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The continuity relationship makes caring for women with anxiety and depression easier, but it is also a heavy responsibility

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ABSTRACT

Background: Perinatal depression and anxiety, experienced by about 20 % of women, are a risk factor for associated morbidities for mothers and babies, including risk of suicide and preterm birth. Traditionally this group of women have not been able to access midwifery continuity of care despite the known benefits.
Aim: This study aims to explore the experiences of midwives providing continuity of care to women with perinatal mental health disorders and women's experiences of receiving care in a continuity of care model.
Methods: We used a mixed methods design incorporating a qualitative exploratory study using a qualitative descriptive approach [1] to understand midwives experiences. We also explored the women's experience of receiving continuity of care and observed mothers interacting with their babies. The quantitative data was collected using the Parenting Interactions with Children Checklist of Observations (PICCOLO) [2], described in detail below, to measure these interactions.
Results: Two overarching themes were generated: Continuity is protective, with subthemes Safe in their hands, Healing from previous trauma and Sustaining breastfeeding; and Having exceptional care deserves equitable access, with sub-themes Having your choices respected, Having a meaningful birth experience, Providing exceptional care requires support.
Conclusion: This study adds to current literature that indicates midwifery continuity of care as emotionally protective, which is particularly important for women with perinatal mental health conditions and may have ongoing positive effects that foster wellbeing. Experienced as providing 'exceptional' care, our findings demonstrate an urgent need to increase access to such models, and ensuring midwives have equally 'exceptional' training, support and referral pathways, to ensure their sustainability.

Statement of Significance

Problem or issue

Women with perinatal mental health conditions are experiencing difficulty accessing midwifery continuity of care.

What is already known

Midwifery Group Caseload Practice (MGCP), provides benefits for mothers and babies but should also target women with complexities.

What this paper adds

Women with anxiety and depression value midwifery continuity

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of care and the emotional benefits, both immediate and long-term, for mothers and babies who received MGCP.

Background

One in five women in Australia will experience, perinatal depression and anxiety, that is around 60,000 women a year [1]. Perinatal mental health disorders are associated with maternal morbidity and mortality [2,3] and adverse neonatal outcomes such as preterm birth and babies born of low birth weight [4]. Perinatal mental health diagnosis is a strong risk factor for suicide in the perinatal period [5].

Suicide is one of the leading causes of death during pregnancy in the first 12 months following birth, surpassing haemorrhage and hypertension [5–7]. The global perinatal suicide rates range between 1.27 and 3.7 per 100,000 live births [5]. Twenty women died from suicide, in the first forty two days following birth in Australia between the years 2012 and 2021, postpartum suicide rates are the fourth most common cause of death during this period [8]. Depression is one of the most common diagnoses among perinatal women who report suicidal ideation and/or who attempt or complete suicide [5].

Women with depression, perceived stress and anxiety are more likely to have a baby born preterm and/or of low birth weight and/or have growth restriction [4,9]. In one state of Australia (New South Wales) women who self-reported anxiety and depression were more likely to have babies born of low birth weight, lower Apgar scores, earlier gestation, and be admitted to the neonatal unit with a longer hospital stay when compared to women who did not report these conditions [10]. Long-term effects of prematurity have been found to have consequences on the pulmonary, cardiovascular, renal, endocrine and central nervous system that can lead to chronic disease and premature death [11]. Long term outcomes include an increased risk of adverse effects on child development, that may compromise infant and early childhood mental health, and contribute to the development of psychiatric disorders across the lifespan [6].

