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Midwives' experiences of supporting women's mental health: a mixed-method study

Abstract

Objective

To explore midwives' skills, knowledge and experiences of supporting women's mental health.

Research design and setting

This paper reports the second phase of a larger project, the 'Mothers' Mood Study', which recruited women and midwives to explore their experiences of perinatal mental health and service provision and focuses on midwives' experiences of supporting women with perinatal mental health problems. This paper reports on midwives' experiences through self-administered questionnaires and focus groups. Descriptive statistics were used to analyse questionnaire data and focus group data were thematically analysed.

Participants

All midwives employed at one Health Board in South Wales UK, were eligible to participate. Recruitment took place between February and October 2018. Questionnaires were completed by 145 midwives and 15 attended one of three focus groups.

Findings

Questionnaire data showed the majority of midwives had cared for women with mental health problems, most commonly anxiety (95.0%, n=138) and depression (87.0%, n=127). Midwives assessed women's mental health informally by observing or asking questions about mood (99.3%, n=144), anxiety levels (94.5%, n=137), levels of support (91.0%, n=132) and mental health history (95.9%, n=139). The majority of midwives (82.8%, n=120) indicated they would make some sort of mental health assessment at least 50% of the time. Around a third of midwives 31.7% (n=46) reported receiving training relating to perinatal mental health in the previous two years, however only 21.4% (n=31) of these suggested this had helped them in their practice. Three themes were generated from the focus groups, 1) Conversations 2) Support 3) Knowledge and skills.

Key conclusions and implications for practice

A lack of time and continuity at appointments and a focus on physical health of mother and baby reduced the opportunity for conversations around mental health. In addition a lack of experience reduced midwives' confidence resulting in a low threshold for referring women to other services for support. Midwives' main concerns were a need for training on aspects of day-to-day practice and referral options to support women's mental health. A package of training to improved skills and confidence as well as a clear pathway of care will enable midwives to be better placed to support women's mental health.

Key words: Midwives; perinatal mental health; knowledge; skills; confidence; training.

Introduction

Rates of mental health problems during pregnancy vary between 10–30% (Pearson et al., 2018; Dennis et al., 2017). Longditudinal studies have found rates of depression to be higher in pregnancy than in the postnatal period (Underwood et al., 2016). One study in South Wales found 8% of pregnant women scored ≥10 on the Generalised Anxiety Disorder 7 (GAD-7) scale (Spitzer et al., 2006) and ≥13 on the Edinburgh Postnatal Depression Scale (EPDS) (Murray and Cox 1990) indicating clinically significant symptoms of anxiety or depression. A further 24.2% scored between 5-9 on the GAD-7 (Spitzer et al., 2006) and 34.1% between 7-12 on the EPDS (McCabe-Beane et al., 2016) indicating symptoms of mild anxiety or depression. (Savory 2021). The rates of moderate anxiety and depression were lower than found in two systematic reviews. Anxiety rates of 20.7% (Fawcett et al., 2019) and depression 16.4% (Okagbue et al., 2019)

Numerous studies have shown mental health problems in pregnancy can have negative consequences for women and their babies (Savory et al., 2020; Smith et al., 2020; Van den Bergh et al., 2020) Even though there has been financial investment and an increase in specialist services available to women with perinatal mental health problems in the UK, a recent report described healthcare professionals being overwhelmed with referrals and the service a postcode lottery (Witcombe-Hayes et al., 2018). Over 90% of women with mental health problems during the perinatal period, the time from conception to a year after birth, are looked after by non-specialist services (Bauer et al., 2014). As midwives are the main carers for the majority of women during pregnancy and the early postnatal period they are ideally placed to provide support but they need to ensure they practice within the scope of their competency (Nursing and Midwifery Council, 2018).

In the UK NICE guidance recommends asking questions at the booking visit to assess women's mental health. Studies relating to midwives experience of asking women about their mental health found a lack of time and confidence led to inconsistencies in asking questions (McGlone et al., 2016). Similarly a scoping review reported midwives' perceptions of barriers to women accessing perinatal mental health care, found midwives lacked confidence assessing women's mental health. Midwives also found imited information on where to refer women, unclear referral pathways and limited specialist services. Only one of the 30 papers reviewed, related to no specialist midwives in the UK using qualitative design (Viveiros and Darling , 2019).

