# Perinatal Pathways:

# A mixed methods study of specialist services for women at risk for poor perinatal mental health outcomes

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**BHSci(Nurs) MN(Hons)**

**A thesis submitted to fulfil the requirements of a**

**Doctor of Philosophy (PhD) Degree**

**University of Western Sydney**

**May 2015**

# DEDICATION

I dedicate this thesis to my son,

Alexander Stewart Myors,

who was young when I started though not so young when I completed,

but kept me going through the tough times.

Your growth and development,

especially your enduring interests in palaeontology and zoology,

have inspired me throughout.

# ACKNOWLEDGEMENTS

There are many people whom I need to thank for their encouragement and support on my research journey.

My research would never have occurred without the participation of the perinatal and infant mental health clinicians, their managers and the key stakeholders. I thank you for allowing me to enter your professional lives and for giving your time during busy work schedules. I am also deeply indebted to the 11 women who allowed me to intrude upon their personal time.

A special thank you to my supervisors, Professor Virginia Schmied, Professor Maree Johnson and Associate Professor Michelle Cleary. Thank you for your wisdom and direction which guided me through the dark days to the light at the end. I especially thank you for your belief that I would eventually get there.

To my friends, work and student colleagues, I thank you for your friendship and support that kept me motivated along the way. I am especially grateful to Rachel and Katrina for the extra support you gave me.

To my family, James, Neil, Andrea and Lesley, without your support none of this would have been achievable.

# STATEMENT OF AUTHENTICATION

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

……………[redacted]…………

(Karen Anne Myors)

# PUBLICATIONS AND PRESENTATIONS

This thesis is presented as a series of five published papers. I am the first author on each of the papers and had full responsibility for collecting and analysing the data that are reported in each paper. I prepared the drafts of each paper and my co-authors and supervisors provided feedback on each draft and the revisions of the papers. Co-author and supervisor contributions involved assistance with the design of the study and data analyses. The initial analysis of all of the data was undertaken by me. This was then reviewed by my principal supervisor and discussed and confirmed by all the authors.

## Published papers

Myors, K.A., Cleary, M., Johnson, M. & Schmied, V. (2015). A mixed methods study of collaboration between perinatal and infant mental health clinicians and other service providers: Do they sit in silos? *BMC Health Services Research*, *15*: 316. DOI: 10.1186/s12913-015-0977y

Myors, K.A., Johnson, M., Cleary, M. & Schmied, V. (2015). Engaging women at risk for poor perinatal mental health outcomes: A mixed methods study. *International Journal of Mental Health Nursing, 24*: 241-252. DOI: 10.1111/inm.12109

Myors, K.A., Schmied, V., Johnson, M. Cleary, M. (2014). Therapeutic interventions in perinatal and infant mental health services: A mixed methods inquiry. *Issues in Mental Health Nursing, 35:* 372-385. DOI: 10.3109/01612840.2013.873100

Myors, K.A., Schmied, V., Johnson, M. & Cleary, M. (2014). 'My special time': Australian women's experiences of accessing a specialist perinatal and infant mental health service. *Health and Social Care in the Community*, *22* (3): 268-277. DOI:10.1111/hsc.12079

Myors, K.A., Schmied, V., Johnson, M. & Cleary, M. (2013). Collaboration and integrated services for perinatal mental health: An integrative review. *Child and Adolescent Mental Health*, *18* (1): 1-10. DOI: 10.1111/j.1475-3588.2011.00639.x

# Published abstracts

Myors, K.A., Schmied, V., Johnson, M. & Cleary, M. (2013). Collaboration in perinatal and infant mental health - by whose definition? Abstracts of the Australian College of Mental Health Nursing 39th International Mental Health Nursing Conference – *Collaboration and Partnership in Mental Health Nursing. International Journal of Mental Health Nursing*, *22* (Supplement 1): 25. DOI: 10.1111/inm.12047 (Appendix 1).

Myors, K.A., Schmied, V., Johnson, M. & Cleary, M. (2013). Specialist perinatal mental health services: Characteristics of women & services provided. The Marce International Society International Biennial General Scientific Meeting "Acting Together Around Childbirth", *Archives of Women's Mental Health, 16* (Supplement 1): s36. DOI: 10.1007/s00737-013-0355-x (Appendix 2).

