term outcomes for women and families and increasing their resilience:

> *…setting up women and dads and families to have good, strong emotional health and good relationships and strategies to fall back on when things aren't going well. (Marigold, p13/15)*

Marigold had a well-developed understanding of a strengths-based approach to working with families to build up resources to be used to cope with difficult times. She was also aware of the importance of well-supported early years for the development of longer-term health of children.

Theme 2 Discovery: Models of care

Four participants (Jemima, Norah, Marigold and Rosie) were practicing in MGP where continuity of care for women was the norm. Not surprisingly then, the issue of continuity of carer became a common theme with assertions that this model of care should be a woman's right and not a privilege that women must fight to get. Many participants who were not working in continuity of care models also spoke positively of the potential benefits of working in this way. Importantly, participants saw continuity of care as providing more time for consultations and relationship-building with women.

Despite working in a midwifery group practice and her strong interest in working in a way that would enable relationship-building with women, Jemima spoke of her early reluctance to take up the role:

> *I always liked the idea of working one-on-one with women doing that continuity of care…what held me back was not having confidence in my ability. I was always interested in that relationship-building instead of just meeting women; it made sense to me from very early in my midwifery career, women-centered care (Jemima, p14/15)*

One of the newer midwives, Charlotte, spoke of her very positive experience as a student where she was able to participate in continuity of care for one woman across all three years of her degree. This was probably a unique opportunity to see the way relationships can develop and be sustained across three childbearing experiences. As a result, Charlotte had a very clear understanding of the concept and she described it as an honor:

> *Part of their continuity experience was to follow them throughout their pregnancy, be on call for their birth and then follow up with them postnatally. And I had one woman who had a baby in all three years of my degree and I followed her for all three pregnancies. Yeah, that was amazing. It was an honour (Charlotte, p8/37)*

While Rochelle worked as a ward midwife, she also had experienced continuity of care as a student and made an astute observation about the differences in women's behavior and stance when in their own home. She noted changes in the balance of power when the setting changed from the institution to the home and she saw these as positive:

> *Continuity of care includes home visiting women – 'cos the women were completely different on the ward to what they were in their own homes – you are a guest in their home and the balance of power changes (Rochelle, p5/26)*

Charlotte clearly articulated her ideas about how continuity of care within midwifery group practice could best be constructed. She was also aware of evidence of the high satisfaction and improved outcomes for women who experience this model of care:

> *What I would like to see change in midwifery is having … a midwifery group practice, but for all women, not just for low-risk or high-risk women. If it was set up with … three people that would be great because they know that one of them would be at the birth as well, one of these three people. Continuity of care has better outcomes and women are most satisfied with their care, you know, all the flow-on effect and benefits of that. The women have less complications and they* [the women] *get home earlier (Charlotte, p7/37)*

Theme 3 Discovery: Clinical practice

The participants revealed how they use the opportunities that arise in daily clinical practice to have conversations with women about their mental health and other significant issues. A non-judgmental approach to women who revealed mental health issues was regarded as important. The following quotes illustrate this very clearly.

In recognizing that it is during everyday activities that women start to talk and don't feel threatened to speak about their concerns and feelings, Grace revealed a sophisticated understanding of the complexities of clinical practice:

> *The best conversations I have are when I am changing the beds because I can get them to open up, you know, how to get the answers you are looking for…After they have a rest or a shower: "Let's talk about this morning when you were feeling a little bit down. How are you? Is this something you expected at this period of time? Are you aware that your hormones can be fluctuating?", or knowing [whether] they [the women] are coming from a history of depression or anxiety… (Grace, p10/19)*

During her clinical practice Louise emphasized normalizing the woman's feelings with a focus on endeavouring not to make women feel judged or stigmatized. She understood the importance of providing reassurance and making sure the women knew where to get help:

> *I try to make women feel non-judged. Everyone has the right to their own feelings and not feel judged; we don't know the story behind them. They need to be reassured they haven't done anything wrong, they need to know where they can get help and they need to be comfortable speaking up about it. (Louise, p6/15)*

Rosie, on the other hand, saw herself as standing behind the woman to provide support in such a way that the mother and father can birth their baby together without the midwife's visible presence. Rosie saw this as a rewarding experience for her:

> *I often have a little chuckle when I hear core staff saying "… students, they take all* ***my*** *births". I would be happy if I never 'caught' another baby* [because] *if I can support a woman to the point that she births her own baby… they are the most rewarding ones, mum and dad birth their baby together and I am just standing there watching (Rosie, p9/24)*

Theme 4 Discovery: Education of midwives

Participants valued the opportunities they had to understand more about PND during their midwifery undergraduate or postgraduate education programs and subsequently in clinical practice and continuing education programs. Developing communication skills around the issue of PND appeared to be a strong component of their educational experiences.

As she had only been a midwife for two years, Rochelle was able to reflect on what she had recently learnt as a midwifery undergraduate about communicating with people experiencing mental illness:

> *Within the mental health subject, we did a lot of role-play, which I found was good, as they had brought in professional actors. We gained insight into how to communicate with people experiencing chronic or an acute mental health episode (Rochelle, p13/26)*

Jemima reported that she learnt new skills during her years of clinical practice rather than through her formal education to become a midwife. This may perhaps reflect the changing curriculum which previously neglected to include subjects addressing mental health and PND:

> … [we learnt in practice] *you can't force someone to accept a referral if they are declining to accept it. I keep an eye on them and tell them it is common…and refer them to their GP (Jemima, p13/15)*

Charlotte and Kaz both had a positive experience of continuing education and were very engaged with the opportunities available to them:

> *Continuing professional development is for a good reason and it comes with good intention and I am willing to do it* [attending lectures in her own time*] (Charlotte, p27/37)*
>
> *Any conference that comes through they* [private hospital employer] *put up on the board*

for everyone to see…I can attend any conference I want to …They [employer] *will pay for me to attend (Kaz, p11/11)*

Despite being a midwife for only two years, Grace revealed her wisdom when she shared an insightful account of how she mentors students and facilitates their learning about the importance of open channels of communication:

When I am working with students I say to them, "You have to open up channels of conversation – not attend to your paper work when you are with the mum" (Grace, p15/19)

Grace's identification of the importance of the need to *open channels of conversation* provides the students with a model of remembering to be 'in the moment' with the mother rather than attending to the often important but distracting work of documentation where important opportunities to identify maternal concerns and distress can be missed.

Theme 5 Discovery: Education of women

Another common theme identified in the analysis of transcripts was the often-voiced idea of providing women with information to educate them about PND and providing realistic expectations of mothering.

Both Rosie and Jemima recognized the importance of providing information to enable women to make decisions about themselves and their treatment options:

Providing women with information allows them to take ownership of what is happening to them and their baby. Telling her [the woman], *allowing her to make her decisions based on her context (Rosie, p8/24)*

Midwives educating women and giving them information, so they can make an informed choice about taking medication (Jemima, p9/15)

A focus for Rosie and Kas was providing women with information to help them understand that some expectations of motherhood and themselves as mothers may be unrealistic:

Helping women to change expectations about being a 'Super Mum' (Rosie, p10/24)

I think in the private system a lot of our clients are very well educated and they research a lot of things and so they kind set themselves up a bit for failure because they have these plans, you know, [but] nothing goes to plan, and they fall down very quickly (Kaz, 5/11)

Building on women's existing knowledge and strengths was an important consideration for Rosie who shared her understanding of the importance of treating women as adults using adult learning principles of co-production or co-design of interventions or strategies:

> *I think the most important thing with teaching* [women] *is to recognize them as adults. We are not teaching a class full of children but recognizing what they* [the women] *understand, where they sit in their lives and what they want to get from whatever they are learning, because not all knowledge is applicable to everybody (Rosie. P4/24)*

This first phase of the AI 4D cycle illustrated what the participants most valued about their work and identified what they felt they did well.

Dreaming

In this second phase of the 4D cycle, participants were encouraged to tell their stories of what they wanted the future to be, based on the 'miracle question'. Four themes were identified following analysis of the transcripts of the participant interviews. Dreaming themes included *mother-baby PND services* which revealed the common dream of an inpatient unit located in their LHD where mothers and babies would not be separated. This service would also encompass a midwifery-led PND service like the ACE team and a 24-hour telephone helpline.

The second theme echoed that of the Discovery phase theme of *continuity of midwifery care* for midwives to be *enabled to spend more time with women. Care in the community* was the third theme identified in the Dreaming phase of the 4D cycle. Finally, participants identified a theme for *midwives to be valued and well supported in order to provide the best care possible.*

These themes are illustrated below:

Theme 1 Dreaming: Mother-Baby PND services

A future where mother-baby PND services were provided in their local LHD was described in detail by many of the participants. This was influenced in part by the local experience of the ACE service in this LHD.

A strong preference for an inpatient unit where mothers with mental illness could be provided

with care in a facility where they could take their babies with them and not be separated from each other, was expressed by Louise and Kaz:

> *I would love a place where they* [women] *could go and get the support and be able to have their babies with them* [a Sydney based private mental health facility which has a mother-baby unit, the only one in NSW] *where you can go …and have all the programs. I would love something like that in this area for mothers and babies (Louise, p12/15)*
>
> *My magic wand would create a designated place for women and their babies to be reviewed and admitted if necessary (Kaz, p11/11)*

Louise in the first quote alludes to '*have[ing] all the programs'.* This suggests that the health system is not equitable in many areas of the state, with some mothers missing out on potential mental health/illness interventions and support.

Evelyn and Norah shared a dream that the ACE service model of care would be reinstated with Evelyn even expressing a wish to work in the ACE team to support women with PND:

> *…to be part of the ACE team* [the PND service that was available in the local LHD for many years] *and work antenatally with women and help them (Evelyn, p1/12).*
>
> This was echoed by Norah who said "*A service based on the ACE service model is ideal…" (Norah, p6/24)*

Kaz thought a locally-based 24-hour telephone helpline for the local region would be beneficial as it would be able to provide details of resources available close to women's homes:

> *A 24-hour help line similar to the … help-line* [a NSW Health affiliated and funded early parenting service] *but …a designated help-line for the* [local] *region (Kaz, p11/11)*

Theme 2 Dreaming: Continuity of Midwifery Care

While Jemima, Norah, Marigold and Rosie worked in a continuity of midwifery model of care, it is important to note that even midwives who did not, raised this as a dream in response to the 'miracle' question.

Evelyn wanted to emphasize the opportunities for the development of trusting relationships which can happen in a one-to-one, continuity of care model. She saw this as also easing the burden on the woman who would not have to repeat her story to different practitioners as is often required in the more fragmented models of care where a range of different care providers

operate in antenatal clinics and postnatal wards:

> *I think the main thing is continuity of care…may be a caseload sort of practice…so they* [women] *feel they have one person they feel they can trust and confide in and not have to go over their story repeatedly (Evelyn, p11/12)*

Sally focused on relieving the time pressure felt when working in the antenatal clinic which she thought would happen in a continuity of care model:

> … [in a] *continuity of care model, if you took two hours or one hour it would be up to you…you haven't got that pressure with someone coming behind (Sally, p5/7)*

Since she was an experienced midwifery group practice midwife, Jemima could see the potential benefits of continuity of midwifery care for women with PND but she also understood the importance of other resources that needed to be made available for women:

> *Women with perinatal depression should have continuity of care with their own care provider… I think… as well as all the services available for them… adequate services for them… good support…mothers and babies kept together, supportive home, supportive family (Jemima, p14/15)*

Dreaming Subtheme: Freedom to have as much time as needed

In the Dreaming phase, time was identified as an issue in relation to the continuity of midwifery care model in its own right.

Working in the antenatal clinic provided Sally with important insights about the time constraints experienced in antenatal visits. These are usually scheduled to take a maximum of 15 minutes in order to accommodate the numbers of women attending each clinic. Sally also mentioned that the required completion of the medical record at each visit impinged on the time available to spend with each woman. Her dream was to:

> [Remove] *time constraints, reduce paper work and not to have to work to such a tight timeframe* [during antenatal visits] *(Sally, p6/7)*

Charlotte wanted more time to provide information and to check that the women understood what was being shared. She felt rushed and wanted more time to cover all aspects of information-sharing:

> *…just being able to take the time, not rush, give thorough information to the women,*

explain what you are doing and why you're doing it and what to expect and what's going to come (Charlotte, p32/37)

Her experience of being a member of a MGP enabled Rosie to provide important insights about working in this way. She was of the view that "…having a chat over coffee…" is also clinical work and this needs adequate time to do well:

In continuity of care models…we can be sitting down having a chat over a coffee…and it doesn't have to be a fifteen-minute [visit] *and you can go over time, it's no big deal (Rosie, p24/24)*

Theme 3 Dreaming: Community-based care

A dream of community-based care was a particularly interesting theme raised by participants who were hospital-based clinicians as well as those working in midwifery group practices.