Health care professionals, including midwives' report a lack knowledge and skills relating to perinatal mental health and recommendations have bee made for midwives to receive further training to understand, assess and provide support to women (Bayrampour et al., 2018; Legere et al., 2017; Higgins et al., 2018). In a recent scoping review relating to the knowledge, skills and attitudes of maternity staff, two related to midwives in the UK, both used survey design. (Coates and Foureur 2019).

This study aimed to explore midwives' skills, knowledge and experiences and assess the barriers to providing mental health care and support for women during the perinatal period. Few studies have explored these topics in depth in the UK. An understanding of midwives' experiences could help inform service provision for women with mental health problems and gain a more in depth understanding midwives training needs.

Methods

This is the second phase of a larger project, the 'Mothers' Mood Study', which assessed women's and midwives' experiences of perinatal mental health and service provision. Ethical approval for the study was granted by the Wales Research Ethics Committee on 10th October 2017 (Ref: 17/WA/0319). Details of the findings from the first phase of the project exploring the prevalence and experiences of women with mental health problems are reported elsewhere (Savory et al., 2021: Savory et al., 2022).

Recruitment took place at a large maternity unit with an annual birth rate of approximately 6000, which serves a diverse population in terms of sociodemographic and ethnic mix. The Health Board provides care for women with low and high-risk pregnancies. During the period of data collection approximately 250 midwives were employed by the Health Board all of whom were eligible to participate in the study, through completion of a questionnaire and focus groups. A multiple methods, sequential design were used (Creswell, Fetters and Ivankova, 2004).

The questionnaire had been previously used with midwives in Australia. The '2000 Victorian Survey of Midwives' was developed to explore midwives' attitudes, skills, knowledge and experiences of caring for women who had mental health problems during the postnatal period (McCauley et al., 2011). Where required, the language in the questionnaire was adapted to reflect use in the UK and questions generalised to perinatal mental health. After modification, the questionnaire was piloted with three midwives and took under 10 minutes to complete.Minor changes were made as suggested to the layout. The paper based questionnaire consisted of 22 items, which comprised a mix of closed, multiple choice and range options. These related to midwives' employment, education and specific mental health skills and training. Knowledge of mental health conditions, experiences of assessing women's mental health and referral services were also explored.

Focus groups aimed to explore in depth the responses covered in the midwives' questionnaires together with the data generated in interviews with women from the first phase of the project (Savory et al., 2022). These included limited knowledge of perinatal mental health problems, especially in pregnancy, stigma related to mental health, reduced conversations with family and friends and that antenatal care often focused on mothers' physical aspects of pregnancy, leaving little time to discuss mental health.

The topic guide for the focus groups included questions related to midwives experience of caring for women, conversations with women and their knowledge of support and service provision for women's mental health. Additionally perinatal mental health training at undergraduate and post graduate levels was explored.

Recruitment

Information was circulated to midwives via posters, face-to-face contact, personal work emails and a closed moderated online page for maternity staff.

Questionnaires

Questionnaires were distributed in each staff area of the maternity unit and community teams as well as via face-to-face invitations from the lead researcher. These were competed and returned either in person or left in an envelope in each area. Information at the beginning of the questionnaire explained the study and its promise of anonymity, with completion implying consent. Questionnaires were completed between February and September 2018.

Focus groups

Recruitment of midwives for three focus groups commenced whilst the interviews with pregnant women (Savory et al., 2022) were near completion and during the last few months of the questionnaires data with midwives being collected. This was an iterative process to allow topics which arose in the interviews and questionnaires to be explored further in the focus groups.

