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Abstract

Aim: To report the findings of a systematic review and meta-synthesis of qualitative studies exploring public health nurses' perceptions and experiences of identifying and managing women with perinatal mental health problems.

Background: Public health nurses play a key role in supporting women who experience perinatal mental health problems and several qualitative studies have explored their role.

Design: Systematic review and meta-synthesis

Data sources: A comprehensive search was developed and multiple databases were searched from 2000-2015.

Review methods: Studies that employed qualitative methods to explore experiences of public health nurses in identifying and managing women with perinatal mental health problems were included. Two reviewers independently assessed the methodological quality of studies. Themes, concepts and interpretations were extracted and synthesised using the process of thematic analysis.

Results: Fifteen papers including 14 unique qualitative studies were included. Two overarching themes emerged: *conceptualisation and detection of perinatal mental health problems*, and *barriers and facilitators to management*. The former of these comprised a number of sub-themes including the use of formal screening tools versus clinical intuition and barriers encountered in detection. The latter theme, *barriers to management* included availability of referral pathways and time. In terms of *facilitators*, training, public health nursing interventions, support groups and referral pathways were identified as factors that optimise management.

Conclusions: Public health nurses use a variety of methods to identify women with perinatal mental health problems. However, a number of support structures are needed to optimise management including access to appropriate referral pathways, support groups and relationship continuity.

SUMMARY STATEMENT

Why is this review needed?

- Public health nurses are particularly well placed to identify and support women who experience perinatal mental health problems, and a number of qualitative studies have explored public health nurses' perceptions and experiences of identifying and supporting women who experience perinatal mental health issues.
- Through a synthesis of these studies we can increase our understanding of public health nurses' preparation for their role and strategies available to support them in their work.

What are the key findings?

- A combination of individualised, flexible home visits, phone consultations and clinic based visits are instigated by public health nurses to meet the needs of women who experience perinatal mental health problems and their families.
- This review found that screening tools supported engagement and decision making however it also acknowledged that engagement is dependent on the relationship that is formed between the woman and public health nurse.
- Detection and management of perinatal mental health problems is informed by the availability of referral pathways.

How should the findings be used to influence policy/practice, research and education

- Referral pathways available to public health nurses should encompass a range of health service initiatives including counselling, listening visits, cognitive behavioural therapy, culturally appropriate community support groups, referral to general practitioners, and referral to perinatal mental health specialists for severe mental health problems.

- Findings highlight a need for further research to explore the referral supports that public health nurses require to support them to undertake a role in perinatal mental health care and to examine the outcomes of training on public health nurses practice.
- The findings of this review can be used to inform continuous professional development programmes that support public health nurses to receive education and upskilling to respond to the spectrum of psychological distress in cross-cultural situations encountered in the perinatal period.

Key words: Perinatal mental health problems, public health nurses, nursing, screening, barriers, facilitators, systematic review, meta-synthesis

Introduction

Perinatal mental health (PMH) refers to the mental health of women during pregnancy and up to one year following birth, and encompasses a preventative approach that considers the mental health outcomes of mothers to be closely linked to their infants (Austin 2003). The term perinatal mental health problems (PMHPs) describes the full range of mental health difficulties from psychological distress experienced by many women to serious mental health problems (SMHPs) and includes minor and major depression, anxiety, post-traumatic stress, bipolar, schizophrenia and postpartum psychoses (Austin 2003, Austin *et al.* 2008). Prevalence of perinatal depression among pregnant women and new mothers are reported as 13% and 19% respectively (Gavin *et al.* 2005). However, variations in prevalence exist due to differences in populations, screening assessments and outcomes examined across studies (Glavin & Leahy-Warren 2013). PMHPs are identified as a significant source of distress and adverse outcomes that impact on the wellbeing of the woman, her baby and significant others (Martin 2012). PMHPs are associated with recurrent depression, increased risk of severe mental health problems (SMHPs), suicide and less responsive care giving (Martin

2012, Knight *et al.* 2014). PMHPs have also been shown to impact on child development (Glasheen *et al.* 2010, Kingston *et al.* 2012) and are linked to perinatal paternal depression and relationship dissatisfaction (Wee *et al.* 2011). The long-term cost to society of untreated PMHPs has been estimated in the UK as £8.1 billion for each one-year cohort of births (Bauer *et al.* 2014).