Throughout Australia midwives from the hospital provide daily visits to postnatal women and their babies in their homes, or telephone daily, for up to six weeks following discharge. This service is particularly important since women will only stay in hospital postnatally for 2-3 days. Following discharge from the postnatal maternity services at six weeks, women and their babies are referred to the Early Childhood Nurse (ECHN) in their local community for follow-up care. While many women take up this option for care, Spicer was concerned that some women are reluctant to go. She saw this as an issue to be addressed as she was very aware of the role the ECHN could play in identifying and supporting women with PND in particular:

I really want women to go to the ECHN. *I* [want to] *influence mothers to believe that the ECHN is important and find out why some mothers don't want to go and suggest solutions to those problems (Spicer, p23/26)*

Rather than simply referring women to the ECHN, Marigold shared her dream that midwives would work out of community health centers together with family doctors (called general practitioners in Australia) and possibly the ECHN as well. In this way Marigold considered care in the community could be better integrated:

I think midwives are better placed in the community in the primary health care setting…I think there is a huge opportunity for midwives to just move into the primary care setting and offer continuity…midwives to work out of the community health center which happens to be attached to GPs (Marigold, p11/15)

Community-based care of women in their own environment was also a dream for Rosie as she felt being in their own environment would enable women to retain a sense of control:

> *Rather than bringing women into* [hospital-based] *care I think it is important to put women into their own environment…it puts them in a position of feeling some sense of control (Rosie, p21/24)*

For Norah the option for women to have care or even to give birth in their own home was the next step in moving maternity care out of hospitals into the community:

> *Ultimately, I would like the ability to give women the option to be in their homes,* [even to birth] *if that is what they chose, would be fabulous (Norah, p1/24)*

Theme 4 Dreaming: Midwives to be valued and supported.

Almost all of the participants shared a dream of midwives being valued and supported. Valuing was seen as recognizing that midwives possess a range of skills and attributes that could benefit women. Participants identified that further education should be made available in key areas such as counselling and to increase skills in the area that is currently the role of the ECHN or the role of the Woman's Health practitioner.

Norah expressed her dream that midwives would be respected as valuable and skilled practitioners with already existing strengths and attributes:

> *Midwives valued, heard, their skills and strengths recognized and attributes respected (Norah, p21/24)*

Rochelle and Louise linked 'feeling valued' to being funded and supported to undertake more education generally and specifically in PND:

> *Midwives to be well-supported with funded and frequent educational opportunities (Rochelle, p20/26)*
>
> *More education for midwives on what actual perinatal depression is; supporting midwives with the skills and confidence to go in and deal with a woman who is crying and feels like the worst mother (Louise, p2/15)*

Further education to develop the role of the midwife into providing counselling for women with PND and their families was a dream shared by Evelyn and Marigold. Evelyn had personal

experience of mental illness and valued the skilled professional counselling which helped her recover. This experience inspired her to see this as a valuable skill that all midwives should have:

> *Midwives to have training in counselling (Evelyn, p11/12)*

Marigold was even more visionary and articulated a dream of midwives having a much broader scope of practice that would see midwives working with women and families beyond six weeks postnatally:

> *…the midwife role evolving into learning* [about] *child and family health* [and] *…midwifery training to enable more skills so midwives* [can then] *provide women and family health, sexual health, vaccination, counselling and child development* [information and assessment] *(Marigold, p11/15)*

Design

In this phase of the 4D cycle the participants were invited to consider how the health service could be designed to realize their dreams. This phase aims to build on examples of past successes and achievements so that the ideal is not totally unrealistic or un-achievable because it is grounded in existing organizational operational reality. Two Design themes were identified that reflected themes revealed in the Dreaming phase of the 4D cycle. These were *Supporting midwives* and *Promoting continuity of care*. Midwives from both the public and private sectors shared the same views and felt that these Design ideas were achievable in their settings.

Theme 1 Design: Supporting Midwives

The Design theme *Supporting midwives* revealed that participants felt strongly that midwives need to be well supported with funded and frequent PND educational opportunities and time to do their work well, as identified and articulated in the Dream phase of the 4D cycle. Participants regarded increasing support for midwives as a realistic design that their health service organizations could achieve.

Grace and Spicer worked in a private hospital where the care of women is led by the private obstetrician and carried out by the midwife. In some private hospital settings, the midwifery staff may have little input into antenatal assessments or identification of women experiencing PND. They must rely on the information provided by the private obstetrician. Grace considered that continuing education including a formal assessment qualification would enable midwives in the private sector to work as equal partners with the obstetricians because they could provide a perspective on the women's mental health that the obstetrician may not have observed:

*…pursue antenatal education so …that whilst … working with the obstetricians [*midwives can] *be an equal partner in providing a midwifery perspective to the women and …* [enrol] *in a Certificate 4 in Training and Assessment (Grace, p 17/19)*

Furthermore, Grace had a belief that midwives could make an impact in the private sector by learning more about PND so that they could ask the right questions of women:

… probe and don't shy away from asking the questions in the right circumstances. In the private sector we …can make an impact (Grace, p10/19)

Spicer regarded the limited face-to-face time with women during the antenatal period as an impediment to understanding women's past and present experience of mental wellbeing. Accordingly, she saw the provision of adequate time as a potentially achievable goal for her organization. She wanted students to be attached to midwives rather than working on their own and being responsible for provision of care, perhaps to increase opportunities for learning from more experienced clinicians:

Allocating adequate time for midwives to support and care for women and their babies with students attached to the midwives and not responsible for care provision … [as well as]… *improve the amount of face-to-face time midwives have with women (Spicer, p 24/26)*

Since Louise provides lectures about PND to midwives in her maternity unit, it is perhaps not surprising that she recommended even more education to increase midwives' comfort in dealing with women with PND:

…more education for midwives so they feel more comfortable dealing with PND (Louise, p6/15)

In the next quote Charlotte extends the need for more PND education to suggest it becomes part of a midwife's mandatory training. The critical issue of more time devoted to education is also raised.

…if that [lectures about PND] became part of your mandatory training it would be something that would be looked at a lot more…need to allocate some time…a day or two a year per person…cause we're doing it [in our] *role (Charlotte p 7/37)*

Theme 2 Design: Promoting Continuity of Care

Continuity of care was identified as a theme in the Dreaming phase of the 4D cycle, encompassing the ideas of increasing opportunities for trusting and supporting relationships to develop between women and midwives, increasing the amount of time available to provide information in a respectful and de-stigmatizing way and normalizing the experiences of women with PND, improving women's satisfaction with care and improving outcomes. In the Design phase this theme also became prominent as it was seen that health service organizations could realistically increase the provision of continuity of care models of practice so that more women could experience the benefits. Importantly, the promotion of continuity of care was a realistic Design in both the public and private sectors.

In the public hospital setting, Marigold saw continuity of care as enabling the building of resilience in families:

> *Continuity enables setting up women and dads and families to have good strong emotional health and good relationships and strategies to fall back on when things aren't going well (Marigold, p13/15)*

Charlotte would like to see all women given the opportunity for maternity care to be provided by a midwifery group practice:

> *I think the entire system needs a restructure…having a midwifery group practice…for all women, not just for high risk or low risk women…a team that look after complex women and someone that sees them through…a little team of midwives that kind of, you know, get 'recycled' in that person's care (Charlotte, p7/37)*

In the private hospital setting, Spicer saw a model of continuity of care with an obstetric and midwifery integrated care model as achievable:

> *Develop a model of care where obstetricians could employ their own midwife* [who would be] *their representative in the birthing suite with their patients (Spicer, p25/26)*

Destiny

The Destiny phase of the AI 4D cycle focuses on creating networks and structures which enable connections with peers to be formed, promoting egalitarian relationships and coming to "the table" as equals (Ludema et al., 2002) with the possibility of creating new ways of working. In this study, this phase of the 4D cycle was not completed as it was not possible to implement the

design articulated by the participants. In an AI inquiry that includes an action research approach, this phase would have been possible.

Skills and Attributes

The next section reflects on the taxonomy of skills and attributes needed by midwives working with women with PND, as revealed in the literature in Chapter 3. Further analysis was undertaken to determine whether these skills and attributes were apparent in the transcripts of the interviews with study participants. The taxonomy identified 17 skills and attributes that are listed in Table 3. Almost all the listed skills and attributes were revealed by the participants in this study as either aspects of the Discovery phase of the 4D AI cycle, or as aspects of the Dreaming or Design phases. The taxonomy is repeated here as Table 6 with quotes from the participants' transcripts illustrating each concept. These are further discussed in the next chapter.

Table 6: Skills and attributes revealed in the participant transcripts

Midwife Skills & Attributes	**Participant**	**Excerpt from Transcript**
Develops trusting relationships	Rosie	*I often have a little chuckle when I hear core staff saying "… students, they take all* ***my*** *births". I would be happy if I never 'caught' another baby* [because] *if I can support a woman to the point that she births her own baby… they are the most rewarding ones, mum and dad birth their baby together and I am just standing there watching. p9/24*
		Rosie is revealing trust in the woman to birth her baby herself with the apparent support of only her partner. This means that she trusts and is confident in the ability of the woman to birth without requiring the direct hands-on involvement of the midwife who can be unobtrusively present, watchful and available if needed. In this way the woman and her partner are supported to trust in their own abilities, knowing that support is there if needed. Rosie also reveals that she derives a feeling of reward in being able to work in this way, which requires a mutually trusting relationship between the woman and a highly skilled midwife. Rosie is also acknowledging the self-determination of women.
	Evelyn	*I think the main thing is continuity of care …so they* [women] *feel they have one person they feel they can trust and confide in and not have to go over their story repeatedly. p11/12*

Midwife Skills & Attributes	Participant	Excerpt from Transcript
		Evelyn saw trust developing in the context of continuity of care where women and midwives have an opportunity over time to develop authentic relationships.
	Sally	*As a midwife I consider it is an honor that women are willing to share and trust me with their personal information. P3/7*
		Sally feels strongly that the personal information the women share with her about their lives and their emotions and mental health or ill health requires a mutual trust between woman and midwife. She calls this trust an honor which recognizes its importance and power in her relationships with women and also reveals that Sally has respect and high regard for the women in her care.
	Jemima	*I was always interested in that relationship building instead of just meeting women; it made sense to me from very early in my midwifery career, women centered care. p6/15*
		Jemima's focus was on the development of relationships with women rather than the passing acquaintance that can occur in a busy maternity practice in order to have an opportunity to develop those relationships. Service where the midwife is present for a shift and may not see the woman again. Not surprisingly, Jemima had chosen to work in a continuity of care model of practice in order to have an opportunity to develop those relationships.
Empathy - the ability to understand and share the feelings of another	Louise	*My own personal experience motivates me and is important as early help has an impact…I like to be open about my own mental illness and I think it is important for society to be understanding and accepting of people with mental illness p6/15*
		Several participants expressed empathy with women experiencing PND. This may have been because of personal experiences with mental illness as was the case with Louise.
	Rochelle	*If I could help families at the very beginning, what sort of a positive impact could that have on their…parenting, their bonds with their children and their own mental health and wellbeing. P3/26*
		Rochelle witnessed domestic violence in her home (her father being the perpetrator). She strongly believed if families (parents) were given support and education at the beginning (time of conception) to address the problems, this may possibly have a major impact on the parental relationship, parenting, bonding with their children and may provide a protective factor for both parents' mental health. Rochelle did not address the importance of the fact that both parents need to be prepared to seek help.
	Evelyn	*I do feel I have a calm way and that maybe because of my own mental health I develop rapport and ask the right questions p3/11*

Midwife Skills & Attributes	Participant	Excerpt from Transcript
		Evelyn felt she was able to develop rapport with women and was able to ask the right questions. Development of rapport means that two people understand each other's feelings and communicate well. Rapport is synonymous with empathy. Her calmness also reflected empathy since calmness implies being free from agitation or strong emotion which, if present, could disrupt communication and the ability to develop an understanding of each other's feelings.
Communication skills	Grace	*… probe and don't shy away from asking the questions in the right circumstances. In the private sector we … can make an impact p10/19*
		Here Grace demonstrates her understanding of the importance of asking questions about mental wellbeing using contextual understanding: "the right circumstances" meaning when it's appropriate to do so. Her assertion that the midwife should "probe and don't shy away" suggests that she is aware that women may be reticent to reveal how they are truly feeling and that midwives may lack confidence. Grace is a confident communicator.
Respect - treats women as individuals	Rosie	*Providing women with information allows them to take ownership of what is happening to them and their baby. Telling her* [the woman], *allowing her to make her decisions based on her context. P6/24*
		Here Rosie has demonstrated that by providing women with information they are able to make their own decisions and in that way they are respected and treated as individuals.
Non-judgmental	Louise	*I try to make women feel non-judged. Everyone has the right to their own feelings and not feel judged; we don't know the story behind them. They need to be reassured they haven't done anything wrong, they need to know where they can get help and they need to be comfortable for speaking up about it. p7/15*
		Louise was very clear in her admonition that women should not feel judged because they have PND or are not feeling emotionally strong. Feeling judged may have been something that she had experienced herself when she was mentally unwell. She appears to understand that women may feel they are at fault for feeling emotionally or mentally unwell and may be reticent to ask for help. Louise wants women to feel comfortable asking for help.
	Norah	*Ultimately, I would like to be able to give women that option to birth in their own homes. p1/24*
		Norah's first delivery with group practice was an unplanned home birth, and the mother talked about it being the best birth. She was ecstatic. The mother was admitted to hospital for two hours and allowed to return home. Norah acknowledges this unplanned home birth gave her a greater understanding of why women opt for home birthing.
Able to de-stigmatize PND	Louise	*…I like to be open about my own mental illness and I think it is important for society to be understanding and accepting of people with mental illness. p3/15*