Three focus groups were conducted between August and October 2018, with 15 midwives encompassing a range of experiences within the Health Board. A purposive sample of midwives was approached for two focus groups. Participants in the first focus group were midwives (n=6) from the specialist community team (SCT) who support women with complex needs including asylum seekers, women with severe mental health problems or women who abuse alcohol or drugs. For the second focus group an opportunity arose during recruitment to invite newly qualified midwives (NQM) (n=5) who had started work in the Health Board the previous week. They had trained in four different universities in England and Wales. The third group comprised midwives (n=4) who had expressed an interest via email or in person and were available on the selected day.

Midwives were provided with an information leaflet prior to attending the focus groups. Written consent was obtained, including consent for audio-recording and use of quotations at the beginning of each focus group and midwives chose their own pseudonyms. Focus groups lasted between 30 and 53 minutes.

Data analysis

Data from the 145 questionnaires were entered into and analysed using IBM Statistical Package for the Social Sciences Statistics 25 (IBM Corporation 2017). Frequency distributions and descriptive statistics were produced. Verification of data entry by a research assistant comparing each variable against the questionnaire indicated an error rate of 0.6%. Audio recordings for the three focus groups were transcribed externally, anonymity was requested at the point of transcription and these were entered into NVivo 11 qualitative data analysis software (QSR International, 2015). Thematic analysis was used to detect, analyse and report on patterns found within the data (Braun and Clarke

2006). To reduce coding bias and improve rigour a second member of the research team independently coded a transcript and discussed this to reach a consensus.

Findings

Questionnaires

Characteristics of midwives

A total of 220 questionnaires were distributed with 145 returned, of which four were incomplete with the remainder yielding data included in the analysis reported here.

Midwives had a mean age of 39.8 years. Just under two thirds worked full time and over two thirds had been qualified for six years or more. All midwives employed by the Health Board were female (Table 1).

Table 1. Background characteristic of midwives.

Background characteristics		**n=145**		
		M	**(SD)**	**R**
Age	n=135	39.8	(11.7)	21-65
Hours worked	n=137	32.1	(7.7)	3-40
Years worked at the health board	n=137	12.3	(10.0)	0-36
		n	**(%)**	
Years in practice				
1 year or less		17	(11.7)	
2-5 years		28	(19.3)	
6-10 years		28	(19.3)	
11-15 years		18	(12.4)	
16 years and over		46	(31.7)	
Missing		8	(5.5)	
Hours per week worked				
12 hours or less		3	(2.1)	
13-30 hours		45	(31.0)	
31 hours and more		89	(61.4)	
Missing		8	(5.5)	
Age				
21-32		46	(31.7)	

33-44	38	(26.2)
45-55	37	(25.5)
56+	14	(9.7)
Missing	10	(6.9)
Main area of work		
Antenatal clinic	13	(9.0)
Antenatal/postnatal ward	13	(9.0)
Assessment unit	10	(6.9)
Midwifery led unit	18	(12.4)
Delivery suite	45	(31.0)
Community	23	(15.9)
Management	3	(2.1)
Preceptor midwife on rotation	4	(2.8)
Specialist role	7	(4.7)
Other	1	(0.7)
Missing	8	(5.5)
Specialist role		
Research midwife	3	(2.1)
Social worker	1	(0.7)
Clinical supervisor	1	(0.7)
Breastfeeding team	3	(2.1)
Specialist community team	5	3.4)
Additional qualifications		
Registered adult nurse	55	(37.9)
BSc psychology	1	(0.7)
Diploma in nursing	1	(0.7)
Nursery nurse	1	(0.7)
Family planning practitioner	1	(0.7)
PGCE	2	(1.4)
Registered mental nurse	2	(1.4)
Experience working as a nurse / student in a mental health setting		
Yes	13	(9.0)
No	123	(84.8)
Missing	9	(6.2)

Experience of a specialist role working with vulnerable women		
Yes	15	(10.3)
No	121	(83.4)
Missing	9	(6.2)

Knowledge and skills

The majority of midwives reported having cared for women with mental health problems, most commonly anxiety (95.0%, n=138) and depressive (87.0%, n=127) disorders. Midwives indicated they informally assessed women's mental health at least 80% of the time. When informally assessing woman's mental health, an assessment of mood (99.3%, n=144), anxiety levels (94.5%, n=137) and levels of support (91.0%, n=132) as well as mental health history (95.9%, n=139) was completed. Intuition/instinct (72.4%, n=105) and clinical experience (70.3%, n=102) were also reported as ways of assessing women's mental health. Midwives indicated they could refer to community mental health teams (93.1%, n=135), general practitioner (88.3%, n=135) or health visitor (69.0%, n=100) if there were concerns for a woman's mental health.