# Presentations - oral

## International

Myors, K.A., Schmied, V., Johnson, M. & Cleary, M. (2014). *Perinatal & infant mental health clinicians: The caregiver as the careseeker.* Compassion and care in a changing world, The 3rd Asia-Pacific International Conference on Qualitative Research in Nursing, Midwifery and Health, 1-3 October 2014, Newcastle, NSW, Australia.

Myors, K.A., Schmied, V., Johnson, M. & Cleary, M. (2014). *Antenatal depression and psychosocial screening: How are women with complex needs supported?* Midwives: Improving women's health globally, International Confederation of Midwives 30th Triennial Congress, 1-5 June 2014, Prague, Czech Republic.

Myors, K.A., Schmied, V., Johnson, M. & Cleary, M. (2013). *Collaboration in perinatal and infant mental health – by whose definition?* Collaboration and partnerships in mental health nursing, 39th International Mental Health Nursing Conference, The Australian College of Mental Health Nurses Inc., 22-24 October 2013, Perth, Western Australia, Australia.

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## National

Myors, K.A., Schmied, V., Johnson, M. & Cleary, M. (2013). *Specialist perinatal mental health services: Engaging and connecting with vulnerable women*. Connections with Families... with Communities... with Colleagues, 5th Biennial Maternal, Child and Family Health Nurses conference, 9-11 May 2013, Canberra, Australia.

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### Local

*Myors, K.A., Schmied, V., Johnson, M. & Cleary, M. (2015). *Mixed methods revelations: Therapeutic interventions in perinatal and infant mental health*. Nursing and Midwifery Research and Innovation Conference, Central Coast Local Health District, 14 May 2015, Gosford, NSW, Australia. ***Awarded runner up for the Best Oral Research Presentation.**

Myors, K.A., Schmied, V., Johnson, M. & Cleary, M. (2014). *Perinatal and infant mental health: a study of specialist services in NSW.* Presented to Central Coast Mental Health Service, 30 October 2014, NSW, Australia.

Myors, K.A., Schmied, V., Johnson, M. & Cleary, M. (2014). *Perinatal Pathways: A mixed methods study of specialist services for women at risk for poor perinatal mental health outcomes.* Feedback session to Site 2, 7 August 2014, NSW, Australia.

Myors, K.A., Schmied, V., Johnson, M. & Cleary, M. (2014). *Perinatal Pathways: A mixed methods study of specialist services for women at risk for poor perinatal mental health outcomes.* Feedback session to Site 1, 28 April 2014, NSW, Australia.

Myors, K.A., Schmied, V., Johnson, M. & Cleary, M. (2013). *Perinatal pathways: A study of specialised services for women at risk of poor perinatal mental health.* 2013 Research and Teaching Showcase, South Western Sydney Local Health District and Ingham Institute of Applied Medical Research, 29 November 2013, Liverpool, NSW, Australia.

Myors, K.A., Schmied, V., Johnson, M. & Cleary, M. (2013). *Perinatal pathways: A study of specialised services for women at risk of poor perinatal mental health.* 2013 Research and Teaching Showcase, South Western Sydney Local Health District and Ingham Institute of Applied Medical Research, Three Minute Thesis Competition, 29 November 2013, Liverpool, NSW, Australia.

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Myors, K.A., Schmied, V., Johnson, M. & Cleary, M. (2013). *Perinatal and infant mental health: a study of specialist services in NSW*. The Journey: An eclectic look across the life span, Mental Health Nursing Conference, Australian College of Mental Health Nurses, Central Coast Branch, 28 June 2013, Ettalong, NSW, Australia.

*****Myors, K.A., Schmied, V., Johnson, M. & Cleary, M. (2013). *Perinatal pathways: A study of specialised services for women at risk of poor perinatal mental health.* Research Futures Forum, University of Western Sydney, School of Nursing and Midwifery 3MT (three minute thesis) competition, 3 June 2013, Parramatta, NSW, Australia. ***Awarded runner up for the Best Presentation and winner of the People's Choice Award.**

Myors, K.A., Schmied, V., Johnson, M. & Cleary, M. (2013). *"Being held": Clinical interventions in perinatal and infant mental health services.* Research Futures Forum, University of Western Sydney, School of Nursing and Midwifery, 3-4 June 2013, Parramatta, NSW, Australia.