Midwife Skills & Attributes	Participant	Excerpt from Transcript
		Here Louise appears to go beyond her interactions with women in the perinatal period and wants the whole of society to be understanding and accepting of mental illness more generally. As a health professional being open about her own mental illness is one way to de-stigmatize PND.
	Rochelle	*But if you were feeling unwell with the flu…you would say "I don't feel so great today". We don't ever comment about our mental health. No, no, it stigmatizes it. p3/26*
		Rochelle recognizes society does not acknowledge mental health issues being openly discussed and society frowns upon open discussion of mental health – it is a taboo subject
Able to offer home visits	Rochelle	*Continuity of care includes home visiting women – 'cos the women were completely different on the ward to what they were in their own homes – you are a guest in their home and the balance of power changes. P5/26*
		Rochelle provided an important insight into the potential for care in the woman's own home to change the balance of power between health professional and 'consumer'. Being a guest in someone's home requires a non-dominant stance where one is invited to behave in a respectful way towards the host. This changes the balance of power and may enable the woman to feel more in control of her own destiny.
Knowledgeable re importance of breastfeeding support	While none of the midwives talked about the relationship between breastfeeding and PND prevention, all are experienced in providing such support. The one study (Madlala & Kassier, 2018) that identified a relationship between breastfeeding and the prevention of PND is very newly published in 2018 so is not likely to be common knowledge.	
Asks about past or present mental health- encourages woman to reveal emotions	Grace	*The best conversations I have are when I am changing the beds because I can get them to open up, you know how to get the answers you are looking for…After they have a rest or a shower "Let's talk about this morning when you were feeling a little bit down. How are you? Is this something you expected at this period of time? You know that your hormones can be fluctuating", or knowing [whether] they [the women] are coming from a history of depression or anxiety… (Grace, p15/19)*
		This is an example of a skilled midwife finding ways to encourage women to reveal their emotions in a non-threatening and non-judgmental way by seamlessly incorporating discussions of emotions into very normal activities such as making the bed.
Sees PND screening as the midwife's role	Sally	Screening for PND is an integral role of the midwife in this setting so it was
		taken as a given by all of the participants. However, many expressed the need for more time to be able to do this well. (p4/7)

Midwife Skills & Attributes	Participant	Excerpt from Transcript
Acknowledges self-determination of women	Rosie	*I think the most important thing with teaching* [women] *is to recognize them as adults. We are not teaching a class full of children but recognizing what they* [the women] *understand, where they sit in their lives and what they want to get from whatever they are learning, because not all knowledge is applicable to everybody*
		In this discussion of education for women about PND (p5/24), Rosie reveals her understanding of the importance of recognizing women as adults with life experiences that are part of their skill repertoire, developed outside of the health system. She regards it important to acknowledge that knowledge needs to be tailored to meet individual needs.
Able to provide support throughout pregnancy/birth/ postnatally and refer appropriately	Marigold	*Continuity enables setting up women and dads and families to have good strong emotional health and good relationships and strategies to fall back on when things aren't going well. p13/15*
		Marigold has a well-developed understanding of the potential benefits of continuity of care in supporting and strengthening the resilience of women, dads and families. She sees strong emotional health and relationships as key attributes for families to draw on in difficult times
	Jemima	*Women with perinatal depression should have continuity of care with their own care provider… I think… as well as all the services available for them… adequate services for them… good support…mothers and babies kept together, supportive home, supportive family. P14/15*
		Jemima wanted continuity of care for all women with PND as she saw this model of care as able to provide the kind of support women and families needed at this time. She was also aware that other services needed to be available to keep mothers and babies together.
Knowledge of PND and positive attitude towards PND	All the participants had a positive attitude towards PND and good knowledge of PND but in the Dreaming and Design phases of the interview midwives wanted more education in this area	
Works in a coordinated primary care service	Marigold	*I think midwives are better placed in the community in the primary health care setting…I think there is a huge opportunity for midwives to just move into the primary care setting and offer continuity…midwives to work out of the community health center which happens to be attached to GPs…the midwife role evolving into learning* [about] *child and family health* [and] *…midwifery training to enable more skills so midwives* [can then] *provide women and family health, sexual health, vaccination, counselling and child development* [information and assessment]. *P11/15*
		Marigold reflects the dream of many of the participants who spoke of midwives working in primary care settings and learning more about primary care for women and families to extend their role.

Midwife Skills & Attributes	Participant	Excerpt from Transcript
Has clear guidelines and referral pathways	Kaz	*…24-hour help line similar to a well-known help-line for mothers and babies but …a designated help- line for the* [local] *region. P11/11*
		This was an aspect of care for women with PND that participants identified as required for the future in their local LHD as reflected in the Dreaming phase by Kaz.
	Louise	*A mother baby unit in New South Wales, in Newcastle, Sydney and Dubbo and probably up the coast somewhere… (p8/15)*
		Louise herself experienced a crucial time after the birth of her first baby when she sought admission to a mental health unit for herself and baby.
		Unfortunately, this was not possible as her baby was 13 months old and could not be accepted into the mental health unit. Louise's experience is a very powerful one and continues to give her courage to fight for adequate maternal mental health residential services.
	Evelyn	*Continuity of care, a caseload practice where the women would see the same four midwives antenatally and in the birthing unit and be followed up in the postnatal period. This model of care would be good for women requiring admission to a mother/baby psychiatric unit (p11/12)*
		Evelyn identifies that women prefer to speak to a midwife about their mental health issues rather than the mental health team. Counselling training for midwives would be helpful.
Able to refer women following high EDPS score	Evelyn	*…to be part of the ACE team* [the PND service that was available in the local LHD for many years] *and work antenatally with women and help them (*p10/11)
		The dream for a PND service such as the ACE service where women could be referred was reflected in the interviews with two of the participants. Evelyn and Norah shared a dream that the ACE service model of care would be reinstated with Evelyn even expressing a wish to work in the ACE team to support women with PND.
	Kaz	*24-hour help line similar to a well- known helpline but …a designated help-line for the* [local] *region (Kaz). P 11/11*
		Kaz thought a locally-based 24-hour telephone helpline for the region would be beneficial as it would be able to provide details of resources available close to women's homes.

The taxonomy of skills was identified in the review of the literature. Its application to the analysis of the interview transcripts and themes that emerged during the analysis of the Discovery, Design and Dreaming phases of the interview has revealed that these skills and attributes are evidenced throughout the participant transcripts. The taxonomy is further discussed in the following chapter.

In the final section of this chapter two clinical practice vignettes have been selected from the transcripts to reveal the embedded knowledge and skills of the participants in a different way to the thematic analyses so far presented.

Knowledge of PND revealed in vignettes

Vignettes provide exemplars of clinical practice, illustrating the knowledge of PND as well as the skills and attributes required to support women appropriately. Analysis of the vignettes of clinical practice provided by Kaz and Spicer reveal their experiences with two women, both of whom delivered in the private sector and went on to develop mental health issues. These issues were first identified by the two midwives caring for these women. The obstetricians were made aware of the concerns expressed by the midwives.

Vignette one

> *I have seen probably two* [women who may have been developing a puerperal psychosis], *one we were very concerned* [about]…*I spoke to her mother when she was visiting to say that some of her daughter's responses appeared to be very inappropriate and she was having difficulty feeding* [the baby] …[Kaz wanted to check whether this was usual behavior]… *I had a lot to do with her and we got the obstetrician involved who didn't feel that she needed to see someone at the time but the mother spoke to him as well and he did* [ultimately] *get it* [understand the need for a referral to a mental health practitioner]. *We have an outside service where we can bring in a private psychologist or psychiatrist, who did come in and had a chat with her. She ended up, we found out later, [in]* [a private mental health facility], *without her baby.* (Kaz, p6/11)

This vignette illustrates several aspects of knowledge about PND. The first is that the midwife identified the woman's responses were inappropriate, meaning she could have been either a flat affect and not been responsive, or agitated or delusional or saying odd things. Asking further questions of the woman's mother demonstrated that the midwife understood how an early psychotic episode can start. She was appropriately checking the woman's usual behavior by discussing her responses with a close family member. The midwife also commented on the difficulties the woman was having with breastfeeding which may also have added to the woman's stress and potentially contributed to the development of mental illness in this situation. It was appropriate for the midwife to refer the woman to the obstetrician for an assessment and diagnosis or referral to another healthcare provider who could do this. Since the

obstetrician did not see the need for referral or consider that there was an issue to be addressed, it was important that the woman's mother raised her concerns. Having already spoken with Kaz, the woman's mother was able to express her concern about her daughter's behavior. Ultimately a referral to a psychiatrist occurred, which provides evidence of the appropriateness and effectiveness of Kaz's actions based on her observations and knowledge.

Vignette two

> *Interviewer: What would you watch for? What would indicate to you that you are a bit worried about this woman? What would make you think that?*
>
> *Spicer: I start to get worried when I am observing the interaction between the mother and the baby. That is the first place I start to see it. I ask how the baby has been feeding and the woman seems to be in a different world and you think there is something wrong with the connection here…[I] look at the notes a little bit further. Has anybody noticed that* [her behavior or interaction] *is a problem? [I] look a little bit more carefully, talk a little bit more, be there when the visitors are there, watching what is happening with the family.* [I ask myself] *is there a logical reason why this woman is reacting perhaps not the same as I would expect? …That would be the first* [sign]*, the interaction with the baby …I would then mention it to the obstetrician who may or may not respond …some of them might come out* [of the woman's room] *and they may discuss it with you, "Yes well um, yes she doesn't seem to be herself", or "Na, she has been like that the whole pregnancy"…and then you would feel good because it* [my concern for the woman's mental health based on what I have observed] *has been acknowledged….they have a referral to the early childhood nurse regardless of where they are. You might like to ask* [the woman] *'Do you have someone?' because some of them have had really good supports put in place before they have actually come to hospital (p11/24)*

In this vignette Spicer has demonstrated that she is a careful observer of women's behavior that might indicate a problematic interaction; she is aware of what behaviors one should have concern about. She observes the woman's interactions and behavior with her family. She appropriately checks her observation against the documentation made by her colleagues and reflects on possible explanations for the woman's behavior. Ultimately, she refers the woman to the appropriate agents such as her obstetrician and the child and family health nurse for ongoing care.

Summary of Chapter 4

This chapter has provided the analysis of the transcripts of interviews with the 12 participants; midwives working in both the public and private sector and in a range of roles, including four who worked in midwifery group practice where they provided continuity of midwifery care.

Three of the four phases of the 4D cycle were able to be addressed through interviews based on open dialogue and where participants were invited to tell stories about their experiences of working with women experiencing, or at risk of experiencing PND. The Discovery phase revealed five key themes describing the midwives' strengths including the importance of their personal motivation; models of care; how they used the opportunities provided in clinical practice to explore PND with women; the importance of their educational experiences and finally their experiences in educating women about PND in subtle ways. When invited to respond to the 'miracle question' in the Dreaming phase, the participants revealed the importance of four main themes which included the provision of specific Mother-Baby PND services; more time to spend with women which seemed to be easier to achieve in continuity of care models; an emphasis on the provision of care in the community; and a dream for midwives to be valued and well supported in order to provide the best care possible.

The two Design themes were: *Supporting Midwives* and *Promoting Continuity of Care*. Analysis of the transcripts in relation to the taxonomy of skills and attributes identified in the literature as essential for healthcare workers demonstrated many skills considered essential for the provision of effective care for women with or at risk of PND. Almost all the 17 skills and attributes were able to be identified in the interviews with the 12 midwives. Finally, two vignettes of clinical practice were analyzed identifying the knowledge underpinning the skills and attributes identified. These findings are further discussed in the following chapter.

CHAPTER 5: DISCUSSION

This research aimed to investigate and make visible the confidence, knowledge and skills of midwives in identifying and supporting women with PND using the lens of Appreciative Inquiry (Cooperrider & Whitney, 1999).

The findings detailed in the previous chapter are further discussed in this chapter. This discussion provides an opportunity to reflect on whether the study was able to fulfil the research objectives:

1. to interview a purposive sample of midwives to explore their understanding, knowledge and skills pertaining to women with PND, using an AI lens,
2. to explore midwives' opportunities to practice and expand evidence-based care for women with PND and
3. to inform the enhancement of PND education for midwives

Secondly the discussion will explore whether the research was able to provide an answer to the two research questions:

1. What knowledge and skill do midwives bring to caring for women with PND? and
2. How does this specialized knowledge and skill inform midwives' role in supporting women with PND?

Reflections on the research process are provided to reveal the learning that took place throughout the process and to reflect on how others might use these insights to enhance their own studies using the 4D Appreciative Inquiry approach to research.

The chapter begins with Section One reflecting on the first objective of the study which was to interview a purposive sample of midwives to explore their understanding, knowledge and skills pertaining to women with PND, using an AI lens. In this section a discussion on the process of recruitment of participants and the interview process is presented revealing that the first objective was well met. The second objective of exploring midwives' opportunities to practice and expand evidence-based care for women is revealed in Section Two which contains the discussion of the findings of the study. Evidence from the themes identified in the Discovery, Dreaming and Design phases of the interviews is presented in relation to the taxonomy of skills and attributes required of health professionals to work effectively with women with PND. The analysis revealed that participants possessed a wealth of knowledge and skill in relation to the provision of midwifery care for women with or at risk of PND, thus answering the first question

posed in this study. The discussion focuses on two particular attributes and related skills revealed by the participants: the first considers the importance of empathy and associated attributes, and the second considers the importance of the model of care available for women or' in the words of the AI approach, the model of care the participants *dreamed of* and *designed* as having the best potential to meet women's needs.