Midwifery continuity of care has been found to mitigate levels of worry, stress and anxiety in pregnant women [12] and has been associated with approximately half the rate of preterm births, for women with perinatal mental health conditions, when compared with women who did not receive midwifery continuity of care [13]. Midwifery continuity of care models are defined as having one midwife who is the lead care professional providing care in either community or hospital settings through pregnancy, birth, and the early parenting period [14]. Women who are able to access midwifery continuity of care have an increased probability of having an uncomplicated or low-risk pregnancy [14]. Presently, in many areas, women with a perinatal mental health condition such as depression and anxiety may not be eligible to receive midwifery continuity of care [15,16]. At this time, there is limited evidence on the effect of midwifery continuity of care for women with substantial medical or psychosocial complications [17]. Studies from the United Kingdom (UK) have established a significant reduction in the preterm birth rate in women with increased social diversity including Black, Asian and Minority Ethnic (BAME) groups, when care was provided within a midwifery continuity of care model [18,19]. In Australia, a midwifery continuity of care model for young women (aged 21 years or less) achieved increased engagement and a reduction in the predictors for preterm birth such as smoking and genitourinary infections [20].

An international systematic review proposes perinatal mental health services should be flexible and woman centred, facilitated by well-trained health professionals working within a structure that facilitates continuity of carer [21]. Currently, in Australia women with perinatal mental health conditions are often referred into complex perinatal health pathways involving multiple caregivers [22]. Midwives who work in continuity models are well placed to coordinate care pathways and help to navigate a fragmented health system for women from socially diverse backgrounds and/or those who have a perinatal mental health condition [18,23,24]. The aim of this study was to explore the experiences of midwives providing continuity of care to women with perinatal mental health disorders and women's experiences of receiving care in a continuity of care model.

Aim

The initial aim of this project was to explore the experiences of midwives who provide continuity of care to women with a perinatal mental health condition. We decided it would be important to also include the voices of women who experience continuity of care, and longer-term interactions with their babies. The following research questions were developed to answer these aims:

1. What are the experiences of midwives who provide continuity of care to women with perinatal mental health conditions?
2. What are the experiences of women who have perinatal mental health conditions and receive midwifery continuity of care?

a. How do mothers interact with their babies?

Methods

We used a mixed methods design incorporating a qualitative exploratory study using a qualitative descriptive approach [25] to understand midwives' experiences. We also explored the women's experiences of receiving continuity of care and observed the mothers interacting with their babies. The quantitative data was collected using the Parenting Interactions with Children Checklist of Observations (PICCOLO) [26], described in detail below, to measure these interactions. The PICOLLO measures added to the characteristics of the participants rather than as an outcome measure and are included in the findings.

Ethics

Ethical clearance was granted from the Local Health District and University Human Research Ethics Committee (HREC) reference number: 2022/PID01558 - 2022/ETH01385

Setting

A tertiary referral hospital in an Australian metropolitan setting that provides maternity care to over 5000 women annually, many of whom are from diverse ethnic and sociodemographic backgrounds [27]. The hospital has a midwifery group caseload practice (MGCP) that employs 22 full-time equivalent midwives, working in pairs or small teams of up to four midwives in each group. The MGCP provides continuity of care through pregnancy, birth, and the postnatal period. Women remain in this model regardless of any medical or psychosocial complications that develop, and the midwives collaborate with other health care providers as necessary, this is known as a no-exit model of midwifery continuity of care.

Participants

Midwives who provided continuity of care through pregnancy, birth, and the early parenting period.

Women who self-reported having a history of anxiety and/or depression and/or scored $\geq$ 13 on the Edinburgh Depression Scale or answered yes to question 10 (the thought of harming myself has occurred to me) and gave birth in the last 12 months.

Recruitment

Midwives who had provided continuity of care to women with anxiety and depression were purposively sampled. The primary researcher contacted the maternity service and asked if midwives would be interested in attending a focus group. There were 22 full-time equivalent midwives working in MGCP at that time and they were invited to attend a focus group if they had provided continuity of care to women with mental health disorders.

Women were recruited via purposive sampling. The MGCP midwives identified women who met the inclusion criteria and provided a flyer with the researchers' contact details. The flyer was also distributed via the maternity service social media page. Women contacted the researcher directly who sent a participant information sheet and consent form and arranged the interview at a suitable time. The recruitment period between November 2022 and March 2024, resulted in a low uptake by the women. At the time of the initial interview the women were invited for a follow up interview with their baby. In addition, one new participant responded to the flyer and agreed to an interview plus observation of interactions with her baby.