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## Presentations - media

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# ABBREVIATIONS

**AHS** - area health service

**CBT** - cognitive behavioural therapy

**CFH** - child and family health

**DoH** - Department of Health

**IPV -** intimate partner violence

**ITP** - interpersonal psychotherapy

**KM** - Karen Myors

**MC** - Michelle Cleary

**MJ** - Maree Johnson

**MR** - medical record

**NGO** - non-government organisation

**NSW** - New South Wales

**PCP** - perinatal care plan

**PhD** - Doctor of Philosophy

**PIMH** - perinatal and infant mental health

**QUAL -** qualitative data given priority weighting in mixed methods research

**qual** - qualitative data given lesser weighting in mixed methods research

**QUANT** - quantitative data given priority weighting in mixed methods research

***SFE Policy*** - *Supporting Families Early Policy*

**SPSS** - Statistical Package for the Social Sciences

**TABEIS** - Theory of Attachment Based Exploratory Interest Sharing

**UK** - United Kingdom

**USA** - United States of America

**UWS** - University of Western Sydney

**VS** - Virginia Schmied

# ABSTRACT

Pregnancy is usually a time of celebration and excitement. It can also be a time of increased emotional and social vulnerability, as women enter a state of personal transition. Women with pre-existing physical or psychosocial needs enter motherhood with additional challenges. Poor perinatal mental health, for example anxiety and depression, stressful life events and poor social health, are associated with adverse outcomes for women, their children and their families. Pregnancy, birth and the postnatal period can therefore be marred by the experience of mental ill-health.

Women experiencing complex health and social needs during the perinatal period (conception until 12 months post birth) benefit from early identification, integrated care pathways and comprehensive management plans to improve their emotional wellbeing and prevent mental health problems. Psychosocial assessment and depression screening has been incorporated into policy in New South Wales (NSW), Australia to assist health professionals to identify and refer women at risk of poor perinatal mental health outcomes to specialised or secondary services. Perinatal and infant mental health (PIMH) services are an emerging specialty area in mental health care in Australia.

This convergent, embedded, mixed methods study aims to explore and describe two specialist PIMH services in NSW. The research questions in this study address: 1. the characteristics and risk factors of women referred to a specialist PIMH service, 2. the engagement practices of PIMH clinicians, 3. the therapeutic interventions that PIMH clinicians use, 4. collaboration between PIMH clinicians and other service providers, and 5. women's experiences of engaging with a PIMH service. Data were collected by reviewing 244 medical records of women who had been referred to the two PIMH services, transcribing textual illustrations from the medical records, and by interviewing six PIMH clinicians, two PIMH managers, five key stakeholders (four midwives and one social worker) and 11 women service-users. The quantitative data were analysed using SPSS (Statistical Package for the Social Sciences). The qualitative data were analysed in two phases: directed content analysis of all qualitative data and then thematic analyses of the interview data. Integration occurred during the design, data analyses, interpretation and reporting phases of the study. In mixed methods research designs, both the quantitative and qualitative data are synthesised or integrated to report the findings or inferences of a study.

The women referred to the PIMH services have multiple and complex needs, indicating that the referral processes and referrals are appropriate. The PIMH clinicians focus on the infant and the mother-infant relationship, and are woman-led to enhance engagement. Clinicians underpin the therapeutic interventions they use with Attachment Theory by modelling a secure-base for women to emulate for their infants. There is a disconnection between the PIMH clinicians' and the key stakeholders' perspectives pertaining to collaboration, PIMH clinicians require support to work in more collaborative ways. Women service-users value their time with the PIMH service, however discharge practices leave some women feeling abandoned. Clinicians enjoy working with women who have been referred to the PIMH service, however they require ongoing support from colleagues and managers to negotiate an emotionally challenging environment and remain effective clinicians. In addition, the review of medical records revealed a lack of documentation about the attachment focus of the PIMH clinicians. Without clear documentation an important component of the clinicians' work remains invisible.

The meta-inferences from this study progress from Attachment Theory to a Theory of Attachment Based Exploratory Interest Sharing (TABEIS). In this thesis TABEIS is presented as a model for PIMH clinicians to conceptualise their work with women who have been referred to their service but also as a way of relating to and understanding the actions of their colleagues, engaging with other professionals and working with them in more collaborative ways. The importance of knowledge translation and implications for clinical practice are also discussed.