Section One: Interviewing a Purposive Sample of Midwives

Reflections on the process of recruitment

Recruiting a purposive sample of midwives to the study was relatively easy following a presentation of the research project to groups of midwives in each of the three hospitals. Midwives soon contacted the researcher and were enthusiastic about sharing their stories of caring for women with, or at risk of, PND. This perhaps reflected the finding that at least five of the 12 participants had experienced PND, domestic violence or mental ill health themselves or within their families and wanted to share valuable insights they had gained. Additionally, midwives working in antenatal services in all public hospitals throughout NSW are required to administer the EDS to every woman at booking as well as enquiring about past and present mental health, and the experience of domestic violence. Postnatally, midwives are required to again administer the EDS to all women. These processes aim to identify any woman who may score above a threshold on the EDS or who identifies previous mental illness or domestic violence. Identification is meant to be followed by referral to mental health review (if the woman is agreeable), although in many settings this is not well done since there are no services to whom the woman can be referred. The result of the universal screening and identification process, however, means that all midwives are aware of the potential for PND. This may have increased interest in participating in the study. The same requirement to screen and identify women with, or at risk of, PND is not yet established practice in private hospital settings, so it was encouraging to find that three midwives from this setting volunteered to take part in the study. The recruitment process resulted in a diverse mix of participants from all three settings who contributed a range of perspectives on PND and their experience of conducting a psychosocial assessment.

Conducting interviews informed by the 4D AI approach

Using the 4D AI approach to interview the participants was an illuminating process. It provided boundaries for questions and responses as it made both the interviewer and the participant

focus on the positive aspects of practice. The participants appeared to be comfortable with the interview setting and unhurried in their responses and not intimidated by the interviewer or the presence of an audio recorder. Some of the interviews lasted more than an hour as participants enthusiastically reflected on past experiences and learnings during the Discovery phase of the interviews and took time to carefully consider the possibilities for how PND services could be idealistically and then realistically improved in the Dreaming and Design phases respectively. Other interviews lasted longer than two hours due to the engagement of the participant in retelling and reflecting on stories of practice.

Section Two: The knowledge and skills midwives bring to caring for women with PND

Findings from this research build on previous literature, which suggests that midwife-woman relationships are important for women's experiences of maternity care, pregnancy outcomes and staff satisfaction (Armstrong & Small, 2010). This research has also contributed new knowledge of the rich repertoire of skills and attributes in relation to women with PND that the participants in this study possessed, which may be reflective of midwives more generally. Rather than revealing skill deficits as the literature suggests (Fenwick, Gamble et al., 2012), these participants were highly skilled clinicians. Participants revealed that relationships were of paramount importance in their approach to the care of women with or at risk of developing perinatal depression (PND). Developing a relationship with women in their care enabled empathic interactions, which assisted with the identification of women in need of support and referral and provided insights into what kind of support women might need. Skills include being knowledgeable about PND, having a positive attitude towards PND, and the ability to de-stigmatize PND and to normalize mood changes and mental ill health as an acceptable part of the human condition. Understanding the EDS as part of a universal screening approach to PND which includes asking about past and present mental health and encouraging women to talk about their feelings/emotions was also part of the skill repertoire identified in the literature. Analysis of the participant interviews revealed that all these skills were evident to varying degrees (Table 8).

Empathy

Empathy is a complex behavioral state encompassing the ability to understand and share the feelings of another (Armstrong & Small, 2010). Several attributes may contribute to the expression of empathy as identified in the evidence-based taxonomy of skills and attributes in

Table 2. These include the development of trusting relationships, being able to communicate well, treating women and their families with respect, and a non-judgmental attitude.

Theme 1 of the Discovery phase (*personal motivation*) revealed that several of the midwives had personally experienced either perinatal depression or general depression or had family members so affected. These experiences appear to have resulted in the development of empathy for women with PND and the motivation to provide skilled, respectful and non-judgmental care (Higgins et al., 2012) where women were treated as individuals (Henderson et al., 2018) and were not stigmatized (Bilszta et al., 2010; Schmeid et al., 2013; Phillips, 2013).

Empathy also assisted the midwives to develop finely tuned communication skills (McCauley et al., 2011) with women as revealed in many of the stories shared during their interviews.

Encouraging women to disclose and discuss their emotional health issues (Armstrong and Small, 2010) was at the forefront of their clinical bedside interactions with women.

Developing trusting relationships

Building strong, trusting relationships with women was revealed in the literature as an "…essential basis for therapeutic interventions and services" (Myors, Schmeid, et al., 2014, pp7) as well as being aware that women will be alert to any criticism or surveillance (Rollans, et al., 2013). This attribute was well demonstrated by all the participants as revealed in Table 6.

Model of Care

The second key finding of this study is that the participants were unified in their understanding of the importance of a continuity of midwifery model of care as being best able to provide all women with the support they need in relation to mental wellbeing. Their knowledge and skills in caring for women with PND, or identification of women at risk of PND, led them to dream of and design a maternity care system that would increase opportunities for women to receive continuity of midwifery care, particularly integrated with primary-care services located in the community. This finding answers the second question posed at the outset of this study: How does this specialized knowledge and skill inform midwives' role in supporting women with or at risk of PND? Participants saw that midwives in continuity of care models were more easily able to develop ongoing and authentic relationships with women, relationships that were facilitated by opportunities to provide care and support in women's homes where the power relationships were different to those in hospital-based services. Participants were also united in their understanding that the continuity of care model would enable more time to be available to provide the care that women need. Improved integration of care was an important future

development of services where seamless transfer of women from the maternity services into child and family health could occur or where midwives' roles could be expanded through education into being able to provide more women's health and early childhood services. The evidence revealed in the taxonomy in Table 8 supports the participants' dreams and their co-design for a maternity care system that included a local mother-baby unit in the community and more local resources for women with PND.

Barriers to implementing the system

While an AI approach aims to elicit positive responses, barriers to the implementation of the ideas and desires of the dreaming phase are evident. These barriers included a lack of time for authentic antenatal consultations, a lack of time allocated for continuing professional education, the need to document while trying to engage with the woman, a lack of equity of services for maternal mental health support and interventions, timely handover to the child and family health universal services, and the greater recognition of the knowledge and skills of the midwife. Women who birth within the private hospital system are significantly disadvantaged if their obstetrician does not conduct or know how to conduct psychosocial assessment.

Lack of Time

The participants identified that rushed antenatal visits were a major impediment to providing the best care possible for women as it takes more than a 15minute consultation to start to develop a relationship with a woman and this is necessary for trust to emerge. Without a trusting and authentic relationship, women may feel unwilling to share their emotions for fear of judgement and negative consequences such as referrals to Family and Community Services. The 15-minute antenatal conversation also precludes careful information-sharing with women and the opportunity to check the woman's understanding. The lack of time prevented the participants from working to their full scope of practice and they felt frustrated and under-valued when having to work to rushed timeframes. Their calls for more time to be made available were motivated by concern for the women whom they felt would benefit from better quality care. Therefore, one of the recommendations arising from this study is that there needs to be a consideration of how more time can be made available in antenatal care. Solutions may lie in two other themes from the Dreaming and Design phases of the study.

Continuity of midwifery care

The dream and design were for increased opportunities for women to access continuity of midwifery care where there was ample time for the development of mutually trusting relationships and time for the sharing of information. Importantly the Design was for the possibility of providing this model of care in the woman's own home where she is more likely to feel at ease and in charge of the conversations. Only a small proportion of the birthing population of women in NSW currently has access to this model of care. Since up to 25% of women may experience PND (McCauley et al., 2011), it is important to expand the model at each LHD. Another option may be to re-introduce the ACE model of care previously offered in this LHD. Here women saw the same midwife who became her case manager throughout her pregnancy and postnatal experience up to six months postpartum. Visits were provided in the woman's own home together with regular contact with the woman's general practitioner and her Child and Family Health Nurse.

Lack of resources for women with PND

Participants all indicated that the lack of adequate resources for women with PND in their LHD also prevented them from working to their full scope of practice. The Design phase included the establishment of a mother-baby inpatient unit where women who were unwell could be cared for without having to be separated from their baby. The design also included other resources to which women could be referred including the reinstatement of the ACE service.

Limitations of the study

As previously stated, the fourth phase of an AI approach, Destiny, was not possible to complete using this study design and within the time available to complete a Master's thesis. Providing recommendations for practice and policy change, however, should support future improvements to the care of women and families.

A further limitation is that this is a qualitative study with a purposive sample of 12 midwife participants, so the findings are applicable only to those midwives and not generalizable to all midwives. It may have been that their personal experiences of mental illness or domestic violence provided them with a positive approach towards women with similar experiences. This may have also influenced their willingness to participate in the research.

The predominant focus on PND rather than the entire psychosocial assessment undertaken by midwives antenatally can be also viewed as a limitation of the study since the psychosocial assessment mandated by the Ministry of Health is much broader in scope than PND alone. Future research in this area should encompass the entire psychosocial assessment.

Personal reflections on the research process

As the researcher I learnt a great deal about midwives' knowledge and skills. I think the participants are an incredibly caring, supportive group of midwives who wanted the best for the women they cared for and whatever the outcomes were for those women I was confident the participants in my study would provide excellent supportive, non-judgmental, empathetic, expert care.

I discovered how flexible the participants were in terms of visiting women at home. One vignette reflected on by a participant who was an MGP midwife (Jemima) marveled that this model of care enabled the midwife to meet the woman where and as she needed, rather than requiring the woman to adapt to the system timetable. Continuity of care appears to be the most effective model possible for the care of all women but particularly for those at risk of or with PND. Its benefits include the possibility of home visits as well as the development of empathetic, relationship-based, respectful care that women find reassuring, empowering and a great source of comfort. Strong personal relationships develop over the course of the woman's childbearing experience and midwives felt part of the intergenerational community support network for women.

I felt it was a privilege to be part of the midwives' lives and grateful that they felt comfortable talking with me and sharing stories about their work and their experiences and insights. Their involvement could have been superficial, but they didn't appear to hold back. The participants provided open, empathic, forthright, insightful responses. It made me think if I was having a baby now I would prefer a midwifery-led model of care rather than obstetric-led, however I didn't talk with obstetricians for this study so maybe a different perspective is yet to be discovered from them.

The AI 4D model made a lot of sense in that focus on the positive perspective gets participants thinking in a particular way. I felt confident that I had a theoretical underpinning to guide my interview questions which kept me focused on my research questions and objectives. I was

pleased to have discovered a paper that revealed the model doesn't always work as sometimes change cannot happen, hence I didn't feel complete responsibility for making changes or raising people's expectations that change was possible. A stance using the positive approach is what I normally take in life so this fit with my schema of the world; this was a congruent method to use. I wondered if maybe I had attracted a group of participants who were positively oriented in the first place to share positive stories. The AI model was a totally new concept for the participants (and the researcher) and this spiked our interest.

What did I learn about being a researcher?

Interviewing is enjoyable/pleasurable because I am a very social person and like to share stories. I like to meet people who may have different views and experiences from mine. In transcribing the interviews, I sometimes realized I had missed opportunities to further explore issues raised. I needed to remember that I was conducting an interview and not offering solutions to issues raised.

The one thing I am left with is a sense of responsibility to the participants to give them some feedback when I finish all of this, perhaps a standard letter to all since perhaps one of the frustrations of participating in research maybe that you don't get to find out the results of the research and what role ultimately do the results play. I am now more willing to participate in others' research as I can more clearly see the potential benefits for society.

Recommendations for further research

A major finding of this research was that all the participants agreed that continuity of midwifery care for women with or at risk of PND was the preferred model of care. Future research needs to establish whether this model of care is indeed effective in identifying women appropriately and can it contribute to the improvements of maternal mental health outcomes.

A further recommendation for future research is that each component of the psychosocial assessment process described in Table 1 needs to be examined individually to determine which of the components has the strongest predictive value for mental illness.

An important aspect of further research is to explore the impact on women of the way the first booking visit psychosocial assessment is currently performed. The imposition on the midwife of having to focus on data entry into a computer during an intensely private, potentially challenging

and distressing interview with women and their companions needs to be evaluated from the perspective of all parties.