Data collection

Data from midwives were collected via two focus groups. The focus groups were recorded, and data were de-identified using pseudonyms.

Three women with a history of anxiety and/or depression attended individual interviews. In total, data was collected from two focus groups of four and six midwives, and six individual interviews with mothers. The focus group numbers are adequate for qualitative research (4−9) particularly because our participants were a homogenous study population, all MGCP midwives, with a narrowly defined objective of discovering their experiences of caring for women with perinatal mental health concerns [28]. However, the small number of women recruited, despite hearing the same concepts over and over, indicates the data can only be interpreted as pilot data and more research is required.

Questions to guide the focus group discussions with the midwives are provided in a supplementary file. The focus group opened with 'tell me about your experience of providing MGCP to women with perinatal mental health conditions?" The group discussion with midwives focussed on their experience of providing care to women with perinatal mental health conditions and what referral systems are available to support the women and the midwives.

Individual interviews were held with women on two occasions. The interviews were audio and video recorded via the university secure online video conferencing platform zoom, data were de-identified using pseudonyms. Women were asked to tell the researcher about their experience of MGCP care. The full guide of interview questions are contained in the supplementary file. The initial interview with the mothers focussed on how they could access MGCP and whether the service addressed all their needs during pregnancy.

Follow up interviews with mothers used semi-structured interviews that consisted of five questions (Supplementary file). The questions were used to probe mothers for their reflections on their birth experience, their relationship with their baby and the supports they relied on to effectively care for their babies and themselves. In the follow up interview mothers were asked what was especially meaningful about their birth, how they would describe their relationship with their baby and what key sources of support are available post birth.

Observation of the mother/baby dyad

At the time of the second follow up interview mothers consented to an interview and five minutes of observation of mothers and their babies engaging in play or a routine activity using the Parenting Interactions with Children Checklist of Observations (PICCOLO) [26]. Parent-infant observations have long been used in practice and research for parents with mental illness [29]. The PICCOLO is a psychometrically robust evidence-based measure for research that identifies key aspects of parenting interactions linked to a child's development [29]. The PICCOLO was designed to assess observable behaviours in parent-child interactions that have been empirically linked with positive child development outcomes [26].

The PICCOLO consists of 30 items and four domains of observable parenting behaviour: affection, responsiveness, encouragement, and teaching. Scores range from a minimum of six to a maximum of 58. Scores over 47 (age 14 months and under) and scores over 49 (age 24 and 36 months), indicate above average scores (highest 16 %). Scores lower than 31 (age 14 months and under) and below 33 (age 24 and 36 months) are below average (lowest 16 %). Items in each domain of the PICCOLO demonstrate moderate internal consistency with scale alpha of .78 in the affection domain, .75 in the responsiveness domain, .77 in the encouragement domain and.80 in teaching domain.

The PICCOLO has been piloted across multi-cultural, multi-lingual families in the United States and with vulnerable families participating in a home visiting program in Australia (PICCOLO-D) [7,30]. Uses of the PICCOLO include both assessment for clinical and research purposes as well as for intervention planning in programs geared towards enhancing positive parenting skills and promoting secure parent-child attachment relationships.

Data management

All data were stored on the password protected university cloud storage system. All data were de-identified using participant numbers for the midwives and pseudonyms for the women/mother's data. All excerpts from the data reported in this paper are de-identified.

Reflexivity

All authors are convinced of the benefits of continuity models of care, given the large body of evidence that supports this model. A number of the authors, AC, CH, SM, DP have previously investigated the association of birth outcomes for women with perinatal mental health conditions who received midwifery continuity of care. We wanted to explore the feasibility of this model, for this group of women, by understanding what midwives need to provide the care. These findings will inform an implementation trial. TE is a social worker with expertise in infant mental health and her interest was to measure the mother baby interactions using the PICCOLO tool and we are all disappointed with the low uptake from the women/mothers to participate in the study.