Background

Public Health Nurses (PHNs) offer a broad-based multifaceted universal primary care service to a multiplicity of new mothers and their babies in the community within a defined period after birth (Hanafin *et al.* 2002, Glavin & Leahy-Warren 2013). The range and scope of public health nursing practice varies between countries as does the terminology used to refer to PHNs. For example the titles 'PHN' or 'health visitor' are used in European countries and Maternal, Child and Family Health Nurse is used in Australia. The term PHN has been used throughout this article. PHNs are particularly well placed to identify and support women who experience PMHPs, and a number of qualitative studies have explored PHNs role in this area. Through a synthesis of these studies we can increase our understanding of PHNs' preparation for their role and strategies available to support them in their work.

The review

Aim: To conduct a systematic review and meta-synthesis of qualitative studies exploring PHNs' perceptions and experiences of identifying and managing women with PMHPs.

Design

This review aimed to comprehensively understand and explore the totality of evidence in relation to PHNs' perceptions and experiences of their role in PMH care and thus a meta-synthesis was identified as an appropriate methodology. A meta-synthesis can identify new insights, facilitate the subtlety of practice and taken-for-granted assumptions to be described, contribute to our knowledge, practice and policy, and lead to improvement in healthcare (Walsh & Downe 2005, Campbell *et al.* 2011). The meta-synthesis allowed for a rigorous and analytical process to amalgamate findings of a group of qualitative studies through comparing, contrasting and collating common themes to create an in-depth

description and understanding of the phenomenon. The meta-synthesis comprised three steps: (i) identifying relevant papers for inclusion (ii) critical appraisal and data extraction and (iii) analysis and synthesis of findings. The Enhancing transparency in reporting the synthesis of qualitative research (ENTREQ) framework guided the reporting of the synthesis (Tong *et al.* 2012).

Search methods

Pre-planned systematic literature searches were conducted in October 2015 of the following databases: Academic Search Complete; AMED - The Allied and Complementary Medicine Database, CINAHL Plus with Full Text, General Science Full Text, MEDLINE, PsycARTICLES, PsycINFO, Social Sciences Full Text, Cochrane, Science Direct and SCOPUS. A combination of key words and MeSH terms were used (table 1) and the search was supplemented by hand searching reference lists of retrieved articles.

Studies were included if they employed a qualitative study design to explore PHNs' perspectives regarding the identification and management of women with PMHPs. Studies were limited to those published in English and from 2000-2015 to capture relevant studies and reflect service and policy development. Two screening questions were applied to each article:

- (i) Does the paper report findings of qualitative research involving both qualitative methods of data collection and analysis?
- (ii) Is the focus of the research paper relevant to the synthesis topic?

Search outcome

Figure 1 describes the search and inclusion process. The initial search string yielded 2225 articles of which 764 duplicates were removed and 1438 were excluded based on review of the title and abstract. Two reviewers independently assessed the full-text of the remaining 23 articles. Eight articles were subsequently excluded as they explored paraprofessionals' experiences. The reference lists of the 15 remaining articles were searched and no

additional studies were identified. Therefore, 15 articles describing the findings from 14 qualitative studies were included in the final review.

Quality appraisal

The methodological quality of included papers were assessed by two researchers (RG and MN) using criteria based on the 10 questions for qualitative study designs derived by the Critical Appraisal Skills Programme (CASP). Studies were appraised for assessment of conduct, and for content and utility of findings (Tong *et al* 2012). Each criterion was recorded as "Yes", "No" or "Unclear" and with reasons for this judgement. Results of the appraisal were discussed between reviewers and discrepancies resolved by consensus. Studies were not excluded on the basis of methodological quality. Overall studies were found to be of good methodological quality. Table S1 displays the findings of the critical appraisal process. All studies identified research aims, appropriateness of design, clear statements of findings and outlined the value of their research. However, studies were unclear regarding: data saturation (n=12, Table S1), acknowledgment researcher/participant relationship (n=10, Table S1) and ethical considerations including an explicit statement of ethical approval and informed consent (n=11, Table S1).