Recommendations for facilitating the work of midwives in supporting maternal mental health

The following section provides a list of the recommendations arising from this research to facilitate the work of midwives in this area. Recommendations include:

- Continuity of care as the preferred model for all women
- Care based in the community rather than totally hospital-based
- More time for psychosocial assessment at the first antenatal visit plus for ongoing antenatal visits so that the woman's progress can be monitored and further assistance provided if required
- Improved automated record-keeping system so that midwives do not have to focus on data entry into a computer during antenatal consultations with women, and particularly during the initial psychosocial assessment and screening for PND
- Seamless transition to perinatal mental health resources/referrals to existing programs
- Seamless transition to Child and Family Health Nurse with access provided during pregnancy for the CFHN
- Respect for midwives' ability to work with women with perinatal mental health issues. A major gap in the literature reviewed was the absence of studies investigating a specific role for midwives to endorse maternal mental health well-being and midwifery-led programs for women experiencing mental health issues.
- More education to be provided on the comprehensive psychosocial assessment which encompasses PND.
    - Education to be completed as part of the mandatory education required in all public hospital maternity settings using dynamic teaching/learning techniques
    - Education to be provided in private hospital settings for all maternity health providers
    - Education to be provided in public hospitals with less than 1000 births per annum (which are currently precluded from having to complete the mandatory perinatal psychosocial assessment)
- Resources to be made available in the local community to improve equity across all LHDs including:

- Mother-baby inpatient unit so that women with mental health issues and their babies could be cared for together as a family unit
- 24-hour telephone helpline with detailed information re local resources rather than a state-wide helpline

CONCLUSION

Despite what the literature suggests about midwives' need for further education in perinatal mental health, the participants in this study were knowledgeable and well informed about PND.

It should be acknowledged however that some participants failed to recognize these skills and called for more education about PND in order to feel more competent and prepared. Although there is no current evidence to support specific midwifery-led interventions that can be recommended, the skills revealed by the participants in this study (Table 6) were those identified in the literature as required for effective care (Table 2). These skills and personal attributes included ability to develop trusting relationships, empathy, having good communication skills (including understanding opportunities for gentle probing questions and attentive listening), respecting women and treating them as individuals, being non-judgmental, being able to de-stigmatize PND, asking women about past or present mental health, encouraging women to reveal their emotions, seeing PND screening as the midwife's role, acknowledging the importance of the self-determination of women, knowledge of PND and positive attitudes towards women with PND.

The participants also identified system issues that prevent them from working to their full scope of practice and providing wholistic care for women with mental health issues. The participants wanted to be able to provide support throughout pregnancy and birth as well as postnatally and to be able to offer home visits, leading to a major finding of this study - a call for continuity of midwifery care for all women with mental health issues.

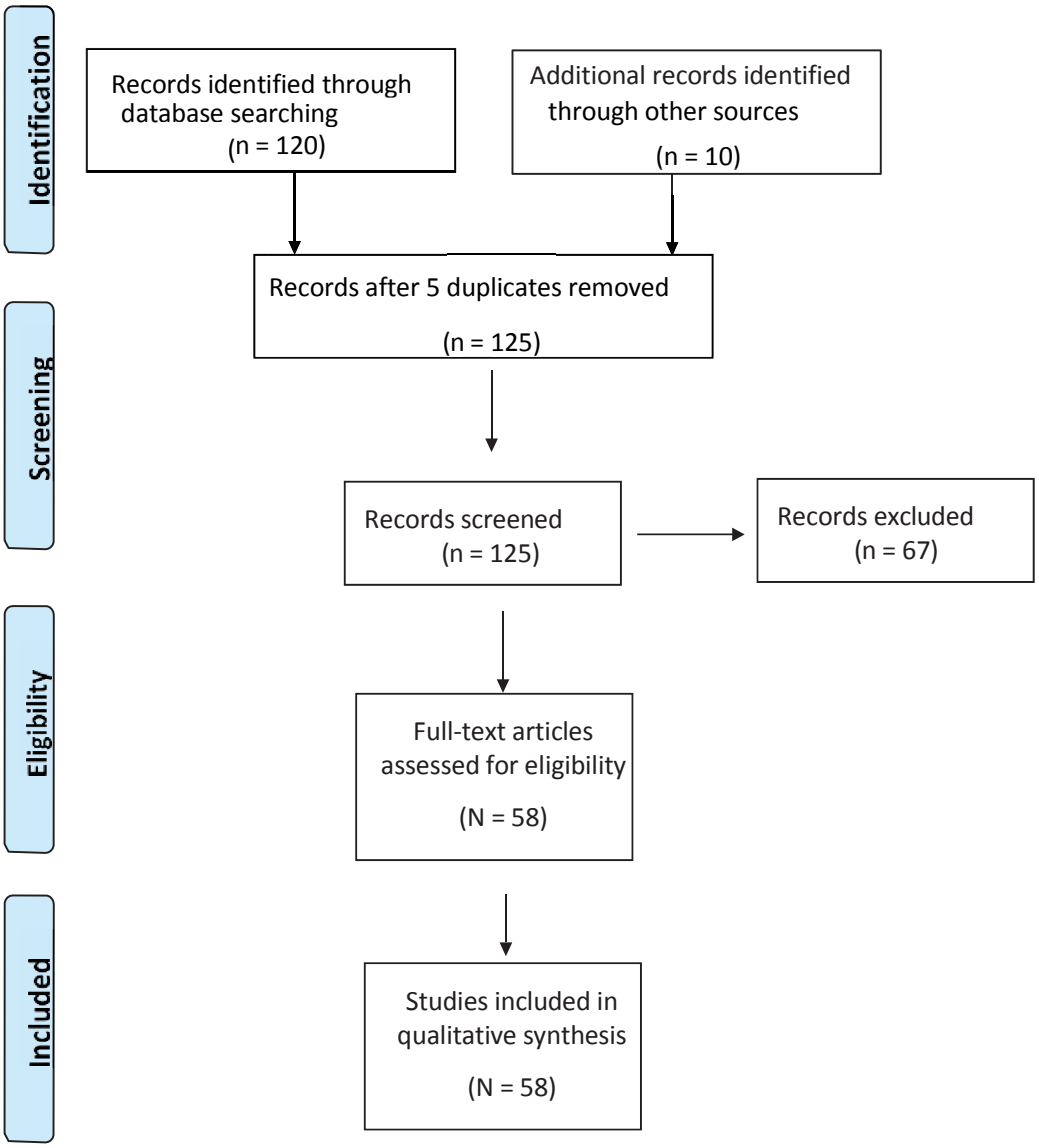
The second major finding was the lack of local referral networks in the local health district, identified by the participants as a major resourcing need in order to have clear guidelines and pathways for women with mental health issues and/or high EDS score. A coordinated primary care service was seen as an ideal model as well as a local mother-baby inpatient unit and a local 24hour telephone helpline. While a recommendation for further education was made, this may have been a result of a lack of confidence in their own skills rather than reflecting a lack of knowledge in this area of clinical practice.

This study has contributed knowledge about midwives' valued role in supporting women with perinatal mental health issues, particularly in the area of PND. System issues are the major barrier to midwives operating to their full scope of practice. Maternity care professionals have

a major role to play in the perinatal period, since regular enquiries about emotional wellbeing provide a woman with opportunities to disclose how she is managing while her responses allow health professionals to determine whether assessment or referral is indicated. This is an important role for the midwife.

APPENDICES

Appendix 1: Figure 3: Prisma Flow Diagram of Literature Search 2003-2018



Appendix 2: Table 7: Studies included in the review of literature (2003-2018)

Author, Date Country	Question Intervention	Study Design & Methods	Population/ Sample	Findings	Limitations
Alderice et al 2013, Ireland	Interventions to improve maternal mental health and wellbeing	Systematic review	32 systematic reviews	Lack of reviews exploring an explicit midwifery role in maternal health and wellbeing during pregnancy. Gap in the literature identified	
Austin, Priest et al, 2008, Australia	To assess the efficacy of antenatal psychosocial assessment on perinatal mental health morbidity	Systematic review	2 RCTs: 600 women drawn from 60 health services	Unable to assess efficacy of antenatal psychosocial assessment in public health settings	More studies needed
Armstrong, Small 2010, Australia	To determine rural women's views on screening for PND	Mixed methods Postal survey In-depth interviews	230 women surveyed, 20 women in- depth interviews	Survey 62% response rate Detection of PND requires more than administration of a screening tool on one occasion; opportunity to disclose emotional health issue with trained and empathic healthcare provider may lead to better outcomes	
Austin, Reilly et al 2013, Australia	To describe the process undertaken to develop the Australian Clinical Practice Guidelines for Depression and related disorders in the perinatal period.	Literature review	Grading of evidence to underpin development of guidelines	Clinical practice guidelines developed and introduced for professionals caring for women in the perinatal period	Largely consensus based rather than evidence based

Author, Date Country	Question Intervention	Study Design & Methods	Population/ Sample	Findings	Limitations
Centre of Perinatal Excellence (COPE) 2017 Australia	Mental health clinical practice guideline	Guideline	Australian Mental Health Guidelines	Recommends universal screening of all pregnant women in Australia	
Austin M-P 2003, Australia	To determine the efficacy of Antenatal screening with the aim of predicting PND	Mixed methods	165 pregnant women	During third trimester of pregnancy prevalence rates of increased EDS is similar to those in the first few weeks postpartum. 40% women with elevated EDS postnatally also had elevated scores antenatally. Clinically there is no evidence that PND exists as a distinct entity that differs from non- postnatal depression.	Further research required
Austin 2014 Australia	Marce Society position statement on screening for perinatal mental health	Position statement		Recommends perinatal mental health screening plus adequate skills training and clinical supervision of those doing the screening	

Author, Date Country	Question Intervention	Study Design & Methods	Population/ Sample	Findings	Limitations
Bick 2003, UK	Strategies to reduce psychological morbidity. This paper summarizes the outcomes of studies that have evaluated interventions provided by midwives	Literature review	12 studies	Significant benefits to postnatal psychological well- being following the introduction of new models of midwifery led care. Further evidence needed to inform how midwifery care can be provided to all women throughout their pregnancy to ensure early detection and management of postnatal psychological morbidity Educational interventions, including those tailored for women deemed more vulnerable to depression have shown limited evidence of benefit and further research in this area is needed	
Biliszta et al 2010 Australia	To explore women's experience of postnatal depression, and determine whether beliefs and attitudes are barriers to women seeking care	Qualitative study Focus Groups	40 postnatal women with PND receiving community based care	Need for women and families to have greater understanding of and recognise PND Health professionals need to be aware of the personal and societal attitudes impacting on women from acknowledging their distress	
Banti et al., 2011 Italy & Pittsburgh	To estimate the prevalence, incidence, recurrence and the new onset of minor and major depression using the Diagnostic and Statistical Manual of Mental Disorders, Fourth edition	Longitudinal study	1660 pregnant women from an unselected population of women recruited at the third month of pregnancy and followed up until the 12th month postpartum	32 (7.3%) had their first episode of depression in the perinatal period whilst 1.6% had a new onset of depression during pregnancy and 5.7% of women in the postpartum period. PND prevalence lower than usually reported	

Author, Date Country	Question Intervention	Study Design & Methods	Population/ Sample	Findings	Limitations
Brown et al 2009, UK	To evaluate practitioners' knowledge of women's needs and available services	Mixed methods Focus groups, Survey, Referral documentation review	Focus Groups 50 RMs 18 second year student midwives Questionnaire to 74 midwives, 19 students, 30 health visitors and 22 obstetricians	Response rates for survey 46- 62%. All expressed dissatisfaction with the availability of clinical training to support their knowledge in this area and lack of clear pathways for care	
Clarke et al 2014, UK	To explore whether non-pharmacological interventions delivered by non-mental health specialists play a role in treating common perinatal mental health disorders?	Systematic review & meta analysis	10 trials 18738 participants	Psychosocial interventions delivered by non-specialists are beneficial. High quality study	
Dennis, Dowswell 2013, USA	To assess effect of diverse psychosocial interventions compared with usual care to reduce the risk of developing postpartum depression	Systematic review	28 RCTS, 17,000 women participants	Women who received a psychosocial or psychological intervention significantly less likely to develop postpartum depression. Possible interventions include, intensive professionally-based postpartum home visits, telephone - based support and interpersonal psychotherapy. Qualitative studies reveal women from diverse cultural back-grounds worry about maternal competence, role conflicts and inability to cope. Articulation of what women identified as their needs did not occur	

Author, Date Country	Question Intervention	Study Design & Methods	Population/ Sample	Findings	Limitations
Dennis, Ross et al 2010, UK	To assess the effects on mothers and their families of psychosocial and psychological interventions compared to usual care	Systematic Review	1 trial with 38 antenatal women	Evidence is inconclusive to allow authors to make any recommendations for interpersonal psychotherapy for treatment of antenatal depression	More research needed
Fenwick, Gamble et al, 2013, Australia	To describe the perceptions of women participating in a study testing the effectiveness of a perinatal emotional support intervention (PRIME) for women identified as experiencing emotional distress after birth	Qualitative descriptive study Semi structured telephone interviews at 12 months post partum	Convenience sample 33 women 16 - PRIME 12- Parenting support 5 – Standard Care	Promoting reflection and feeling cared for were phrases used by all participants regardless of group allocation PRIME women reported getting in touch with their feelings and moving on as beneficial outcomes. 2 women said some things left unresolved 2 women found this was not not hugely helpful or needed	Convenience sample of women may not reflect all women
Fisher et al 2012, Australia	To investigate the implementation of Australia's National Perinatal Depression Initiative (NPDI)	Survey	14/30 women from Australian Women's Healthcare Australasia completed the survey (46.6%)	Implementation of the NPDI does not occur in all Australian maternity units. Little is known about screening practices in the private hospitals or hospitals with less than 1000 births	Small sample not representative of all women or services
Glavin, Leahy-Warren, 2013, Norway and Ireland	Discussion of concept of PND prevalence and outcomes in two countries where PHN practice-exploring benefits of social support for new mothers	Opinion piece	Focussed on Public Health Nurse and Primary Care for women in the community	Promoting the role of PHN in an integrated model of primary health care for women with PND	Opinion piece