Data analysis

A qualitative descriptive approach [25] underpinned the research project, and we used reflexive thematic analysis to analyse the data [31].

Analysis began with close readings of transcribed focus groups and interview data. Initially the data were coded in NVivo using an inductive and reflexive approach undertaken by AC and TE. This approach involves initial coding, clustering similar concepts, while acknowledging and testing assumptions [31]. The codes were refined through discussion between these two authors followed by concept mapping, before arriving at the final themes.

Observations of the parent-infant dyad during the second interview were assessed and scored by an expert in infant mental health (TE). Following the interview the video recorded interactions were reviewed again to ensure the score for each of the four domains (affection, responsiveness, teaching, and encouragement) were accurate. Two authors reviewed the video and the scores (AC and TE) to ensure accuracy.

Participants

There was a total of ten midwives (n = 10) who participated in this study. Three women (n = 3) attended the first interview and two agreed to a second interview with observations of their baby and one new woman consented to an interview and observation of her baby. Three

parent- child observations (n = 3) were conducted. Midwives' demographic data are presented in Table 1. Women's demographics are not presented due to the risk of re-identification.

Findings

We constructed the following two overarching themes: 'Continuity is protective' and 'Having exceptional care deserves equitable access', with corresponding sub-themes (Fig. 1).

Continuity is protective

The theme continuity is protective encompassed women feeling safe with the MGCP midwife through regular contact, reassurance, and physical assessments. By building a relationship of trust, midwives' identified women were able to confide in them, providing a safety net for the women's mental health and wellbeing. Women reported this experience provided a sense of healing from previous trauma and that the continuity of care was protective of initiating and sustaining breastfeeding.

Safe in their hands

The mothers reported feelings of emotional and physical safety from the pregnancy care and birthing experiences they received in the MGCP model. The regularity of contact, check-ins on their mental health and wellbeing and the availability of their midwife instilled feelings of safety. As stated, by two of the women participants:

> *"I just trusted her because I felt safe in her hands." (Lana, mother of an 8-month-old, PICCOLO score 43)*

> *"They would, you know regularly check in with me and my mental health and wellbeing." (Jane, mother of a 13-month-old PICCOLO score 49)*

The midwives corroborated this sentiment, acknowledging the continuity model enables a unique connection with the women that makes it easier for the women to confide about their mental health needs, in ways that they may not confide in with other health care providers, such as a general practitioner or mental health care providers.

> *"We have quite a special connection with the women, so they are flagging things with us they're not flagging with their other healthcare providers." (Midwife 5)*

The essence of the theme continuity being protective continued in the sub-theme healing from previous birth trauma and loss.

Healing from previous birth trauma and loss

Previous trauma due to pregnancy and birth loss as well as mental health hospitalisations were prevalent in this sample of mothers. Mothers also reported being treated insensitively in their healthcare interactions before becoming engaged with MGCP. The connection between previous history of adverse health and pregnancy experiences, and the current pregnancy birth experience, loomed large for this sample of mothers.

Table 1
Demographic details of Midwives.

	Age	Pathway to becoming a midwife	Years of experience
1	27	Graduate Diploma of Midwifery	4 years
2	26	Bachelor of Midwifery	New Graduate – first year
3	26	Graduate Diploma of Midwifery	3 years
4	34	Graduate Diploma of Midwifery	2 years
5	30	Graduate Diploma of Midwifery	2 years
6	32	Bachelor of Midwifery	8 years
7	32	Bachelor of Midwifery	4 years
8	25	Bachelor of Midwifery	5 years
9	26	Graduate Diploma of Midwifery	3 years
10	Not completed		

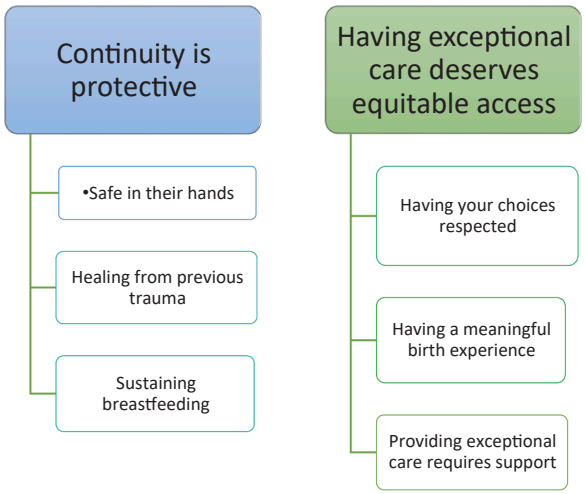

Fig. 1. Summary of findings.