The importance of the perinatal period for the health and wellbeing of future generations has growing international recognition. The inferences and meta-inferences of this study add to the extant literature to promote the further development of policy, education and clinical practice for professionals who work with women and their infants at risk of poor perinatal mental health outcomes.

# CHAPTER 1: **INTRODUCTION**

## 1.1 Introduction

Pregnancy is usually a time of celebration and excitement. It is also a time of increased emotional and social vulnerability, as a woman enters a state of identity transition (Grant *et al*. 2012; Price & Cohen-Filipic 2013). Being a new mother can present unexpected challenges for many women. Women with pre-existing physical or psychosocial needs, however, enter motherhood with additional challenges (Blegen, Hummelvoll & Severinsson 2012; Grant *et al*. 2012; Price & Cohen-Filipic 2013). Mental health problems experienced during the perinatal period, conception to 12 months post birth (Austin, Priest & Sullivan 2008), for example anxiety and depression, difficult life events and poor social health, are related to adverse outcomes for women (Yelland, Sutherland & Brown 2010), their children (Huntsman 2008) and their families (Edge, Baker & Rogers 2004; Meltzer-Brody 2011; Sampson, Zayas & Seifert 2013). Pregnancy, birth and the postnatal period can therefore be marred by the experience of mental ill-health (Wilkinson & Mulcahy 2010).

Women's wellbeing in the perinatal period is inextricably linked to their infant's wellbeing (Glover & O'Connor 2006). For example, a warm and happy home life, supported by nurturing caregivers provides an optimal opportunity for infant development and growth. Whereas, poor childhood experiences, which expose the infant to stress and raised cortisol levels, increases the risk for long term adverse outcomes, such as mental health problems (Robinson *et al.* 2008; Silburn *et al.* 1996).

Women with complex health and social needs benefit from integrated care pathways, early identification and intervention programs and comprehensive management plans to improve their emotional wellbeing and to prevent mental health problems (*beyondblue* 2008; Dennis 2005; Frayne *et al.* 2009). As many women engage with the health care system when they become pregnant, the antenatal period is an ideal time to implement public health policy (Lewis *et al*. 2014). Therefore, services that aim to identify and support women with physical, mental and social health needs are required (Fenwick *et al*. 2013).

Routine psychosocial assessment and depression screening during pregnancy and after birth has been incorporated into policy in New South Wales (NSW), Australia to assist health professionals identify and refer women who are at risk of poor perinatal mental health outcomes, to specialised or secondary services (NSW Department of Health [DoH] 2009). Perinatal and infant mental health (PIMH) services are an expanding specialty area in mental health in Australia. These prevention and early intervention services provide case management and therapeutic interventions to women and their infants who are at risk of poor perinatal mental health outcomes (NSW DoH 2009).

The study reported in this thesis uses a convergent, embedded, mixed methods research design to explore and describe two specialist PIMH services in NSW, Australia. Theoretical pragmatism guides the design of this study as it can encompass both qualitative and quantitative methods of data collection and analysis (Biesta 2010; Creswell & Plano Clark 2011).

## 1.2 Perinatal mental health

Mental health disorders are the principal cause of maternal morbidity and mortality in both Australia and the United Kingdom (UK) (Hayes 2010), and are the primary cause of maternal morbidity in the United States of America (USA) (Robertson *et al*. 2004). An Australian cross sectional survey of over 40,000 women in the perinatal period has found that a point prevalence rate of 7.8% of women in the general population have a high risk of being depressed and 15.7% have postnatal distress (*beyondblue* 2008). Other longitudinal studies have found that between 10% and 20% of women report depressive symptoms or have a diagnosis of depression at some stage in the first year after birth (Schmied *et al.* 2013). A study conducted in an area of known disadvantage, found that 29% of postnatal women met the criteria of depression, anxiety or stress (Aslam, Kemp & Harris 2006). Schmied and colleagues (2013) report anxiety at a point prevalence of 8% to 10% for women during pregnancy and six months post birth. Many women also enter the perinatal period experiencing significant stress. A large population-based survey has found that at least one stressful life event or social health issue is experienced by two-thirds of women preceding birth (Yelland & Brown 2014) and that 18% of the women experience three or more significant issues associated with social adversity (Brown *et al.* 2011; Yelland & Brown 2014). Despite this growing trend, depression, anxiety and stress during the perinatal period are frequently undetected and therefore untreated (Glover 2014; Schmied *et al*. 2013).