Author, Date Country	Question Intervention	Study Design & Methods	Population/ Sample	Findings	Limitations
Gureje et al., 2015, Nigeria	To test the effectiveness of a stepped care intervention package for women with PND delivered by community midwives in primary maternal care.	A two-arm parallel cluster randomised controlled trial	686 pregnant women between 16-28 weeks gestation with an EDS score > 12	Primary outcome was women had recovered from PND at 6 months with an EDS<6. Secondary outcomes included measures of disability, parenting skills, maternal attitudes, health care utilization and infant physical and cognitive development using the Bayley's Scale.	Participant recruitment was slower than anticipated extra recruitment was required, but did not reach the desired number of recruits (only 90 recruited).
Hauck et al 2015, Australia	To explore midwives' knowledge of and attitudes towards mental health disorders in childbearing women and their perceived mental health learning needs.	Cross sectional study to explore the perceived perinatal mental health learning needs of midwives	238 midwives employed in a public maternity hospital. 50.1% of midwives participated	95% of participating midwives reported sometimes having frequent contact with childbearing women with a mental health disorder. Less than a quarter of midwives had previous experience in mental health. Nearly half the midwives had attended an education session on perinatal mental health within the last 2 years. 87% of midwives agreed it was within their role to assess the mental health status of women within their care.	Staff have negative attitudes due to lack of skills and training in regard to mental health
Hewitt & Gilbody 2009, UK	To evaluate clinical and cost effectiveness of antenatal and postnatal identification of depressive symptoms	Systematic Review	Meta analysis of 5 studies (included 12,810 women)	No systematic review or meta- analysis has critically appraised currently available data to establish whether the routine methods to identify PND are clinically cost- effective	

Author, Date Country	Question Intervention	Study Design & Methods	Population/ Sample	Findings	Limitations
Henderson et al 2018, United Kingdom	To describe the care received by women self-identifying with mental health problems in pregnancy and to describe the effects of support, advice and treatment outcomes in the postnatal period.	Cross-sectional survey - data collected in 2014 was used to describe women's experience of maternity care	4578 women responded to the survey (47% response rate) Participants were students under- taking a 4-year undergraduate direct entry midwifery degree	Women with antenatal mental health problems significantly more worried at the prospect of labour and birth, had lower satisfaction with their birth experience, worse postnatal mental health and indications of poorer attachment to their baby. They received more care than other women, but did not always view this positively. Support, advice and treatment for mental health problems had mixed effects.	Health care professionals may need additional training to effectively support women with mental health problems during the perinatal period
Higgins et al 2016, Ireland	To examine the impact of the perinatal mental health module on student midwives' knowledge, skills and attitudes when addressing mental health issues with women	Pre-module and post- module surveys	Participants were students under- taking a 4-year undergraduate direct entry midwifery degree program. The pre- survey had 28 participants and post-survey had 26 participants and 25 matched pairs	Comparison of the pre and post measures, based on paired samples t-tests, showed the program statistically increased participants' knowledge and skills. Students self-reported even more positive attitudes following the course. Written feedback by students also reported these positive feelings.	

Author, Date Country	Question Intervention	Study Design & Methods	Population/ Sample	Findings	Limitations
Higgins et al 2012, Ireland	To determine student midwives' satisfaction with an education module on the provision of emotional support to women during pregnancy, birth and the postnatal period	Mixed Methods Surveys Quantitative data were analysed using descriptive statistics.	105 students completed the module and 79 students returned evaluation surveys = 75% response rate	Overall students reported their satisfaction with the module as high, with more than 85% of the students agreeing that the module was very interesting, valuable and relevant to their clinical practice. Students were well able to conduct timely and appropriate mental health assessments	
Highet et al., 2014 Australia	To explore women's lived experience of postnatal depression and anxiety	Grounded theory: Telephone and face to face interviews	28 women, from metro and rural areas; who had experienced PND/Anxiety in the last 5 years	Major issues: Loss and frustration of previous life, pregnancy and motherhood experience	Women recruited from Beyond Blue website may limit generalisability
Homer et al 2009 Australia	To determine the views of women and midwives on the role of the midwife in Australia	Mixed methods Survey of women Interviews with midwives	28 women 32 midwives	Midwives and women identified key elements required of a midwife: being woman centred, provide safe,	
Jardri et al 2010, France	To improve early PND screening by midwives	Survey at 2 distinct periods, Period 1 before the midwives were trained and Period 2 after the midwives had been trained. A simple two- component self- report questionnaire designed for the study was used.	21 midwives 472 postpartum women were included in a 2 phase study with each assessment period lasting 10 weeks	After a specific training course correlation between early clinical assessment by midwives and the EDS improved. Secondly the clinical assessment by midwives in the first week postpartum correlated better with the MINI-DSM-1V interview at 8 weeks postpartum after the training course. This improvement was particularly noted for the most severe forms of depression.	This type of screening program is only of use if it ends in confirmation of the diagnosis and suitable treatment of the mother

Author, Date Country	Question Intervention	Study Design & Methods	Population/ Sample	Findings	Limitations
Jarrett P. 2014, UK	To explore the attitudes of student midwives caring for women with mental health problems	Qualitative study	7 student midwives (all RN's) enrolled in a BSc in midwifery participated	A better understanding of the complexity of mental health issues and the importance of evidenced based knowledge among student midwives is needed. Students need better understanding of risk factors and require training and support in using appropriate screening tools	Small study of 7 students, need further studies
Johnson and Galal 2014, Australia	Midwives are highly skilled in developing relationships with childbearing women	Position paper		Call for increasing midwives skills in mental health assessment and care	Opinion piece only
Jomeen et al., 2018 United Kingdom	To develop and evaluate a 'professional issues in maternal mental health scale (PIMMHS)' and its psychometric properties and potential application	A cross-sectional design and instrument evaluation approach	266 student midwives from 10 UK institutions completed the PIMMHS via Survey Monkey.	The PIMMHS is made up of two sub-scales, an emotional sub scale and training sub- scale. Both sub-scales validate a 'divergent and convergent validity'	
Jones, Creedy et al., 2012, Australia	To assess Australian midwives' attitudes towards caring for women with emotional distress, as well as the perception of how workplace policies and processes hinder such care	Survey Descriptive cohort study design	815/3000 midwives from the Australian College of Midwives completed postal survey (804 females and 11 males. Response rate 74.3% (based on 743 of respondents engaged directly in caring for women).	42% reported their workload didn't allow for time to address women's depression or anxiety problems. - organisational priorities encourage midwives to focus only on problems presented by the women rather than exploring underlying issues. Over 50% of midwives found time to assess women's emotional health and did not find emotional problems too time consuming	Midwives who completed the survey may have had an interest in the emotional aspects of care and saw themselves as competent to care for these women. Therefore the above results may be skewed towards a positive response

Author, Date Country	Question Intervention	Study Design & Methods	Population/ Sample	Findings	Limitations
Kurtcu & Golbasi 2014, Turkey	To determine knowledge and attitudes of nurses and midwives in primary health care centres.	Cross sectional survey	136 nurses and midwives	Only 16.2% of nurses and midwives have performed postpartum screening and 22.8% have had contact with a woman experiencing PND. Nurses and midwives have good levels of PND knowledge, but this awareness is not affecting their practice sufficiently	
Legere, Wallace et al., 2017, Canada	To explore the education and professional development required by health-care providers to enable effective screening, assessment and interventions for PND	Systematic review	12 articles focussed on perinatal mental health, continuing education and professional development in practicing health- care providers	Many midwives felt their education was inadequate. None of the 12 studies had a rating of a strong methodological quality. The search did not identify a strong argument for one educational strategy or approach. Future research should consider exploring strategies that use theoretical concepts and opportunities for clinical practice on perinatal depression.	Four of the 12 studies were rated as weak, 8 were rated as moderate in methodological quality
Lusskin et al., 2007, Canada	To explore the promotion of prompt identification and treatment for women with PND	Literature Review		Depressive disorders are more common in pregnancy and postpartum than widely assumed, and there is no predictable protective effect of pregnancy. Relapse rates are high, and the postpartum period represents a time of increased vulnerability to depression. Early identification and treatment of perinatal depression will minimize morbidity and mortality for the woman, the child, and the family	

Author, Date Country	Question Intervention	Study Design & Methods	Population/ Sample	Findings	Limitations
Madden, Sliney et al 2017, Ireland	To identify and develop midwives' skills to support women with perinatal mental health needs	Action research 3 cycles	Mental health nurse and team of midwives	Uncertainty about how to support women so education tailored to help them. Midwives value education and support to identify and refer women at risk of perinatal mental ill health	
Madlala & Kassier 2018, South Africa	To explore the effects of perinatal depression on infant and young child health and feeding practice	Literature Review	Perinatal South African women Evidence from randomised controlled trials and cohort studies	Prospective cohort studies show breastfeeding can reduce the risk of developing PND	Paucity of data regarding the screening or treatment of PND
Mathibe-Neke et al 2014, South Africa	To explore the perceptions of midwives regarding psychosocial risk assessment during antenatal care	Qualitative Descriptive study Focus group	16 midwives	Midwives identified women with psychosocial problems but felt not equipped to offer psychosocial assessment and care	Midwives may have been reluctant to share psychosocial care in the presence of colleagues
Marnes et al 2013, Australia	The national perinatal depression initiative	Position Paper		Recommended screening, clinical interview, physical assessment, discussion with partner – recommended midwifery care options	Opinion only
Martin et al 2017, UK	To determine the measurement veracity of the perinatal Mental Health Awareness scale (PMHA)	Cross-sectional study	10 universities across the UK 266 student midwives	The PMHA appears to provide a sound psychometric instrument for assessing student midwives' knowledge and confidence in identifying and managing perinatal mental health and physical health in a maternity context. Education and training providers for midwives should ensure that the curricula are designed and developed to meet the	

Author, Date Country	Question Intervention	Study Design & Methods	Population/ Sample	Findings	Limitations
				skills, knowledge and confidence deficits.	
McAuley, Elsom et al., 2011, Australia	To explore midwives' attitudes, skills, knowledge and experiences of working with pregnant women who have a mental illness during the perinatal period, identifying the implications of their experience and make recommendations for practice	Survey	160 female midwives and one male midwife	Depression and anxiety disorders were the most commonly encountered mental illness by midwives. Midwives rated communication skills, teamwork, rapport building and grief counselling as the 4 most important skills. Four least important were mandatory reporting, suicide risk assessment, relationship counselling and psychiatric assessment. Mental status examination was ranked by midwives as the least important skill	
McLoughlin, 2013, UK	To explore women's experience of postnatal depression	Literature Review	8 primary qualitative studies	Lack of consistency in how women experience PND, their expectations of motherhood and subsequent stigma of PND	Despite the range of studies, the findings were similar
Mollart et al 2013, Australia	To determine the incidence and level of work-related stress and burnout in midwives and the contributing and protective demographic factors that may influence those levels	Survey	152 midwives	Response rate 36.8%. 60.7% experienced moderate to high levels of emotional exhaustion, 30.3% low personal accomplishment, 30.3% depersonalisation related to burnout (used Maslach Burnout Inventory). There is a need for a holistic approach to burnout prevention	Not all participating midwives conducted mental health assessment of women

Author, Date Country	Question Intervention	Study Design & Methods	Population/ Sample	Findings	Limitations
Myors, Schmied et al, 2014, Australia	To explore the characteristics of women referred to specialist PIMH services and the therapeutic interventions the PIMH clinicians use	Mixed methods: interviews and audit of medical records	13 health professionals 11 women service users	Trusting relationship between woman and clinician is an essential basis for therapeutic interventions and services	Small convenience sample only, therefore limited generalisability
Myors, Cleary et al 2015, Australia	To explore the nature and extent of collaboration between two PIMH services in Australia	Mixed methods: interviews and audit of medical records	13 health professionals 11 women service users 244 medical records	Themes were: we don't sit in silos…but they do; we need to enhance communication; collaboration is hard work. Building trusting relationships with other service providers is challenging	
Myors, Schmied et al, 2013, Australia	To explore women's experiences of accessing a specialist perinatal and infant mental health service	Mixed methods: interviews and audit of medical records	11 women service users	Themes: there is someone out there for me; it wasn't just a job; swimming or stranded; feelings about leaving the service- importance of relational aspect of care	Small sample limits generalisability but provides insights
Noonan, et al., 2017 Ireland	To synthesise primary research findings on midwives' perceived role in perinatal mental health.	Integrative literature review	Research articles retrieved from 2006 to 2016, 22 papers included in the review	Midwives need ongoing professional education that concentrates on approaches to PMH, communication and evaluation skills. Without referral pathways and support services education will have little value	Different study designs prevented commonalities between studies to be identified.
Noonan, et al., 2018, Ireland	To determine midwives' knowledge and confidence to identify and manage women with perinatal mental health issues and perceived learning needs	A cross-sectional survey design	428 midwives v	High levels of learning (71.1%) and confidence in recognising PND, not confident caring for women (43.9%), only 17.8% (n=28) prepared to support women, 15.3% (n=24) had the necessary information, Positive views towards women with major mental health	Non random sample Small sample - 36.7% response rate may limit generalisability