> *"I didn't think I was going to have a viable baby. It was extremely distressing and traumatic. Because of being on caseload, having the same faces. And knowing the protocol, it was so beneficial to me." (Jane, a mother with history of multiple pregnancy losses, PICCOLO 49)*

The midwives demonstrated an intricate understanding of the consequences of being affected by a previous traumatic birth and other health events, the restorative power of acknowledging this in the next birth and providing the opportunity to process a previous traumatic birth.

> *"I'm not saying that I can resolve [trauma] for them, but doing a thorough debrief, particularly when you're the clinician who was there [at the birth] and understands everything that happened puts them in a much better position, in terms of going forward into the postnatal period and the mental health in that." (Midwife 3)*

This midwife reiterates the protective power of continuity at the time of birth:

> *"Giving birth can be such a form of empowerment for a woman [who has experienced previous trauma]" (Midwife 4)*

Sustaining breastfeeding

All of the mothers reported that they sustained breastfeeding for at least six months or more and attributed their success with breastfeeding and relationship with their infants to the support they had received from their midwife.

> *"My midwife was essentially there to help…. I thought that because of the c-section would mean it would be harder for me. And I was able to do it… I'm still breastfeeding now." (Jane, mother of a 13-month-old PICCOLO 49)*

The importance of continuity of care and its contribution to sustaining breastfeeding was described by one participant as:

> *"I think I wouldn't be breastfeeding [15 months on) if I didn't have the continuity of care. I think I would have had to throw in the towel very early on." (Mary, mother of a 15-month-old PICCOLO 57).*

Such accounts are important because of the protective health, economic and emotional benefits of breastfeeding for mother and baby which are well-documented and demonstrate how continuity is protective to mother and baby. Continuity being protective leads to the next theme of Having Exceptional Care.

Having exceptional care deserves equitable access

Women reported receiving an exceptional level of care through the caseload model and they wanted everyone to be able to access this level of care.

> *"Such an exceptional level of care that I hope to share with anyone who gets pregnant…Every woman should have the right to it." (Jane, mother of a 13-month-old PICCOLO 49).*

All of the mothers in this sample understood that in order for MGCP to be more universally accessible, increased resources and spreading the word about the model of care is necessary.

> *"It was really positive. When I talk to other mothers that's kind of unusual." (Mary, mother of a 15-month-old PICCOLO 57)*

> *"So, my first child, I didn't know there was such a thing as midwife caseload." (Jane, mother of a 13-month-old, PICCOLO 49)*

Another participant stated something very similar:

> *"Making sure more people know about it." (Lana, mother of an 8-month-old, PICCOLO 43)*

This woman refers to the resources required:

> *"I wish there was enough funding for everyone to have the opportunity." (Mary, mother of a 15-month-old, PICCOLO 57)*

Having your choices respected

The mothers expressed a sense of agency in how they participated in their care while pregnant and birthing. They framed having exceptional care with the concept of choice and a relationship as the foundation of their care experience with their midwife.