There are known risk factors for poor perinatal mental health outcomes (Buist & Bilszta 2005). These include: idealistic expectations of motherhood, unsupportive partner and family (Knudson-Martin & Silverstein 2009), a history of depression (Lancaster *et al.* 2010), life stress, lack of social support, intimate partner violence (IPV) (Austin *et al*. 2005; Schmied *et al.* 2013) and substance misuse (Ross & Dennis 2009). Risk factors are cumulative, that is, the greater the amount of risk, the greater the risk of morbidity. This cumulative effect is especially relevant with regard to psychosocial stressors, as they may not be ameliorated by psychological or pharmacological therapies (Yelland *et al*. 2010). Importantly, women with bipolar affective disorder and those with a history of a major depressive disorder are at an increased risk of relapse during the perinatal period (Meltzer-Brody & Stuebe 2014; Munk-Olsen *et al*. 2006). Women with a past history of mental ill-health are also more likely to experience an induction of labour or assisted birth, resulting in the infant being admitted into a special care nursery (Frayne *et al*. 2014), which links perinatal mental ill-heath with birth complications (Meltzer-Brody & Stuebe 2014). Women with a past history of mental ill-health are also more likely to perceive the birth as being traumatic (Boorman *et al*. 2014) with possible subsequent post-traumatic stress disorder (O'Donovan *et al*. 2014). Reduced initiation and duration of breastfeeding are also negative consequences of perinatal mental ill-health (Meltzer-Brody & Stuebe 2014).

Maternal social and emotional distress in the perinatal period can also have negative consequences for the infant and beyond (Glover & O’Connor 2006). These include, but are not limited to: prematurity and low birth weight (Brown *et al*. 2011; Class *et al.* 2013; Nkansah-Amankra *et al.* 2010; Zhu *et al.* 2010), a higher blood cortisol level at birth, which can be maintained for many years (Hay & Kumar 1995; O'Connor *et al.* 2005), deficits in neurological development (O'Donnell, O'Connor & Glover 2009), decreased immune function with concomitant allergic reactions (Veru *et al*. 2014), impairments in language functioning, physical and psychological development, emotional and behavioural problems (Mrazek & Haggerty 1994; Murray, Cooper & Hipwell 2003), and an increased risk of depression in adulthood (Pearson *et al*. 2013). An infant's risk increases if both parents experience mental health problems (Mrazek & Haggerty 1994). Therefore, families where parental functioning is compromised can directly affect infant wellbeing, resulting in long-term negative trajectories (Hauck *et al*. 2013).

The long-term consequences of the early caregiving environment have also been reported in the literature on epigenetics. Epigenetics refers to environmental influences that alter an individual's phenotype, the expressed characteristics of an individual's genetic code (Letourneau *et al*. 2014). Research has identified that the early caregiving environment may have a direct impact on an individual's phenotype with resultant positive or negative outcomes (Letourneau *et al*. 2014). As the mother is usually the primary caregiver of infants, the developing mother-infant relationship is of particular concern. These implications, therefore, should be a strong motivation for governments to support early intervention and prevention programs which aim to improve maternal, infant and child health (Brown *et al.* 2011).

## 1.3 Policy and service context in NSW

In response to the growing evidence to support perinatal wellbeing, mental health care in the form of routine psychosocial assessment and depression screening has been incorporated into mainstream maternity and child health services in NSW over the past decade (Austin, Reilly & Sullivan 2012). More recently, the *NSW Supporting Families Early (SFE) Policy* (NSW DoH 2009) was developed. The *SFE policy* is a broad framework for primary health care providers who work with mothers and infants/children. It incorporates a specific mental health component known as *SAFE START* (NSW DoH 2009).

The *SFE policy* outlines a model of perinatal care consisting of routine psychosocial assessment and depression screening with routine care in the early antenatal and postnatal periods. The psychosocial assessment is divided into three levels of risk: Level 1 – no vulnerabilities detected; Level 2 – predominantly social concerns such as relationship issues, financial stress, poor support networks; and Level 3 – complex risk factors such as maternal substance misuse or maternal mental illness. Women identified with multiple Level 2 or any Level 3 risk factors are referred to a multidisciplinary case review meeting where referral to more specialised services, for example, drug and alcohol, is determined (NSW DoH 2009). The *SFE policy* aims to increase collaboration and integrated care to promote a seamless transition between primary services (for example, maternity, child and family health nursing), secondary services (for example, family care centres) and tertiary services (for example, drug and alcohol), for women and their families (NSW DoH 2009). Some health areas have discreet specialist PIMH services. These multidisciplinary teams provide case management and therapeutic models of care for women identified as being at risk for poor perinatal mental health outcomes and their families.