Training

Around a third of midwives 31.7% (n=46) reported having received training relating to perinatal mental health in the previous two years either through in house mandatory training (10.4%, n=15) or an e-learning package (4.8%, n=7) provided by the Health Board. Reported training reflected aspects central to the midwives' role, for example in relation to alcohol use/abuse (42.1%, n=61), illicit drug use/abuse (33.8%, n=49), physical/sexual abuse (34.5%, n=50) and grief and loss (32.4%, n=47). Minimal training had been received by midwives around family (2.1%, n=3) or individual therapy (0.7%, n=1). Rates of training in mental status assessment (11%, n=16), mental health pharmacology (2.8%, n=4) and suicide risk assessment (3.4%, n=5) were low. Midwives recorded training as important (80.8%, n=117) but only 21.4% (n=31) of midwives who had completed PNMH training suggested it had helped them in their practice.

Most of the skills in relation to perinatal mental health were learnt during clinical practice (86.9%, n=126) and from peers (39.3%, n=57), rather than through formal education (53.1%, n=77). Nearly all midwives thought they could be better prepared (94.5%, n=137) and just over half (53%, n=77) implied they were confident supporting women with mental health problems.

Focus groups

Conversations

The National Institute for Health and Care Excellence (NICE) (2020) recommends UK based suggests midwives ask about women's mental health at each routine visit during the antenatal and postnatal periods. All participants agreed asking women was important and had incorporated this into their practice:

> *I agree….I'm comfortable talking about it but whether you're doing it right…you do the best that you can…(Lucy, focus group 1 – SCT)*

Even midwives in the SCT expressed a fear they might not be 'doing it right'. A newly qualified midwife suggested midwives reading questions verbatim and treating the questions as a 'tick box' exercise reduced the opportunity for conversations. With no guidance or training the decision has been left to individual midwives as to how they broach the topic. Many midwives had developed their own way of opening conversations:

> *…I'll use different words…are you ever nervous, are you ever unable to sleep, can you concentrate… (Amber, focus group 1 – SCT)*

Using different terminology and questions is important especially when women have cultural or language differences. In addition midwives employed other ways of assessing mental health.

Midwives in SCT said they observed women's reactions to hearing their babies' heart beat which gave some indication if they were bonding with their baby.

Midwives described barriers to discussions with women. The majority mentioned a lack of time at appointments, leading to a focus on physical care of mothers and babies:

> *…appointments are so short, so in 10 minutes you have to go through all of the physical elements…then mental health is really pushed aside. (Georgia, focus group 2 – NQM)*

Conversely continuity was mentioned by several midwives as an important aspect of facilitating discussion regarding mental health:

> *…they're feeling down but because you've got that regular contact covering the pregnancy they do trust you…(Lottie, focus group 3)*

Building relationship also assisted midwives to detect when the women might not be ‘themselves’. In addition midwives referred to continuity as an enabling factor for women to feel comfortable and share concerns.

Support

Midwives in the SCT care for women with multiple physical, mental and social issues, making it difficult to know which source of support to prioritise. They described confusion around the referral criteria to specialist perinatal mental health service (PNMH) that provide care for women with severe mental health disorders. Sometimes it was not clear which service to refer women to:

> *… whatever has happened to them[asylum seekers], the trauma, when they come in they’re pregnant, the pregnancy makes it worse so it’s really hard to differentiate then isn’t it, is it pregnancy related or is it from their other stuff…(Amber, focus group 1 – SCT)*

If trauma support was required rather than support from the PNMH team this was a complex process for referral and delayed access to care, sometimes for several years:

> *…go to the GP first, the GP then refers to the primary mental health services, primary again refer to a community mental health team…then refer to another clinic who then refer her now for the specialist. (Bramble, focus group 1 – SCT)*

Midwives were also critical of the local referral process to PNMH which often took weeks and relied on women ringing to opt into the service, which was described as inappropriate especially for those with a language barrier or limited phone access. Despite the narrow criteria for referral and the assessment process midwives described those who were accepted into the service receiving good care.