Data abstraction and synthesis

The following information was extracted from each article: number and description of participants; methodology, data collection and analysis method Table 2. A descriptive meta-synthesis guided by Salter *et al.* (2008), Thomas and Harden (2008) and Walsh *et al.* (2015) was undertaken where unchanged texts under the headings "results/findings" of each primary study formed the data for analysis and these findings were not deconstructed prior to synthesis. Two authors (RG and MN) independently reviewed and coded line by line the extracted data from each primary study and developed a list of key concepts with subsequent studies coded into pre-existing concepts and new concepts created when required. The concepts were compared, consolidated and categorised into 'descriptive themes' until no new themes emerged. The 'descriptive themes' were clustered around

common dimensions of PHN experiences and perceptions of caring for women with PMHPs and grouped to form analytical themes presented as the synthesis findings. The process of derivation of themes was inductive through independent, iterative and interactive readings of the empirical data to the final themes. Examples of data from the original studies that support each theme and subtheme are presented in Table S2.

Findings

Descriptive characteristics of the included studies

The 14 studies/15 articles in the final synthesis represent PHNs from 6 countries (UK n=8, Sweden n=1, Greece n=1, Australia n=2, Finland n=1 and Norway n=2) and include data from 204 participants (minimum 3, maximum 83). Studies employed a range of methodologies: 2 qualitative descriptive (Borglin *et al* 2015, Glavin *et al* 2010), 1 ethnography (Rollans *et al* 2013), 1 phenomenology (Rush 2012), 1 grounded theory (McConnell *et al* 2005), 1 case study (Almond and Lathlean 2011), 1 mixed methodology (Jomeen *et al* 2013) and 1 which was within a multi-centre pragmatic RCT and the qualitative findings of this study were reported in two independent publications (Chew-Graham *et al.* 2008, Chew-Graham *et al.* 2009) and 6 studies where the methodology was a qualitative approach (Agapidaki *et al* 2014, Tammentie *et al* 2013, Vik *et al* 2009, Brown and Bacigalupo 2006, Baldwin and Griffiths 2009, Clark 2000).

Synthesis of the identified themes

Two overarching themes were identified describing the typology of approaches used by PHNs working with women experiencing PMHPs. The overarching themes were *conceptualisation and detection of PMHPs*, and *barriers and facilitators to managing PMHPs*. These themes comprised a number of subthemes and supporting text from the primary studies to highlight these themes is contained in Table 4.

Conceptualisation and detection

Within this overarching theme several factors were identified as affecting the conceptualisation and detection of PMHPs. These subthemes included: conceptualisation of the problem, use of formal screening tools versus clinical intuition, use of individualised holistic approaches to detection and barriers encountered in detection of PMHPs.

Conceptualisation of the problem

PHNs had developed their own conceptualisation of what postnatal depression (PND) was which varied from a discrete condition to ambivalence about the status of PND as a separate condition (McConnell *et al.* 2005, Chew-Graham *et al.* 2008, Borglin *et al.* 2015). Some participants viewed PND as a social response to the transition to parenthood (Chew-Graham *et al.* 2009, Agapidaki *et al.* 2014). Multifactorial causes of PND were identified including reference to the idealised representation of perfect motherhood and a constant influx of information that parents are exposed to (Chew-Graham *et al.* 2009, Agapidaki *et al.* 2014, Borglin *et al.* 2015).

Participants used lay terms to deconstruct postnatal distress and normalise mental health (McConnell *et al.* 2005) with a focus on possibilities rather than problems (Vik *et al.* 2009). There was a reluctance to label women as this would lead to a medicalised approach where women were referred to a General Practitioner (GP) (McConnell *et al.* 2005, Chew-Graham *et al.* 2008). The openness of the woman facilitated easier recognition of PMHPs (Jomeen *et al.* 2013) however participants had to look beyond the surface to uncover how the woman was really feeling (Rush 2012, Tammentie *et al.* 2013, Borglin *et al.* 2015). This was more difficult when cultural differences existed and participants spoke about imposing English standards on the cultural experience and lack of cultural supports as factors that hinder the identification of PMHPs (Baldwin & Griffiths 2009, Almond & Lathlean 2011). While PHNs were committed to equity of service and emphasised the importance of not discriminating because of cultural background some PHNs did not avail of interpreters as there was a fear that information would not be interpreted correctly (Almond & Lathlean 2011).