There is debate, however, about the implementation of universal psychosocial assessment and depression screening. Some authors argue that assessment and screening should not be implemented unless there are ongoing services, referral pathways and appropriate interventions to support women and families identified as being distressed or at risk (Austin, Kildea & Sullivan 2007; Stenson, Sidenvall & Heimer 2005). Others, however, argue that depression screening in the postnatal period should be implemented as there are effective treatments (Meltzer-Brody 2011).

None-the-less, seamless referral pathways require collaboration and integrative care between services. While the *SFE policy* (NSW DoH 2009) documents the importance of collaboration it does not, however, describe what this care looks like in practice. The complexity of the perinatal period warrants systems and services that are well networked. Poor communication and cooperation between services only widens the gap between what is needed and what is available to support women and families experiencing mental ill-health (Lagan *et al*. 2009). Women with a history of a serious mental illness need a well-planned, coordinated approach to care that involves case management and the maintenance of support networks (McCauley, Cross & Kulkarni 2014).

The two sites chosen for this study provided broad data from both metropolitan and regional areas. Both areas had implemented a multidisciplinary PIMH service at least 10 years prior to the commencement of this study.

### 1.3.1 Interventions that promote positive perinatal mental health

The identification and application of evidence-based practice is the 'gold standard' of treatment in health care settings (Rice 2008). However, it is difficult to implement randomised control trials in complex environments, especially in mental health settings where an individual's experience of, and how they engage with, the world around them is integral to mental health care (Rice 2008). Likewise, there is a dearth of literature that describes how clinicians can best implement intervention strategies in clinical mental health settings (Powell, Proctor & Glass 2014). These issues are compounded in PIMH settings, when both the woman and her infant need to be considered (Miller 2009).

A large systematic review of the literature, prior to 2009, regarding interventions to prevent or improve perinatal mental ill-health, was conducted by *beyondblue* (2011). The review provided the background for the development of clinical practice guidelines in Australia, for women experiencing mental ill-health in the perinatal period. The guidelines recommend the following:

- Non-directive counselling[1] (grade C[*]), cognitive behavioural therapy[2] (CBT) (grade B*), interpersonal psychotherapy[3] (ITP) (grade C*) and psychodynamic therapy[4] (grade D[*]) for women experiencing mild to moderate depression in the postnatal period;
- The use of pharmacological therapy; however pharmacology needs to be weighed against the risk of not taking medication and the risk to the unborn infant or the infant if the mother is breastfeeding;
- Women experiencing psychosocial issues need psychosocial support such as active listening and psycho-education;
- Specific mother-infant psychotherapies are recommended if a mother is experiencing difficulty interacting with her infant; however a specific intervention is not recommended except for a referral to a specialist PIMH service (*beyondblue* 2011).

A recent review of the literature on psychosocial interventions for perinatal depression only (Dennis 2014) has identified that support by a partner or peers, non-directive counselling, home visiting conducted by mental health nurses and collaborative models of care[5] may be beneficial interventions for perinatal depression, especially as perinatal depression is linked to a lack of social support (Dennis 2014). Research has

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[1] Non-directive counselling involves active listening, empathy and person-centred discussions (*beyondblue* 2011).

[*] Levels of evidence: Grade A - can be relied upon to guide practice, Grade B - can be relied upon to guide practice in most instances, Grade C - provides some support for the intervention but care is needed, Grade D - is weak and caution is needed for the intervention's application (*beyondblue* 2011).

[2] CBT aims to correct flawed beliefs and distorted ways of processing information to reduce distress and enhance coping mechanisms (Dennis & Hodnett 2009).

[3] ITP is a three phase formulated therapy that involves a diagnostic assessment, manualised strategies for the chosen interpersonal area and identification and the prevention of relapse (Dennis & Hodnett 2009).

[4] Psychodynamic therapy focuses on an individual’s self-awareness and understanding on how the past can influence present behaviour (Dennis & Hodnett 2009).