> *"Always putting the power back on me and the choice back on me but making me aware of all my options." (Jane, mother of a 13-month-old PICCOLO 49)*

Again here:

> *"My decisions…my decisions were always respected." (Lana, Mother of an 8-month-old,PICCOLO 43)*

Midwives validated the centrality of the relationship between the expectant mother and her midwife and understood that establishing a relationship characterized by continuity organically creates conditions for trust which may foster agency in decision making in the women. Explained by this midwife:

> *"So, with the continuity relationship, a lot of this information gathering, this assessment of how they're going is conversation-based." (Midwife 10)*

Discussed again here:

> *"It's fantastic she's got a continuity midwife, because you are looking at big picture, because that's you. This is your responsibility, to have these discussions. But I think it's about liaising and communicating with the woman." (Midwife 7)*

Providing continuity of care through the whole experience enabled a meaningful birth experience as the next sub-theme illustrates.

Having a meaningful birth experience

When probed about their birthing experience, the women identified their midwife was integral to the sense of meaning they found in birthing. As expressed in the quotes below:

> *"It made it so much better [the birth], because if you have a mental health concern, you probably have some horrible trauma associated with hospitals at some point." (Mary, mother of a 15-month-old PICCOLO 57).*

And again, the importance of having a known midwife at the birth:

> *"The most meaningful thing would be the support I got in that [birthing] room." (Lana, mother of an 8-month-old PICCOLO 43)*

> *"A relief to have her, especially in the delivery [birth] room." (Mary, mother of a 15-month-old PICCOLO 57)*

In their focus group responses, midwives were keenly aware of the power of the continuity relationship to make birth a restorative, transformative experience for mothers. Hence this aspect of exceptional care is integral to making meaning of the birthing experience.

> *"Birth can actually be a way that a woman can reclaim power and ownership over her own body." (Midwife 4)*

Providing exceptional care led to the midwives feeling a greater sense of responsibility for this group of women. Although happy to take on the responsibility, there was a perceived need for better referral pathways, to support them to provide this care.

Providing exceptional care requires support

Providing exceptional care meant the midwives felt a sense of accountability and responsibility that sometimes felt burdensome. All the midwives reported a lack of clear referral pathways and felt if they had these, some of the responsibility would be lifted. Concerns were expressed about delays in mothers receiving adequate healthcare once they were referred (up to 8 weeks on a waitlist) and the high level of acuity required for mothers to meet criteria in order to receive specialised mental health services.

> *"Unless someone is seriously in a full-on crisis or has severe bipolar or schizophrenia sort of things, then we need to be, they basically won't accept the referrals that we're giving them." (Midwife 3)*

> *A lot of GPs have started to charge gap fees, so that's another barrier for referring women to GPs, which is often what the recommendation is … that's just a barrier to accessing care and making it that one little bit harder" (Midwife 9)*

Midwives worried they might be practicing outside of their professional scope.

> *"She had a really good outcome, but I think I felt like hang-on, I'm out of my depth here big time." (Midwife 9)*

Midwives valued continuity but recognised the responsibility:

> *"The continuity relationship makes that a lot easier, but it is also a heavy responsibility." (Midwife 6)*

The connection with the woman could contribute to workload stress:

> *"But I find… anxious women ruminate on things…they just can't let it go the whole way through the pregnancy, it'll be the same thing that I get calls about." (Midwife 3)*

> *"The worry about the woman, you build a relationship with them. You want to look after them. You want them to be ok." (Midwife 6)*

The continuity of care model described in this study is a no exit model designed for women who had a low-risk pregnancy at their first visit however if complications developed, they would remain in the model. The benefits of midwifery continuity of care were recognised by obstetric colleagues, described here:

> *"I got a call from one of the consultant obstetricians saying, she's had essential hypertension, but I think her mental health concerns far outweigh the medical risk. Can you please look after her in a shared care model with me? That doesn't exist…I said" (Midwife 9)*

This midwife describes a similar situation:

> *"My consultant has found a really high-risk, complex patient with me and she said, this person needs continuity. It will completely make her*

experience a million times better. I completely agree…she had terrible things happen to her, … I was still her primary care provider, she's not actually seeing the obstetrician for the rest of her pregnancy (Midwife 9)

Through providing continuity of care midwives were invested in the woman's wellbeing and wanted the best outcome, they became frustrated when there was a lack of referral pathways and clearly articulated the need for support.