Author, Date Country	Question Intervention	Study Design & Methods	Population/ Sample	Findings	Limitations
				problems Clinician's Attitude Scale=36.31	
Phillips 2013, UK	To evaluate student midwives' awareness of perinatal mental illness and the approach that midwife educators take when teaching about perinatal mental illness	Mixed methods	Purposive sample 9 BSc Hons student midwives: focus groups 6 midwife educators: semi- structured interviews	Focus group themes 'sensitivity to women experiencing mental health problems, cultural awareness, insights of mothers with mental illness, observations about midwives and views on midwife training'. Interview themes 'the important role the midwife plays, barriers to building relationships, teaching perinatal mental illness to student midwives, the student midwifery curriculum and the teaching of perinatal mental illness in practice. Notably, 'you have to hear the things behind the words that are said and feel what the woman is feeling'. The lack of time for teaching mental illness in the midwifery curriculum.	Student midwives did not want to repeat some of the less than ideal practice they had witnessed. Qualitative study with small sample provides insights but is not generalisable.
Reilly, Black et al 2017, Australia	Study protocol for a comparative effectiveness (clinical and cost effectiveness) trial of two models of perinatal integrated psychosocial care: the PIPA project	Comparative effectiveness trial: study protocol Time 1 and Time 2 assessment	Aiming to recruit 20% of 4000 women based on psychosocial assessment at booking-SAFESTART compared with PIPA	Future trial so no outcomes known until 2020 or later. May be able to establish the effectiveness of antenatal screening	

Author, Date Country	Question Intervention	Study Design & Methods	Population/ Sample	Findings	Limitations
Reilly, Harris et al., 2014, Australia	To evaluate the impact of early intervention on reported referrals for emotional health issues during pregnancy and the first postpartum year	Survey	1,804 women were drawn from the Australian Longitudinal Study on Women's Health	Enquiry into risk factors such as past history and current mental health enhances initiation of referrals; Results suggest enquiring about current mental health is associated with appropriate rates of referral.	
Rollans et al 2013, Australia	To explore women's experience of psychosocial assessment and depression screening examining the meaning they attribute to assessment and how this influences their response	Ethnographic study	34 pregnant women 18 midwives Observed during the booking visit	Midwives require support to discuss experiences of listening/responding to women's trauma – require ongoing training/education/supervision to reduced negative impact of vicarious trauma from women's stories and receive ongoing training and support	
Ross-Davie et al 2013, UK	To identify any barriers to successful implementation of screening by midwives following the recommendations from the Confidential Enquiries into Maternal Deaths	Survey	187 midwives completed the questionnaire	Midwives will take on a more developed role in relation to mental health, but often lack training, knowledge and confidence in this area. Midwives lack of education often prevents midwives from supporting women with PND	
Schmeid et al 2013, Australia	To describe the factors that impact on the mental health of Australian and New Zealand women in the perinatal period	Systematic Review	48 papers	10-20% of women depressed one year after birth. Two strongest predictors are previous history of depression and poor relationship with partner. Midwives have VIP role with these women	Limited to Australian and New Zealand studies; different cut off scores to determine perinatal distress therefore synthesis across studies difficult

Author, Date Country	Question Intervention	Study Design & Methods	Population/ Sample	Findings	Limitations
Seimyr, Welles-Nystrom et al 2013, Sweden	To elucidate the effect of prior mental health disorders on newly delivered women's mental health and compare different instruments to screen for maternal distress and depression	Survey	232 women	Women with prior mental health problems are more vulnerable for maternal distress and midwives should encourage women to express emotional issues during their transition to motherhood	
Serge et al 2011, USA	To assess the acceptability of nurses screening and counselling women for postpartum depression	Survey	823 women (691 high income, 132 low income)	Response rate 72% high income, 30% low income. Majority in both groups felt that it was acceptable for nurses to perform screening for postpartum depression and do the necessary counselling.	Low response rate in low income group may affect generaliseability to this group
Sidebotham et al 2015 Australia	To determine midwives' perceptions of their role and how they might conceptualise a change in working patterns and environment to provide greater level of continuity of care	Appreciative Inquiry	23 midwives from three maternity units in south- east Queensland participated in one of six focus groups.	Midwives endorsed the reforms and considered the concept of continuity of midwifery care as fundamental to achieving woman centred care. Most participants found it difficult to conceptualise how they could contribute to any level of system change maternity system.	The Appreciative Inquiry approach did not facilitate a positive view of the future and how change could occur
Strass and Billay 2008, Canada	To increase the number of health and community services accessed by pregnant women	Health promotion project	163 pregnant women	Public health nurses in key position to routinely screen and assess women for risk factors. Providers were unanimous in support for public health care nurses	
Thombs et al 2014 Canada	To determine whether depression screening improves outcomes for women during pregnancy or postpartum period	Systematic review	Only 1 RCT of screening postpartum was included	No evidence found to recommend screening of all women during pregnancy or postpartum period	More studies needed

Author, Date Country	Question Intervention	Study Design & Methods	Population/ Sample	Findings	Limitations
Williams, et al., 2016, United Kingdom	To explore views and experiences of screening for antenatal depression in conjunction with a validation study of the depression case finding questions	Qualitative study using semi-structured interviews	15 midwives and 20 pregnant women	Midwives and pregnant women found the depression case finding questions useful for introducing mental health issues	Midwives and pregnant women sometimes found it hard to differentiate symptoms of early pregnancy and depression

Appendix 3: Interview trigger questions

Thanks for giving up your time and coming along to support my research. I am interested in your views about caring for women with perinatal depression (PND).

Give definition of PND.

You may have remembered that this interview will be recorded – is that okay with you?

Most importantly, there are no right or wrong answers so please what you think. Some house-keeping before we start. Please read and sign the consent form; before you sign the form, do you have any questions about the consent form you would like to ask? As you probably know it is a requirement by the ethics committee that all people participating in a research project must sign a consent form agreeing to participate. You will be given a copy of the consent form to keep.

Probably, you remember from reading the information that I gave you that there will be no identifying information attached to the interview transcript, again please feel to say what you like.

That brings me to asking you to choose a pseudonym – for the remainder of the interview and on your transcript you will be known by your pseudonym. Because I will need to have further contact with you I need to be able to match your pseudonym with your contact details. Do you mind completing this form please with your pseudonym and your contact details? This form will be kept independent from your data.

At the completion of the study all the recorded interviews will be deleted.

If you are unsure how to answer a question or didn't hear the question clearly, just ask me to repeat the question or explain it; if you do not want to answer a question just let me know.

At any time during the interview you may ask for the interview to be stopped. You can withdraw from the study at any time. If you choose to with draw from the study any information that has been collected will be destroyed. Withdrawing from the study will not impact on tour employment.

After the completion of the interview I will email you a copy of the transcribed interview for you to read, if you would like to make any changes about the information I have sent, you can please correct it and email me back your corrected copy? I will make the appropriate changes on the transcribed copy which I will keep and then return to you a corrected copy. I would be happy to meet you a second time if you would like to talk further about the interview or your transcribed copy. You may elect to have a phone call rather than a second interview.

The interview will last between 40-60 minutes. Do you have any questions at present you would like to ask in relation to the interview or anything to do with the study from what you have read?

I am interested in your views about caring for women with perinatal depression (PND). The particular method I am pursuing is known as Appreciative Inquiry, focusing on the positive aspects of care provided to women, as well as how we may translate our thinking into a positive frame when planning support to women in our care. During the interview I may bring you back from time to time, for you to think about the positive aspects of the care being delivered to women.

Discovery Questions

Tell me a little about yourself? What areas of nursing/midwifery have you worked in over the years? Did you do your training through the hospital system or University?

What made you decide to go into midwifery? Since you became a midwife have you always worked in midwifery, or maybe worked in other areas; (if yes) what areas have you worked in? Have you been working in midwifery for long?

Can you tell me about the women you see who may have perinatal depression (PND) or a history of PND?

If you haven't had the opportunity to work/support women with PND, you may have observed some of your colleagues supporting women with PND – can you tell me about this?

The women you see with PND or women you think may have PND would they usually talk openly about PND or perhaps they are reluctant to talk about it?

If a woman is reluctant to talk about her 'emotional' problems (PND) do you have some strategies that you use/find may help the woman 'to open up' about her problems?

Tell me about what services are available where you can refer women for further support. Is it challenging sometimes to get women to accept referrals.

Keeping up to date with PND education is an important aspect of the care provided to women – as a midwife where do you sit with this aspect?

While we are talking about education, was there a trigger for you to become interested in the area of PND? And that then leads me to ask when did you first become interested in furthering your knowledge in the area of PND?

Often midwives talk about it being scary caring for women with PND, particularly the first time because they are afraid they may say the wrong thing or they don't know how to handle a teary woman, or a woman with mood swing and often are uncertain about referral pathways. Can you make comment about that statement?

When you have supported a woman/family with PND, it can be quite harrowing for the carer and you may find yourself wanting to talk about this experience with others – where or with whom would you talk too? If you don't feel comfortable at present to talk about this aspect of your work that is okay?

Dreaming questions

I would like to ask you what I am going to call a 'miracle question' – I think we all like to believe in miracles at times. If you woke up tomorrow morning and there were no constraints placed upon your work with women experiencing PND or women at risk of PND how would that look for you?

Destiny questions

My last question, what recommendations would you like to make if you were able – able being the operative word to influence the way we care for women with PND from your own personal experience?

Thank you for talking to me today and sharing your knowledge and skills with me. It is important for midwives to have the opportunity to have ongoing PND education and for them to be aware of the valuable role they can play in supporting women with PND. The aim of my research is to create an awareness of the role midwives can play in supporting women with PND.

Appendix 4: Ethical Approval Documentation

NSW GOVERNMENT Health
Hunter New England
Local Health District

27 May 2016

Ms Dianne Hurt
Faculty of Health
University of Technology

Dear Ms Hurt,

Re: Midwives perceived role in supporting women with perinatal depression (16/04/20/5.09)

HNEHREC Reference No: 16/04/20/5.09
NSW HREC Reference No: LNR/16/HNE/118
SSA Reference No: LNRSSA/16/HNE/166

Thank you for submitting an application for authorisation of this project. I am pleased to inform you that authorisation has been granted for this study to take place at the following sites:

The following conditions apply to this research project. These are additional to those conditions imposed by the Human Research Ethics Committee that granted ethical approval:

1. Proposed amendments to the research protocol or conduct of the research which may affect the ethical acceptability of the project, and which are submitted to the lead HREC for review, are copied to the research governance officer;
2. Proposed amendments to the research protocol or conduct of the research which may affect the ongoing site acceptability of the project, are to be submitted to the research governance officer;
3. Annual Report submitted to the lead HREC for review and the acknowledgment, are copied to the research governance officer;
4. Final Report submitted to the lead HREC for review and the acknowledgement, are copied to the research governance officer.

Yours faithfully

Production Note:
Signature removed prior to publication.

Dr Nicole Gerrand
Research Governance Officer
Hunter New England Local Health District

Hunter New England Research Support & Development Office
Locked Bag No 1
New Lambton NSW 2305
Telephone: (02) 49214950 Facsimile: (02) 49214818
Email: HNELHD-HREC@hnehealth.nsw.gov.au
http://www.hnehealth.nsw.gov.au/ethics/Pages/Research-Ethics-and-Governance-Unit.aspx

Di Hurt

From: "Dianne Hurt" <Dianne.H.Hurt@student.uts.edu.au>
Date: Thursday, 7 July 2016 12:16 PM
To: <dhu91246@bigpond.net.au>
Subject: FW: UTS HREC Approval - ETH16-0527

From: Research.Ethics@uts.edu.au
Sent: Thursday, July 7, 2016 12:16:19 PM (UTC+10:00) Canberra, Melbourne, Sydney
To: Dianne Hurt; Maralyn Foureur; Research Ethics; Cathrine Fowler
Subject: UTS HREC Approval - ETH16-0527

Dear Applicant

[External Ratification: Hunter New England Local Health District – 16/04/20/5.09 – 27/05/2016 to 27/05/2021]

The UTS Human Research Ethics Expedited Review Committee have reviewed your application titled, "Qualitative Descriptive Study of Midwives knowledge of perinatal depression and their perceived role in supporting pregnant and postnatal women experiencing depression: an appreciative inquiry.", and agreed that the application meets the requirements of the NHMRC National Statement on Ethical Conduct In Human Research (2007). I am pleased to inform you that your external ethics approval has been ratified.

Your approval number is UTS HREC REF NO. ETH16-0527
Approval will be for the period specified above and subject to the provision of annual reports and evidence of continued support from the above-named Committee.

Please note that the ethical conduct of research is an on-going process. The National Statement on Ethical Conduct in Research Involving Humans requires us to obtain a report about the progress of the research, and in particular about any changes to the research which may have ethical implications. This report form must be completed at least annually, and at the end of the project (if it takes more than a year). The Ethics Secretariat will contact you when it is time to complete your first report.

I also refer you to the AVCC guidelines relating to the storage of data, which require that data be kept for a minimum of 5 years after publication of research. However, in NSW, longer retention requirements are required for research on human subjects with potential long-term effects, research with long-term environmental effects, or research considered of national or international significance, importance, or controversy. If the data from this research project falls into one of these categories, contact University Records for advice on long-term retention.