Use of formal screening tools versus clinical skills and intuition

The main screening tool identified was the Edinburgh Postnatal Depression Scale (EPDS) and participants found its use enabled them to initiate a conversation about mental health and shift the focus from the baby to the woman thus creating an openness about mental health issues (Clark 2000, Vik *et al.* 2009, Glavin *et al.* 2010, Rush 2012, Borglin *et al.* 2015). The importance of both the PHN and woman engaging in the screening process was identified. Participants also reported that the autonomy of the woman to respond to sensitive questions was supported through the consistent use of screening tools (Vik *et al.* 2009). The EPDS supported the participants to identify possible PND when mothers appeared to be well which provided them with an opportunity to intervene early in order to prevent more severe PND (Clark 2000, Vik *et al.* 2009, Borglin *et al.* 2015). In utilising the EPDS screening tool participants reported increased professional confidence, sensitivity and alertness to PMHPs and increased engagement with the woman which supported a quality interaction (Brown & Bacigalupo 2006, Vik *et al.* 2009, Glavin *et al.* 2010, Borglin *et al.* 2015). Participants perceived that the use of formal screening also increased the possibility that a mother would seek support outside of the routine health visits (Glavin *et al.* 2010). Participants emphasised the importance of organisational commitment to training and supervision in the use of culturally sensitive screening tools and in ensuring that a follow up referral is available to the PHN (Brown & Bacigalupo 2006, Vik *et al.* 2009, Glavin *et al.* 2010, Almond & Lathlean 2011, Jomeen *et al.* 2013, Rollans *et al.* 2013, Agapidaki *et al.* 2014).

From a clinical skill perspective, PHNs reported using their senses to assess the woman's psychological wellbeing (Rollans *et al.* 2013, Agapidaki *et al.* 2014). Strategies included observation of the woman's appearance, mood and interaction with her baby and family, and listening to the woman (Baldwin & Griffiths 2009, Rollans *et al.* 2013, Agapidaki *et al.* 2014). These observations supported PHNs in identifying PMHPs and PHNs valued what they referred to as 'silent' or intuitive knowledge in detecting 'all was not right' (Brown & Bacigalupo 2006, Chew-Graham *et al.* 2009, Jomeen *et al.* 2013, Borglin *et al.* 2015).

Individualised holistic approach to detection

The importance of the relationship between PHN and the woman was identified as key in detecting PND (Clark 2000, McConnell *et al.* 2005, Brown & Bacigalupo 2006, Chew-Graham *et al.* 2008, Jomeen *et al.* 2013, Rollans *et al.* 2013, Tammentie *et al.* 2013, Agapidaki *et al.* 2014) and central to this relationship was engagement and getting the first introductions right (Rollans *et al.* 2013). Participants used different strategies to develop rapport with the woman including humour and creating comfort/trust for the woman to open up about her feelings (Tammentie *et al.* 2013). Home visiting varied according to each individual woman's needs (Brown & Bacigalupo 2006, Rush 2012, Borglin *et al.* 2015) and in cases where PHNs had a role antenatally this was perceived to support the development of the relationship and continuity of care (Clark 2000, Brown & Bacigalupo 2006). The role of the PHN differed throughout their encounters with the women from formal to informal and in instances where the woman was experiencing psychological distress, a formal approach was used to detect PMHPs (McConnell *et al.* 2005, Tammentie *et al.* 2013). Participants identified the importance of having time to undertake a meaningful visit and assessment and it was acknowledged that there was more time available in the home in comparison to clinics (Rush 2012, Borglin *et al.* 2015). The importance of non-judgemental communication was emphasised (Rollans *et al.* 2013, Borglin *et al.* 2015). However one study identified reluctance by some PHNs to provide care to women with PND because of potential of overreliance of the woman on the PHN (Rush 2012).

Barriers to detection of PMHPs

Barriers to detection were identified across studies including the role of evidence based practice, stigmatisation, cultural diversity and referral processes. The PHNs described non-evidence based approaches, lack of a uniform framework, variations in visiting patterns and organisational pathways for PMH in the community settings as barriers to providing care (Brown & Bacigalupo 2006, Baldwin & Griffiths 2009). In one study, PHNs' perceived that PND was not prioritised from a systemic level (McConnell *et al.* 2005). In some studies, guidelines were available to participants but they were not uniformly implemented (Jomeen *et al.* 2013). Lack of continuity of care impacted on the ability of PHNs to form and maintain relationships with parents (Chew-Graham *et al.* 2009). PHNs perceived that a woman's