Discussion

This is the first study, we are aware of, to explore midwives experiences of providing continuity of care to women with a current or previous history of anxiety and depression. Having the women's voices in the data was invaluable, midwifery continuity of care was experienced as protective and restorative. Research demonstrates midwifery continuity of care can reduce a woman's level of anxiety, worry and depression in the antenatal period, which is valuable for women with perinatal mental health conditions [12]. Women reported the value of not having to repeat their story when they receive midwifery continuity of care from a known midwife and they felt able to disclose their mental health history to a midwife with whom they have developed a trusting relationship [12]. Previous research has found that when women have a known midwife they feel safe to discuss their concerns throughout pregnancy and prepare for birth as the midwife understands their story [32]. Similarly, we found the women felt both emotionally and physically safe through the regular contact provided in the midwifery continuity of care model. Midwives reported a sense of connection with women, which fostered an environment of trust and safety, enabling women to open up about sensitive issues they might have hesitated to share with other health care professionals. Evidence suggests that midwifery continuity of care may be a preventative intervention to reduce maternal anxiety, worry and depression [12] during the perinatal period and provide some protection against deteriorating mental health with devastating consequences, such as maternal suicide [5].

The women in the study described their care as exceptional, as it allowed them to have a choice and take some power over decisions about their care. This concept has existed in the literature about midwifery continuity of carer since the early research of one-to-one midwifery [33]. The immediate birth outcomes, such as less intervention at birth including caesarean sections, longer rates of breastfeeding and having a known midwife at birth, as a result of receiving midwifery continuity of care are demonstrated in high level evidence [14]. Impacts on women's mental health have also been reported as beneficial [12]. However, there are no reports on the longer-term outcomes for children. This study is the first to attempt to measure parental behaviours that support optimal child development for this group of women. We found all the PICCOLO scores were average or above average scores however our sample provides an insight only and cannot be conclusive, more research is required in this area.

The findings from our study suggest midwifery continuity of care provided a meaningful birth experience for the women. These findings demonstrate the importance of the midwifery continuity of care at the time of birth. Other research has demonstrated the importance of a named and known midwife present during labour and birth, stating that her appearance was one of the most welcome events during labour [32]. Women have expressed feelings of abandonment when their midwives had left the hospital after finishing their shifts [32]. Having a meaningful birth experience was important to the women as they reported having experienced previous trauma from hospital admissions and this was exacerbated by their perinatal mental health conditions. The experience of receiving midwifery continuity care has been found to be healing for those women who have experienced previous birth trauma [34] and provides women with a satisfying birth experience [35].

Receiving exceptional midwifery care is not a new finding, similar findings have been found from previous qualitative studies which focused on midwifery continuity of care [32,35–39]. This study had a focus on midwifery continuity of care for women diagnosed with a perinatal mental health condition/s and the results would suggest providing 'exceptional care' appears to take a toll on the midwives' wellbeing. This is particularly noticed when there was an absence of clear referral pathways, or if the midwives felt the current referral services were not providing adequate care to the woman or their baby. This contrasts with other research which has shown high levels of midwifery satisfaction from working in midwifery continuity of care and lower rates of professional burnout [40–42]. This research also highlights midwifery continuity models are successful when clear referral pathways are created [43]. The midwives in our study provided exceptional care to this group of women but reported limited support or referral pathways and felt a heavy responsibility caring for women with anxiety and depression. Currently, limited studies have examined midwifery continuity of care for women with complex pregnancies [17].

Our findings also demonstrate a need for midwives to have further professional development to care for women with perinatal mental health conditions. Health professionals who work with traumatised populations are vulnerable to experiencing secondary traumatic stress, particularly when they are working in unsupportive work environments where the emotional impact of their work is not acknowledged [44,45]. Midwives who engage in regular clinical supervision reported feeling more positive about such work, feeling both supported and valued [46]. Suggesting clinical supervision may be an important support intervention for midwives who may be feeling stressed and emotionally depleted due to the demands of providing continuity of care to women with perinatal mental health conditions. The Nursing and Midwifery Board of Australia have recently recognised the emotional toll that midwives and nurses are facing in their work and have introduced a free counselling service [47] which may be helpful to this group of midwives.