[5] Collaborative models of care involve clear referral pathways for more intensive or specialised treatment (Dennis 2014).

also found that women who experienced a traumatic birth and had a history of mental health problems did respond positively to a brief counselling intervention (at birth and at six weeks) in regard to their quality of life (Turkstra *et al*. 2013). It is possible that a combination of behaviourally-based and psychodynamic therapy may provide the most favourable outcomes for women (Guedeney *et al*. 2014).

Most of the studies cited above had small sample sizes and other methodological shortcomings; therefore, further research is needed to help identify interventions which may assist women to overcome depression, anxiety and psychological distress in the perinatal period (*beyondblue* 2011; Dennis 2014; Dennis & Hodnett 2009). Further research also needs to include women service-users to identify women's perceptions of the interventions they receive, as well as infant outcomes (Dennis & Hodnett 2009).

### *Relationship-based interventions*

Maternal perinatal depression, specifically postnatal depression, up to and beyond the first 12 months post birth, is often linked to unresolved childhood trauma and loss (Guedeney *et al*. 2014; McMahon *et al*. 2005). Many women who perceived that they did not receive love and care as a child have difficulty in providing the love and care their infant needs due to few, if any, positive images of motherhood (Blum 2007). Motherhood then becomes an internal conflict (Blum 2007) as the transition to parenthood involves relationship changes and reflection on past caregiving experiences (Milan *et al*. 2007). Negative intergenerational experiences are therefore linked to perinatal depression and poor parent-child relationships (Grant *et al*. 2012).

Research has demonstrated that depressed mothers are more subdued when interacting with their infants (Guedeney *et al.* 2011). Likewise, infants of depressed mothers are more passive when interacting with their mother and others (Guedeney *et al.* 2011). Maternal anxiety and depression have been associated with decreased parental sensitivity or synchrony, that is, the extent to which the parent can reliably understand and react to their infant's cues (Guedeney *et al*. 2011; Kaplan, Evans & Monk 2008).

The relationship between a mother and her infant, however, evolves during pregnancy and is known as maternal-fetal attachment (MFA). Women who experience high levels of stress have difficulty focusing on their unborn infant, and therefore their relationship with their infant, resulting in lower levels of MFA. Interventions that increase the quality of the mother's feelings towards her unborn infant may promote the development of an optimal mother-infant relationship after birth (Maas *et al*. 2014).

Attachment-based parent-infant interventions may be helpful as they aim to enhance the mother's mood and the impact of postnatal depression on the infant (Guedeney *et al.* 2014). Two types of attachment-based interventions are described in the literature: interventions that assist the mother to gain insight into her internal working models (described below), which may affect her interactions with her infant, and interventions that use video feedback and manualised procedures to assist the mother to identify her infant's cues and thereby better meet her infant's needs (Guedeney *et al.* 2014). Within parent-infant therapy, the attachment relationship between the clinician and the mother is a significant component of the therapeutic alliance (Guedeney *et al.* 2014). Research also supports the notion that clinicians who provide a secure-base (described below) for their clients can help them to move from insecure to secure attachments with others (Mikulincer, Shaver & Berant 2013). Within PIMH, the 'others' are not only other adult relationships, but more importantly the development of a positive mother–infant relationship (McCauley *et al.* 2014).

Despite the clinical advances in relational-based interventions for women who have experienced childhood trauma, more research is needed to define what actually works for which emotional disorders (Toth *et al*. 2013), and the long term outcomes for clients (Mikulincer *et al.* 2013). Toth and colleagues (2013: 1613) therefore caution that it is too early to state "less is more" in regard to relational-based interventions, as proposed by Bakermans-Kranenburg and colleagues (2003).

### *Attachment Theory*

Attachment Theory was first described by John Bowlby in 1958 (Bowlby 1978). In his seminal work, Bowlby discussed five instinctual responses: sucking, clinging, following, crying and smiling, and coined them attachment behaviours. These attachment behaviours aim to evoke maternal care and thereby the survival of the infant (Bowlby 1958). The mother, or primary carer, became known as the attachment figure, the figure who provides the child with a secure-base, from which to explore and to which to return when comfort is needed (Bowlby 1978). The way in which the attachment figure is able to provide a secure-base, by being available and responsive, as well as by intervening when necessary, has a determining impact on how an individual will develop positive mental health (Bowlby 1978). The attachment figure must therefore be physically and dependably present to the infant's cues to create the security of the secure-base. The infant's initial attachment figure is a parent or other caregiver; however, as individuals develop, other attachment figures evolve, such as relatives, friends, peers, teachers and health care providers (Fitton 2012). Throughout this chapter, the attachment figure will be referred to as the mother.