The majority of women with mental health problems were supported by midwives, most of whom were aware they could refer women to the general practitioner if there were concerns, as recommended by NICE (2020). A few midwives were reluctant to refer women to general practitioners:

> *… in my experience your GP is very quick to go for the medical route… without the extra support and all the talking therapy but because that’s expensive and there’s a longer waiting list… (Sara, focus group 3)*

Conversely several midwives were aware of general practitioners who had advised women to stop taking medication during pregnancy due to concerns of its effect on the baby. It was clear that midwives were enthusiastic in supporting women's mental health themselves rather than referring women to other services but they did not feel confident in knowing what to do if women disclosed a problem:

> *…but it's not being able to act on it and it's really frustrating…with mental health we don't really seem to have any toolkits apart from saying to go elsewhere. (Charlotte, focus group 2 – NQM)*

There were examples of resources which had been developed to assist midwives in making decisions about sources of support. The SCT had a list of support services, information and referral pathways but these had not been noticed by midwives outside the team. Midwives were aware of some services such as the Birth Afterthoughts clinic, led by midwives for women traumatised by birth. However this service is not provided by the PNMH team due to a lack of evidence base:

> *…they said if you open up that little can of worms it'll turn into a terrible can of worms. (Jane, focus group 1 – SCT)*

'Debriefing' women straight after birth was suggested as more appropriate although not all midwives were in favour of this, suggesting they had not had sufficient training and advice on timing and discussion.

Suggestions for support for women were recommended by several midwives:

> *… an outreach service…one of the things about mental health is that people aren't likely to reach out…or a maternity specific mental health helpline. (Carol, focus group 2 – NQM)*

Midwives suggested services need not require health care staff to facilitate them, in a similar way to peer supporters who help women with breastfeeding, reducing the cost implications.

Knowledge and skills

All midwives stated they had looked after women with anxiety and depression and were generally sympathetic and aware of the negative effects of poor perinatal mental health on the mother, baby and family:

I think there is recognition that you know, conditions like mental wellbeing as well as social and environment can impact on adverse childhood…(Anna, focus group 3)

When it came to severe mental health problems NQMs stated they had only encountered a few women with bipolar disorders and schizophrenia during their three years training, similar to the majority of midwives. This may be because women with severe mental health problems are cared for by the SCT and the conditions are uncommon, resulting in a lack of experience for the majority of midwives:

With my women I feel they are judged…I think staff are a bit scared to look after her, they're frightened because they don't know what to expect … (Jane, Focus group 1 – SCT)

One midwife reported how a woman had overheard a midwife calling her 'bonkers' and classed as a 'challenging patient', which had a detrimental effect on the woman's anxiety. Midwives cited a lack of skills and knowledge leading to a fear of looking after women with mental health problems, resulting in negative attitudes and derogatory language.

Training was suggested as one way to improve midwives' confidence in supporting women's mental health. Expectations that midwives in the SCT, due to the nature of their job, would have attended more training were unfounded:

We're the experts who haven't had any training (Louise, focus group 1 – SCT)

Midwives highlighted the lack of training around antenatal mental health. In addition there was agreement training focused on the physical health of mother and baby during pregnancy:

… I don't feel as confident with mental health in comparison to the physical side of pregnancy. (Georgia, focus group 2 – NQM)

Even where perinatal mental health training had been undertaken midwives suggested it had not fully prepared them for supporting women:

It felt like loads of theory, facts and but I don't think it really helps you, it doesn't really help you when I'm in that situation where I am with somebody who's…mentally just struggling a little bit…(Lily, focus group 3)

This was a general view that whilst midwives might know the theory they still felt unprepared to provide day-to-day support to meet women's mental health needs. Their main requests were training related to practical aspects of care, such as how to talk to women, how to ask questions and on information relating to medication and its side effects.