reluctance to seek help was related to the stigma associated with PND and a reluctance to accept the label of PND (Brown & Bacigalupo 2006, Chew-Graham *et al.* 2009, Agapidaki *et al.* 2014). It was felt that this reluctance to seek help was also reinforced by fear of child protection issues and links to social services (Brown & Bacigalupo, 2006, Agapidaki *et al.* 2014). A further challenge identified was caring for a culturally diverse client group with limited support structures such as a lack of translated PND literature, cultural specific validated tools for assessing PMHPs, language barriers and lack of understanding of PMHPs within different cultures (Baldwin & Griffiths 2009, Almond & Lathlean 2011, Jomeen *et al.* 2013). PHNs across the studies expressed a reluctance to identify PND because of the limited services and referral options available to them (Chew-Graham *et al.* 2009). The main referral option available to PHNs was onward referral to the GP. However, PHNs perceived that GPs primary management of PMHPs was limited to the prescription of antidepressants (Chew-Graham *et al.* 2009). In studies where PHNs perceived that inadequate services were available to women, they felt that this hindered disclosure of symptoms of PMHPs and PHNs were left to take on the additional responsibility of supporting the woman and her family (Jomeen *et al.* 2013, Agapidaki *et al.* 2014).

Barriers and facilitators to managing PMHPs

This overarching theme explores the factors that hinder and facilitate PHNs to support women who experience PMHPs.

Barriers to management were identified across studies and two components of this theme were identified including availability and adequacy of referral pathways and time. On the contrary, the provision of adequate training as well as PHN interventions, referral to community support groups and appropriate referral pathways were identified as factors that enhanced or supported the management of women with PMHPs (Brown and Bacigalupo 2006, Vik *et al.* 2009, Baldwin and Griffiths 2009, Almond and Lathlean 2011, Rush 2012, Tammentie *et al.* 2013, Borglin *et al.* 2015).

Availability and adequacy of referral pathways

Referral pathways were identified as the main barrier to managing PMHPs and conflict was evident with regards to whose responsibility it was to support women with PMHPs (Brown & Bacigalupo, 2006, Jomeen *et al.* 2013, Rollans *et al.* 2013, Agapidaki *et al.* 2014). This conflict referred to the GP and PHN as PHNs felt neither confident nor qualified to deal with psychological issues uncovered and this was compounded by a lack of availability and adequacy of appropriate service provision e.g. free counselling, fragmentation of primary services, lack of collaboration across transitions of care and lack of mental health specialists in primary care (Jomeen *et al.* 2013). This led to a sense of professional frustration among the participants in the studies (Jomeen *et al.* 2013).

Time

Participants discussed the importance of having adequate time to support women who experience psychological distress. Finding sufficient time to undertake a role in PMH and also reflect upon their encounters with woman was challenging in some work environments (McConnell *et al.* 2005, Baldwin & Griffiths 2009, Glavin *et al.* 2010, Rush *et al.* 2012, Rollans *et al.* 2013, Agapidaki *et al.* 2014).

Training

Training was identified as essential to support PHNs to develop the knowledge and skills to support women who experience psychological distress. In instances where training had been effectively delivered, PHNs reported an increase in confidence in their ability to undertake a role in PMH (Glavin *et al.* 2010, Jomeen *et al.* 2013, Tammentie *et al.* 2013). Targeted training interventions that address stigma, knowledge, skills and referral options that address specific cultural and ethnic population variations facilitated effective PMH care (Vik *et al.* 2009, Glavin *et al.* 2010, Almond & Lathlean 2011, Agapidaki *et al.* 2014).

PHN interventions

When PHNs identified that a woman was experiencing psychological distress, they subsequently instigated a number of PHN led interventions which included an increase in visits in which open discussions with no set agenda and listening visits were offered to clients (Clark 2000, Brown & Bacigalupo 2006, Rush 2012). In some cases, a covert meeting would be arranged to weigh the baby at which the mother's psychological wellbeing would be reassessed (Borglin *et al.* 2015). The skills and experience of the PHN determined the management strategies used in managing PND as an alternative to automatic referral to a GP (Chew-Graham *et al.* 2009). The PHNs focused on the mother's wellness rather than illness and encouraged the woman to reflect on her available resources (Borglin *et al.* 2015).

Community support groups

PHNs valued the availability of community voluntary support groups to refer women to including cultural specific support groups (Baldwin and Griffiths 2009, Almond & Lathlean 2011, Rush 2012, Borglin *et al.* 2015).

Referral pathways

While availability and adequacy of referral pathways were acknowledged as a barrier to detection, they were also identified by participants as facilitators in the overall management of PMHPs. In instances where PHNs had access to consultation with a mental health specialist and site referral pathways, this supported them in undertaking their role in PMH care (Vik *et al.* 2009, Rush 2012, Jomeen *et al.* 2013, Agapidaki *et al.* 2014, Borglin *et al.* 2015).