The midwives' concerns about a lack of referral pathways may be mitigated with new and evolving online services such as the e-Cope directory [48]. This online referral service allows women and their care providers to put in a postcode or address, select the current perinatal status such as planning a family, expecting a baby and birth, new parents and grief or loss [48]. Users can select a topic such as anxiety and depression, there are 28 options under the tab expecting a baby and birth. Once all selections are made the website offers a map outlining services available [48]. This is an excellent resource for midwives providing continuity of care for women with perinatal mental health conditions and may reduce the feelings of such a heavy responsibility described by the midwives in our study.

Additional findings from our study highlight midwives who work in MGCP have a strong relationship with woman and are able to work to their full scope of practice providing care throughout the pregnancy, birth and early parenting period, even when the women had perinatal mental health complexities. The midwives demonstrated a collaborative partnership with obstetricians who could see the value and importance of midwifery continuity of care for women experiencing anxiety and mental health issues. Working to their full scope of practice, midwives' enhanced decision-making abilities, and a positive working environment are protective factors to prevent emotional exhaustion and burnout compared with traditional models [40]. Evidence suggest midwives working in continuity of care models have greater job satisfaction, due to working to their full scope of role, which allows them to provide more personalised care compared with hospital midwives [49]. Multi-discipline care from obstetricians, psychologists and psychiatrists, where necessary, are important elements of exceptional care [50].

Finally, and importantly, it is vital we find a way to scale up midwifery continuity of care, so this model of care is widely available, as our findings demonstrate a desire that everyone should have access to MGCP. There is a need to increase community awareness and funding for more programs. Further research will focus on an implementation trial to assist with scale up of midwifery continuity of care for all women including those with perinatal mental health conditions.

Strengths and limitations

A strength of this study was to explore what midwives need when providing continuity of care to women who have perinatal mental health conditions. This will be helpful in the scale up to ensure equitable access of midwifery continuity of care for all women, including those with perinatal mental health conditions. A limitation of the study was the small number of women who participated. The difficulty in recruitment requires further investigation potentially with a co-design framework, to understand the optimal approach for participation in research to understand the barriers faced. The small number of observations of the mother/baby interactions can only offer a preview of what is possible for the long-term effects of midwifery continuity of care for mothers and baby's wellbeing. Furthermore, although the PICCOLO has been administered to parents of infants younger than 10 months of age with promising results, sample sizes are not large enough to establish reliability. Therefore, the authors urge caution in interpreting PICCOLO scores for children younger than 10 months of age.

Conclusion

Our study explored midwives' experiences of providing continuity of care to women with anxiety and depression and found they require support and professional development. Clinical supervision of midwives and engagement with online referral pathways and counselling may alleviate some of the challenges in providing care for this group of women. The women described the care as exceptional, with choice about the care they received giving power back to the women. Importantly around the time of birth they particularly valued having a known midwife attend. Midwives were in a unique position to provide an individualised debrief following birth. The midwives supported women to transition to parenthood, successfully initiate and maintain breastfeeding and demonstrated developmentally supportive parenting behaviours towards their infant.

Author Agreement Statement

We the undersigned declare that this manuscript is original, has not been published before and is not currently being considered for publication elsewhere.

We confirm that the manuscript has been read and approved by all named authors and that there are no other persons who satisfied the criteria for authorship but are not listed. We further confirm that the order of authors listed in the manuscript has been approved by all of us.

We understand that the Corresponding Author is the sole contact for the Editorial process. They are responsible for communicating with the other authors about progress, submissions of revisions and final approval of proofs.

Ethical statement

Ethical clearance was granted from the Local Health District and University Human Research Ethics Committee (HREC) reference number: 2022/PID01558 - 2022/ETH01385.

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Conflict of interest

The authors have no conflict of interest to declare

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.wombi.2025.101886.

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