No clear difference was noted between experienced midwives and NQMs. The NQMs had trained in several different Health Boards and had mixed opinions on how prepared they were to care for women who present with mental health problems. In addition to theoretical teaching half of students' time is spent in clinical practice. Midwives commented that they learnt most of their skills through clinical experience:

> *…I think that's more come from experience and watching other people, talking to them and hearing how other people have handled it. (Lily, focus group 3)*

Midwives' eagerness to learn about mental health was evident and other forms of study had been undertaken:

> *…the birth trauma conference last year… that seven and a half hours I learnt so much more than I ever did in my training. (Jayne, focus group 2 – NQM)*

Suggestions were made from several midwives about how training could be improved such as through scenario based training and case study reviews.

Discussion

As primary carers for women in the perinatal period, midwives are ideally placed to support their mental and physical health. Previous literature has concentrated on midwives' experiences of asking women about their mental health history at the initial antenatal appointment (McGlone et al., 2016; Rompala et al., 2016), student midwives knowledge of mental health, (Higgins et al., 2016; McGookin et al., 2017) or reviewing training packages (Davies et al., 2016).

This study focused on midwives' knowledge, skills and experiences of supporting women's mental health throughout the perinatal period. Questionnaires were completed by 145 midwives and 15 attended focus groups to explore their experiences of caring for women with perinatal mental health problems. Midwives' experience ranged from newly qualified to 36 years, offering a unique opportunity to consider if experience alters perception and confidence in supporting women's mental health.

Asking questions regarding mental health is an important part of perinatal care. In line with NICE (2020) guidelines, opportunities to discuss mental health occur early in pregnancy when women book their maternity care with a midwife. A history of mental health problems is known to be strongly associated with depression or anxiety in early pregnancy (Savory et al., 2021). The majority of midwives stated they would take note of the woman's history and current mental health status at each appointment. Informal mental health assessments were tailored to individuals, taking into account women's circumstances especially for those who did not speak English or where mental health and depression were words not easily understood in the woman's culture. Midwives described how they observed women's behaviour as a way of assessing their mental health, as noted previously (McCauley et al., 2011; Jarrett 2014) and also using 'instinct/intuition'. It is more likely intuition reflects previous or learnt experience (Baker 2011) rather than reflecting instinct alone. None of the midwives mentioned using screening tools such as the EPDS and GAD-7 as a method of assessment, even though they are recommended by NICE (2020) if there are concerns about a woman's mental health. This is possibly due to a lack of training and experience alongside the lack of pathways for woman who screened positive for anxiety or depression.

Barriers were noted by midwives relating to discussions regarding women's mental health. Antenatal appointments have remained the same duration for years, one hour for the first and 10 minutes for subsequent appointments in the local Health Board. England already has appointments of 15 minutes which women have reported insufficient time to allow conversations relating to mental health (National Health Service UK, 2018). Documentation and the list of tasks carried out during antenatal appointments reflect NICE guidelines (2019). Consequently the increasing complexity of antenatal care over the years has reduced the opportunity to discuss mental health (McGlone et al., 2016; Higgins et al., 2018) which is the latest addition to antenatal appointments. In addition midwives expressed that short appointments resulted in the women's physical care taking precedence over mental health.

More time in appointments could improve discussions around mental health, as would improving continuity of carer. Continuity in maternity care is important and is endorsed by

NICE and the NMC and is also UK government policy (Department of Health, 2016; Scottish Government, 2017; National Institute for Health and Care Excellence, 2019; Nursing and Midwifery Council, 2018), with the aim of providing continuity of the person looking after women before, during and after birth. This has been recognised to lead to better outcomes for the woman and baby (Sandall et al., 2016)). Even though most midwives in this study supported the idea of continuity, reservations have been reported. An anonymous online survey of 798 midwives, after the introduction of the 'Better Birth' report recommending continuity schemes found only 35% were willing to work in continuity-based models and 59% reported they needed to update their clinical skills to work across all settings (Taylor et al., 2019). In England seven early adopter sites commenced the roll out of some or all of the Better Birth recommendations (Taylor et al., 2019). Continuity schemes for antenatal and postnatal care in Wales are also recommended (Healthcare Inspectorate Wales 2020 ; Welsh Government 2019) and are being cautiously introduced.