Discussion

In the studies included in this review there was a focus on postnatal depression to the exclusion of other PMHPs which may prevent women from identifying their PMHP and seeking appropriate treatment (Highet *et al.* 2014). It is now acknowledged that there is a need to look at the spectrum of psychological health (Jomeen *et al.* 2013) and this will have implications for education and preparation of PHNs for their role in PMH. In the review, ambivalence to the existence of PND as a discrete disorder was identified as was the tendency to normalise depressive symptoms. Misconceptions regarding the nature and manifestations of PND have been identified as a barrier to care, leading to maternal reluctance to seek help and inadequate treatment and referral (Dennis & Chung-Lee 2006). The stigma associated with mental health is globally recognised as a major barrier to women seeking help. While the usefulness of the 'label' PND to legitimise the woman's symptoms was acknowledged among PHNs, it was also identified as a limitation because of the stigma associated with the label.

The importance of developing a relationship with the woman was identified by PHNs across studies. Relationship building is identified as a complex skill that requires the PHN to have excellent communication skills and is in itself therapeutic (Aston *et al.* 2015). PHNs who had an existing relationship with the woman and her family found that this supported them to detect PND. Jack *et al.* (2005) recommend that PHNs continually assess the quality of their relationships with clients. Cowley *et al.* (2015) found that where an effective parent PHN relationship was formed over repeated contacts, it was more likely that parents would seek help from PHNs. Likewise Drennan & Joseph (2005) identified the importance of continuity of long-term relationships with women who were settled refugees to support disclosure of PMH issues, a view supported by Edge (2010) where antenatal contact was identified as the key to recognizing changes in postnatal mood. Furthermore, Cowley *et al.* (2015) noted that the use of a therapeutic approach designed to psychologically support individuals who are experiencing distress and awaiting appropriate referral may prevent an escalation of distress, and increase the likely uptake of services and support the disclosure of PMH issues.

PHNs incorporate a variety of strategies to comprehensively conduct complex assessments of woman's mental health and Jomeen *et al.* (2013) contends that such a flexible approach.

This may enable questioning to extend beyond the parameters of a formulaic approach and facilitate a broader consideration of the interaction of complex psychosocial factors and psychological health (Jomeen *et al.* 2013). However they also acknowledge that this may not be an option for PHNs with limited experience a view supported by Cowley *et al.* (2015) who found that when PHNs were inadequately skilled this led to missing cues, poor cognition of maternal needs and lack of effective communication which risks future opportunities for consultation.

PHNs in the studies included in this review observed mother infant interaction as a means for identifying PND but were aware of the tension between support and surveillance and Aston (2008) contends that while the intent of the PHN may be to support the mother infant relationship some mothers may experience this expectation as a type of surveillance of their mothering abilities that may cause stress. Aston (2008) stresses the importance of undertaking this approach in a sensitive and respectful manner incorporating a discussion of both social and personal perspectives.

A combination of individualised, flexible home visits, telephone consultations and clinic based visits were arranged by PHNs to meet the needs of women and their families and Cowley *et al.* (2015) identify the importance of this form of flexibility to ensure service uptake across the social spectrum. The home environment was identified as an important setting which supported relationship formation, the woman to open up about her situation and identification of psychological needs and this finding is supported by the findings of reviews by Brealey *et al.* (2010) and Cowley *et al.* (2013).

PHNs were concerned with their ability to grasp different cultural perspectives or needs around PND. These findings are in keeping with recurring themes in the research about immigrant populations (Edge 2010, Crowley *et al.* 2015). In a systematic review of maternal health care in migrant populations, Almeida *et al.* (2013) found that while immigrant mothers were more likely to experience PND they were less likely to be asked about their emotional well-being and may receive less optimal care due to poor communication between women and caregivers. Research indicates that PHNs require additional support

and education to facilitate a contemporary understanding of the spectrum of perinatal psychological health experienced by women from different cultural and ethnic backgrounds (Drennan & Joseph 2005, Edge 2010, Jomeen *et al.* 2013), which serves to support PHNs to develop knowledge and skills in the identification and psychological intervention methods to prevent perinatal depression (Leahy-Warren & Corcoran 2011). A large randomised cluster trial that explored the cost effectiveness of PHNs role in the detection of PND found that women in the intervention group treated by PHNs trained on cognitive behavioural therapy and person centred care had a significantly lower risk of PND at six months (OR 0.62) (Morrell *et al.* 2006, Morrell *et al.* 2009ab, Brugha *et al.* 2011). There is also evidence to support the benefit of listening visits provided by PHNs (Morrell *et al.* 2009a, Segre *et al.* 2010).