7/07/2016

You should consider this your official letter of approval. If you require a hardcopy please contact Research.Ethics@uts.edu.au.

To access this application, please follow the URLs below:
* if accessing within the UTS network: https://rm.uts.edu.au
* if accessing outside of UTS network: https://remote.uts.edu.au , and click on "RM6 - ResearchMaster Enterprise" after logging in.

We value your feedback on the online ethics process. If you would like to provide feedback please go to: http://surveys.uts.edu.au/surveys/onlineethics/index.cfm

If you have any queries about your ethics approval, or require any amendments to your research in the future, please do not hesitate to contact Research.Ethics@uts.edu.au.

Yours sincerely,

Professor Marion Haas
Chairperson
UTS Human Research Ethics Committee
C/- Research & Innovation Office
University of Technology, Sydney
E: Research.Ethics@uts.edu.au

UNIVERSITY OF TECHNOLOGY SYDNEY

PERINATAL DEPRESSION

Midwives needed to share (talk about) their confidence, knowledge and skills in identifying and supporting women with PND

Please consider becoming part of the research project **'MIDWIVES PERCEIVED ROLE IN SUPPORTING WOMEN WITH PND'** Can you spare time to talk with the midwife researcher Di Hurt email: Dianne.H.Hurt@student.uts.edu.au

Please take a participant information sheet/consent form if you would like to contribute to this thought-provoking project

Version 3: 07/04/2016

When
Recruitment will start in July 2016
Interviews
It is anticipated the first interview will last 40-60 minutes second interview 30-40 minutes

Interviews will be digitally recorded

Interviews will take place in your own time at your work place or in a location you nominate

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UNIVERSITY OF TECHNOLOGY SYDNEY

PERINATAL DEPRESSION PROJECT

Site Name: Hunter New England Local Health District and [redacted] Hospital

Title of research project: 'Midwives perceived role in supporting women with perinatal depression'

Coordinating and principal investigator: Dianne Hurt, University of Technology Sydney

Associate Investigators: Professor Maralyn Foureur, University of Technology Sydney

Professor Cathrine Fowler, University of Technology Sydney

PARTICIPANT INFORMATION PACKAGE

PART 1
Introduction

You are invited to take part in the research project 'Midwives' perceived role in supporting women with perinatal depression'. At present it is not considered an integral part of the midwife's role or responsibility to provide perinatal depression support even though midwives are frequently the primary contact for women in the perinatal period.

The purpose of this research

This qualitative project will explore participants' confidence, knowledge and skills when caring for women with perinatal depression as well as investigating the opportunities participants have to practise and expand evidence-based care for women with perinatal depression. The importance of the research is: by exploring midwives level of confidence, knowledge and skills in this area, midwives may gain insights into their ability to provide care for women with perinatal depression. This may inform future innovation in expanding the scope of practice of the midwife to include this aspect of maternity care.

UNIVERSITY OF TECHNOLOGY SYDNEY

What does participation in this project involve?

- Up to 12 participants (midwives) will be recruited and interviewed individually by myself.
- If you agree to participate in this project, you will be asked to participate in up to two interviews.
- The interviews will take place in your own time, at a time convenient to you, and at place which is convenient for you.
- The first interview will be a face to face interview and take between 40-60 minutes and the second interview between 20-30 minutes; there is an option for the second interview to be a phone interview.
- Face to face interviews will be digitally recorded and the interviewer will take notes.
- You will be provided with a transcribed copy of the first interview and be asked if this is an accurate record of what took place at the interview. This document will be emailed to you for review. You may request changes to the interview document. The requested changes will be made and the corrected document returned to you.
- If you choose a face to face interview for the second interview, the process will be as above. For those who select a phone interview, the phone notes taken by the interviewer will be sent to you for review and you may request changes to these notes. The corrected notes will then be forward to you.
- All participants will be identified by a pseudonym of their choosing. Because, there will be need to have further contact with you, it will be necessary to be able to match your pseudonym with your contact details.
- All participants will be given a copy of the two interviews or corrected copy of the interviews which you may keep for your own records.
- All interview material and questionnaires will be kept in a locked filing cabinet, in a locked room and after 15 years will be shredded.
- At the completion of the interview you will be asked to complete a short demographic questionnaire.

You will be asked to sign the Participant Consent Form. By signing the consent form you are telling us that you:

- Understand what you have read.
- Consent to take part in the research project.
- Consent to the research that is described.

You will be given a copy of this Participant Information Package and Consent Form for your records.

Voluntary Participation

Participation in this project is entirely voluntary. You do not have to take part. If you do take part, you can withdraw at any time without giving a reason and your withdrawal will not affect your ongoing employment. If you withdraw from the research project any information you have provided to the interviewer will be destroyed.

Confidentiality

All the information collected from you for the project will be treated confidentially, and only the researchers named above will have access to it. Each participant will be de-identified and given a pseudonym. The project results may be presented at a conference or in a scientific publication, but individual participants will not be identifiable in such a presentation.

Benefits and Risks

There is no anticipated direct benefit to you through your involvement in this project. The risks of participating in this project are limited to discomfort you may feel during the interviews. If at any time during the interviews you become uncomfortable or distressed by the process you may discontinue your involvement. You will be offered support from the Employee Assistance Program provided by Hunter New England Local Health District if required. For participants from Newcastle Private Hospital who require support this will be provided by Newcastle Private Hospital.

Costs

Participation in this project will not cost you anything, nor will you be paid.

UNIVERSITY OF TECHNOLOGY SYDNEY

Further information

This project has been initiated by the researcher Dianne Hurt. The results of this project will be used by Dianne to gain a Masters Degree in Midwifery by research at the University of Technology Sydney. The project has not been funded. The project will only take place within The Hunter New England Local Health District [redacted]

When you have read the information you have been given, Dianne Hurt will discuss the project with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to email her: Dianne.H.Hurt@student.uts.edu.au

When all the data has been gathered and results have been analysed a summary of the results will be forward to you. It may take up to six months from the time of initial participation for you to receive the summary of results.

Thank you for considering this invitation.

Dianne Hurt, Coordinating and principal investigator, University of Technology Sydney

Professor Maralyn Foureur, Supervisor, University of Technology Sydney

Professor Cathrine Fowler, Supervisor, University of Technology Sydney

UNIVERSITY OF TECHNOLOGY SYDNEY

PART 2

Who has reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC). The ethical aspects of this research project have been approved by the HREC of Hunter New England Local Health District and University of Technology Sydney.

This project will be carried out according to the National Statement on Ethical Conduct in Human Research (2007). This statement has been developed to protect the interests of people who agree to participate in human research studies.

This research has been approved by the Hunter New England Human Research Ethics Committee of Hunter New England Local Health District. (External Ratification: Hunter New England Local Health District – 16/04/20/5.09 – 27/05/2016 to27/05/2021).

The UTS Human Research Ethics Expedited Review Committee has agreed that the application meets the requirements of the NHMRC National Statement on Ethical Conduct in Human Research (2007). External ethics approval has been ratified. Approval number is UTS HREC REF NO. ETH16-0527

Complaints about this research

Should you have concerns about rights as a participant in this project, or you have a complaint about the manner in which the project is conducted, it may be given to the researcher – Dianne Hurt, or, if an independent person is preferred it may be forwarded to:

> Dr Nicole Gerrand, Manager Research Ethics and Governance Unit, Hunter New England Human Research Ethics Committee, Hunter New England Local Health District, Locked Bag No 1, New Lambton NSW 2305, telephone (02) 49214950, email Nicole.gerrand@hnehealth.nsw.gov.au
> The research project reference number is 16/04/20/5.07.

Dianne Hurt, Coordinating and principal investigator, University of Technology Sydney.
Email - dianne.h.hurt@student.uts.edu.au
Telephone: [redacted]

UNIVERSITY OF TECHNOLOGY SYDNEY

PERINATAL DEPRESSION PROJECT

Site Name: Hunter New England Local Health District [redacted]

Title of research project: 'Midwives perceived role in supporting women with perinatal depression'

Coordinating and principal investigator: Dianne Hurt, University of Technology Sydney

Associate Investigators: Professor Maralyn Foureur, University of Technology Sydney
Professor Cathrine Fowler, University of Technology Sydney

Midwives interested in participating in this research project please complete the form below:

Name: (please print)_____

Signature:_____

Email address:_____

Telephone Numbers

Mobile:_____

Landline:_____

Completing this form does not imply you have agreed to participate in the research, when I make contact with you, you may decline to participate.

If you have any questions about the above research study I may be contacted on the following email address:

Dianne.H.Hurt@student.uts.edu.au

Thank you for completing this form
Dianne Hurt

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UNIVERSITY OF TECHNOLOGY SYDNEY

Site Names: Hunter New England Local Health District [redacted]

Title of research: 'Midwives perceived role in supporting women with perinatal depression'

Coordinating and principal investigator: Dianne Hurt, University of Technology Sydney

Associate investigators: Professor Maralyn Foureur, University of Technology Sydney
Professor Cathrine Fowler, University of Technology Sydney

Consent Form – Adult providing own consent

Declaration by Participant

I have read the Participation Information Sheet in a language that I understand.

I understand the purpose and risks of the research described in the project

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project; I understand I do not have to give reason for leaving the project. I understand withdrawal from the project will not affect my employment. Any information I have contributed to the project will be destroyed if I withdraw from the project.

I understand that I will be given a signed copy of this document to keep.

Name of Participant (please print)_____

Signature_____Date_____

Version 3: 07/04/2016

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UNIVERSITY OF TECHNOLOGY SYDNEY

Site Names: Hunter New England Local Health District [redacted]

Title of research: 'Midwives perceived role in supporting women with perinatal depression'

Coordinating and principal investigator: Dianne Hurt, University of Technology Sydney

Associate investigators: Professor Maralyn Foureur, University of Technology Sydney and Professor Cathrine Fowler, University of Technology Sydney

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Pseudonym/Contact Details

All participants will be identified by a pseudonym of their choosing. Because, there will be need to have further contact with you, it will be necessary to be able to match your pseudonym with your contact details. Your pseudonym will be kept separately from your data. My two supervisors, Maralyn Foureur and Cathrine Fowler and myself will be the only people who will have access to your pseudonym, your name and contact details (email address).

Pseudonym:_____

Name:_____

Contact Details (email):_____

Appendix 5: Table 8: Audit trail describing the data analysis process

Excerpt from Transcript	Key words or phrases	Minor themes	Major themes
We [MGP midwives] *get a lot of referrals for women who have had previous birth trauma then you have to undo a lot of that and that is really gratifying in your job… because I would say a hundred percent of the time* [at the end] *the response is 'oh my god I did it - when can I come back for another one* [baby]*' and they say things like 'I am healed' and* [I say] *'you weren't broken'. They require a lot more postnatal visiting for this baby and then for the next one they are fine.* *If a woman needs me to visit three times a day and I am able, that is what I do.* *Rosie p12/24*	…previous birth trauma, you have to undo a lot of that… …really gratifying in your job …I am healed If a woman needs me to visit three times a day…that is what I do	MGP Midwives working in continuity of care manage their own time.	Continuity of care Time available
I would say a large percentage of women we work with have a, current history of depression or a strong family history of postnatal depression and it is one of the great fears they come to us with [questions about it] is it going to be you know - I will be like my sister, I will be like my mother - and a lot of times it has been difficult for anyone to actually listen to that concern. You know, simple things that we should be talking about, like, when you start to feel like that, just acknowledge it, get engaged in the support around you , go for that walk in the sunshine, ask for help, don't feel you are alone …I think we are lucky that we have that connection with women that they do, they bring that to you quite often, I am not feeling as well as I was, or- I am so much better than I was. ***Rosie p13/24***	…current history of depression… strong family history of postnatal depression …it has been difficult for anyone to actually listen to that concern …when you start to feel like that, just acknowledge it, get engaged in the support around you …we are lucky that we have that connection with women …they bring that to you quite often, I am not feeling as well as I was, or- I am so much better than I was	Women's fears not heard Normalising the experience Respectful, non-judgmental Encouraging women to express feelings	Continuity of care Respectful, non-judgmental Connection with women

Excerpt from Transcript	Key words or phrases	Minor themes	Major themes
I think you know the women with perinatal depression should have continuity of care with their own care provider I think as well as the services available for them, adequate services for them even if they have that low lying depression or severe depression, you know no matter where they fall on the spectrum that they have got that support. Mothers and babies kept together, supportive home, supportive family. ***Jemima, p14/15***	Continuity of care with their own care provider Adequate services for women with all levels of PND Keep mothers and babies together	Continuity of care for women with PND Ensure adequate services for depressed women Mothers and babies together	Continuity of care Plus PND services Mother Baby services
It would be continuity of care model…with a caseload to share it with the group practice…we make well over 90% of our births and that makes a huge difference to women, that known face…the miracle part would be having the hospital acknowledge so you don't always feel you are having to prove it…to know what benefit it is…that is what the miracle would be ***(Norah, p21/24)***	The miracle- continuity of care model Continuity of care makes a huge difference to women Wants the hospital to acknowledge the benefits it brings to women	Continuity of care makes a huge difference to women Needing to have the model acknowledged	Continuity of care Hospital to acknowledge benefits

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