One of the main areas of concern for midwives was the lack of perceived support for women's mental health. Findings from this study indicate the majority of midwives were keen to support women themselves, as noted previously (Coates and Foureur 2019) but lacked confidence and experience discussing mental health problems. In addition the professional codes for midwives in the UK and Australia state that midwives should refer women to other health practitioners if the care is not in the scope of their practice (Nursing and Midwifery Council 2018; Nursing and Midwifery Board 2018). It is possible that midwives' perception of mental health problems as deviation from the norm could explain why they looked for other services to refer women to.

Midwives in this study reported referral to the PNMH as one of their main options for women with severe mental health problems. Investment in PNMH service by the UK Government has resulted in improved care for women over the last five years as pledged but the scope and size of each is different (Centre for Mental Health, 2021). General practitioners were the second most reported option for referring women with mental health problems. Mixed reviews from midwives showed an inconsistency within non specialist services from general practitioners and community health care settings. In addition midwives expressed concern that women who had built a trusting relationship with their midwife and disclosed a problem, would have to retell their story when referred to their general practitioner.

Midwives were aware of the Birth Afterthoughts clinic, for women traumatised by birth. This offers appropriate women the rewind technique, facilitated by midwives (Moore, 2020) or a listening and debriefing service. A UK study found over 40% of midwives offering such services had no specific training and over 80% of the services lacked a formal evidence base (Thomson and Garrett, 2019). A systematic review found limited studies relating to psychological interventions for birth trauma (Slade et al., 2021). One recent study found a reduction in anxiety, negative mood symptoms and post traumatic stress disorder from a birth trauma psychology clinic which was run alongside a Birth Afterthoughts clinic (Williamson et al., 2021) but not specific to this intervention. Midwives were divided in their opinion of this service and suggested 'debriefing' women after birth rather than waiting for an appointment was more beneficial. This can be offered by any midwife and involves listening to women answering questions related to their birth experience.

Even though keen, midwives did not specify how they could better support women. Close to one third of midwives in a large postal survey (n=815) in Australia stated they would offer empathy and understanding to women with moderate to severe postpartum depression (Jones et al., 2011). Emotional support has always been part of midwifery care (Myles 1955), and asking questions and listening to women is sometimes enough with studies reporting the therapeutic effect of taking part in interviews (Staneva et al., 2017). Conversely midwives who spend time listening to women have been classed as 'slow' by their colleagues (Phillips 2015).

Neither the duration in practice nor training appeared to influence the confidence of midwives. It was the experience of midwives such as those in the SCT who support women with severe mental health issues, which resulted in them being more comfortable asking women about their mental health. In addition they had built up a list of resources, frequently asked questions and supported each other. All midwives reported experience supporting women with anxiety and depression but lacked confidence when women presented with severe mental health problems, which were often combined with complex social issues, as noted previously (Jarrett 2015). The lack of understanding and confidence could be a reason for negative behaviour directed towards women with severe mental health problems in this and other studies (McCauley et al., 2011; Hauck et al., 2015). Provision of a team with experience and time to support women with multiple needs may enhance the care women receive but this does reduce the opportunity for the majority of midwives to gain experience and confidence caring for women with complex issues.

Practical experience and observing more experienced staff may increase midwives confidence. Another area midwives highlighted was the lack of training at undergraduate and postgraduate level. The majority of midwives implied they could be better prepared (94.5%, n=137) to look after women with mental health problems. This is similar to previous studies where 93% (McCauley et al., 2011) and 90% (Witcombe-Hayes et al., 2018) of midwives stated they would benefit from further training relating to perinatal mental health. This is supported by NICE (2016) and the Maternal Mental Health Alliance (2019) in the UK.