Detection and management of PMH is informed by the availability of referral pathways and Chew-Graham *et al.* (2009) suggest that PHNs make conscious decisions about whether or not to facilitate women's disclosure of symptoms of PND depending on the availability of resources and appropriate referral options. A barrier to the provision of PMH care identified in this review was the lack of availability and knowledge of co-ordinated PMH referral pathways. The most recent report on Confidential Enquiries into Maternal Deaths and Morbidity 2009-2013 in the UK and Ireland identified the importance of the establishment of perinatal mental health clinical networks and to the need for development of local services and clear pathways of care to prevent care being fragmented and uncoordinated (Knight *et al.* 2014). PHNs were reluctant to refer to the GP because they associated GPs with prescription of antidepressants. It is recognised that only a minority of women require anti-depressants and evidence of the effectiveness of psychological therapies for the treatment of perinatal depression has been established (Rahman *et al.* 2013). Tandon *et al.* (2014) argues that a shift in focus to prevention services is required because of the limited success in linking women with PMHPs to treatment services. PHNs are already undertaking a preventive role and this could be strengthened with further training underpinned by a perinatal mental strategy where prevention is a key focus. To this end, redesigned postpartum care comprising training of PHNs, increased focus on PMHPs at home visits, screening and the provision of supportive counselling by trained PHNs may serve as effective strategies to optimise management of PMHPs (Glavin *et al.* 2010).

Strengths and weaknesses of the review

The qualitative methodology employed in this review allowed the authors to explore in detail factors associated with the identification and management of PMHPs from the perspective of PHNs. A robust methodological approach was employed to identify and select articles relevant for inclusion. However, there are some limitations to this review. Firstly, the process of qualitative meta-synthesis is not yet well defined and the methodology of this review was based on previously published descriptions of the process (Walsh et al. 2015). Furthermore, the use of a checklist approach to critical appraisal within qualitative research remains controversial. Acknowledging this, the process of meta-synthesis may facilitate the incorporation of qualitative research findings into evidence-based practice and is therefore important.

In some countries PHNs and equivalent healthcare professionals may not have a recognised role in PMH as this may be the remit of other healthcare professionals working in the community. Therefore the findings of this review are only applicable to PHNs working in the community with women during the perinatal period. The researchers involved in the review do not have a background in public health nursing and a lack of understanding of the context of public health nursing may have impacted on the interpretation of the data. However it may also be identified as a strength in that the researchers do not have any preconceived presumptions about this area of practice and the transparent methodical approach used in the selection and synthesis of articles served to minimise potential bias. The authors endeavoured to occupy the middle ground so “emic and etic” viewpoints were recognised and the authors remained objective and reflexive in interpreting the findings.

Clinical and policy implications

In order to support PHNs to continue to optimally fulfil this role, there is a requirement for continuous professional development (CPD), designed to increase knowledge, enhance psychosocial assessment and referral skills that are sensitive to the needs of women from different cultural backgrounds. Other support systems such as collaborative models of clinical supervision and improved access to specialist guidance are also required. Consideration must be given to continuity of care as an effective strategy to support the

development of parent/PHN relationships and the provision of emotional care to women in the community. There is a need for further research to explore the referral pathways that PHNs require to support them to undertake a role in PMH care and to examine the outcomes of training on PHNs practice.

In terms of policy implications, these findings highlight inadequacies in the range and availability of referral pathways accessible to PHNs to support them in their role in perinatal mental health care. There is a need for policy makers and service planners to map the range of services available to community needs thus ensuring that PHNs with a remit for women and child health care have access to further assessment, intervention and support services. These referral pathways should encompass a range of health service initiatives including counselling, listening visits, Cognitive behavioural therapy, culturally appropriate community support groups, referral to GPs and perinatal mental health specialists for SMHPs.

Conclusion

PHNs are well placed to identify and care for women who experience psychological distress. However, a number of support structures are needed to optimise PMH care including access to CPD opportunities, appropriate referral pathways, community support groups, and relationship continuity.

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