NQMs expressed concern that the majority of their training had been in relation to the physical care of mothers and baby or postnatal mental health. Midwives relied on the one hour annual mandatory update from the SCT, although only 21.4% (n=31) of midwives suggested it had helped them in their practice. Conversely a systematic review of 12 articles found training made a positive improvement in knowledge regardless of its content or mode of delivery (Legere et al., 2017). Understanding the theory behind mental health issues was described as insufficient to prepare midwives for practice. Suggestions for training included the practical aspects of supporting women, such as how to ask questions or knowledge of medication for mental health problems.

Limitations

The questionnaire for midwives was originally designed for midwives in Australia, rewording was used to make it applicable to the UK. Although not noted when piloted for consistency, some questions caused ambiguity, resulting in annotated questionnaires and data queries, resolved through discussion in the research team. Questions relating to assessment of mental health did not specify whether they were formal or informal which could leave them open to interpretation.

Although many midwives expressed an interest in the focus groups the number participating in one group were low. This group was open to midwives from all areas of the maternity unit and community teams. Due to the limited number in this group findings may not reflect the experiences across the breadth of midwives.

Acknowledgement is made that a research midwife undertaking the interviews and focus groups could have influenced participants and the subsequent interpretation of data. The frank conversations that took place in the focus groups with midwives who knew the researcher and the NQMs who did not suggest this was not the case. In addition PNMH services vary throughout the UK and generalisations from this study cannot be made regarding other services.

Recommendations for practice

Midwives and NQMs in this study did not find their training helpful for their clinical practice. The majority of training packages have been designed specifically for research and may not be sustainable (Davies et al., 2016). Postgraduate training could be offered as short-topic based face-to-face and recorded sessions, linked to online resources. Topics could include medication, assessment of mental health and support services. Time between sessions would allow midwives to assimilate information and put this into practice. This flexible approach would allow midwives to access training at a convenient time and recorded session make it more sustainable. This could improve midwives' confidence, in turn providing better care for women.

Increasing the duration of antenatal appointments may provide time for midwives to ask about mental health and allow women time to ask questions which may allay anxiety for some. Additionally continuity of carer was shown to be important. For women seen by the same midwife improvement or deterioration of mental health could be observed and enable women to build relationships and feel comfortable discussing concerns.

Compared to physical health problems, midwives suggested there was no clear pathway to follow if they believed women needed more support than they could provide. England has a PNMH pathway in place (NHS England, NHS Improvement, National Collaborating Centre For Mental Health, 2018). More resources and a clear pathway to follow could increase midwives confidence to ask women about their mental health.

Recommendations for future research

Design and evaluation of a training package which is flexible and fits in with ongoing continued professional development and includes aspects of everyday clinical practice is required. In addition future design, implementation and facilitation of new interventions to support women's mental health should involve midwives (Lavender et al., 2016). Training in psychosocial approaches to build up relationships between women and their midwife (Brugha et al., 2016) and interventions such as motivational interviewing (Chisholm et al.,

2016) have been shown to improve confidence and made consultations more effective. Research to assess if these could be implemented into maternity settings is required.

Conclusion

Midwives are the main carer for the majority of women during the perinatal period and are keen to support women's mental health. Barriers to conversations with women including a limited time at appointments, lack of continuity and priority given to the physical care of mother and baby. Midwives expressed a fear that they might make situations worse or not know what to say if women disclosed an issue with their mental health. Midwives frequently suggest referring women for support, even though services are limited, few were aware of how they could support women themselves.

Contrary to previous studies, midwives stated training had not prepared them for the practical aspects of supporting women's mental health. Midwives stated they needed more or different training to respond effectively to the mental health needs of women in the perinatal period. Providing midwives with skills and confidence to offer support, as well as referral options will ensure they are better placed to support women's mental health and provide women with access to evidence based interventions to reduce the negative consequences for women and their families.

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