The aim of attachment behaviours is mother-infant proximity (Ainsworth 1969). These behaviours may change under certain circumstances, for example, childhood illness, fatigue, discomfort or if the child explores beyond the mother's own limits of comfort. During the pre-locomotor stage of infancy, it is the mother's responsibility to maintain mother-infant proximity by either responding to her infant's signals or her own set goal of proximity (Ainsworth 1969). Infants and young children turn to their mother during frightening situations for comfort and security. If she is unavailable, anxiety is aroused. Depending upon the level and length of the stressful event and individual genetics, infants may then develop anxiety when new situations are experienced, predisposing the infant to emotional dysregulation, insecure attachment patterns and an increased responsiveness to stress (Rutten *et al*. 2013). The more secure a child feels, the more he/she is able to tolerate separation, and the converse is true (Bowlby 1960). In this way, an infant's experience with his/her mother is internalised and becomes what Bowlby described as internal working models (Bowlby 1973). Internal working models can also be described as procedural memory, the experience of knowing something rather than the experience of remembering (Powell *et al.* 2014).

An infant therefore learns to see him/herself as worthy of love and support and whether mother, and later others, are trustworthy and available (Bowlby 1973). Therefore, if the mother does not respond to her infant's signals, attachment disorders may develop (Seso-Simic *et al*. 2010), and become emotional and behavioural problems in childhood, which are often linked to adult mental ill-health (Rutten *et al.* 2013).

The mother who experienced an insecure attachment as a child may, however, be unable to provide the secure-base for her infant. The infant in turn may therefore develop an insecure attachment, demonstrating the possible intergenerational transmission of insecure attachments (Karakurt & Silver 2014; Rutten *et al*. 2013). It is important to note, however, that attachment describes a relationship not an individual (Powell *et al*. 2014).

Four attachment styles have been identified, one secure and three insecure: anxious-avoidant, anxious-ambivalent and disorganised (Araneda, Santelices & Farkas 2010; Powell *et al*. 2014). The attachment styles are defined as:

- Secure - the infant has learnt that mother is consistent and trustworthy. The infant is able to explore his/her environment, that is, become vulnerable, knowing that mother is available for support if needed;
- Anxious-avoidant - the infant has learnt that mother is unable to give comfort, therefore the infant becomes self-reliant and dismissive of the relationship;
- Anxious-ambivalent - the infant has learnt that mother needs comfort, therefore the infant feigns distress to stay in proximity with mother;
- Disorganised - the infant has learnt that mother can give comfort, but she is also a source of fear. The infant is therefore confused as to which response he/she will receive from mother, comfort or fear. The disorganised attachment style is the most damaging for the infant as he/she cannot predict what mother's response will be (Powell *et al*. 2014).

Individuals may form multiple attachment relationships throughout their life (Fitton 2012) and attachment relationships may change over time (Powell *et al.* 2014; Siegel 2001). Secure relationships can promote confidence and competence in the way an individual interacts with their social environment (Fitton 2012). In this way, attachment relationships and social networks also have an impact upon resilience and the ability to adapt, recover and remain healthy after experiencing adversities. Individuals with secure attachments are more resilient and less reactive to stress in adulthood compared to those with insecure attachments (Rutten *et al*. 2013). Ongoing negative experiences such as stress during the perinatal period, lack of maternal care and childhood trauma can sensitise an individual's response to stressful events and thereby increase the risk of mental ill-health later in life (Rutten *et al*. 2013). Insecure attachment relationships may also alter or compromise the internal reward system (behavioural patterns that produce positive feelings/emotions) with negative consequences on adult interpersonal relationships and social and cultural commitments (Seso-Simic *et al.* 2010). An individual's attachment system is active throughout life and is particularly sensitive to experiences of fear, pain or uncertainty, such as the transition to parenthood (Guedeney *et al*. 2011). Attachment-based parent-infant interventions may therefore, assist clinicians to work with women referred to PIMH services.

Irrespective of the intervention used, unsuccessful treatment can lead individuals to believe that treatment is ineffective, which may decrease service engagement in the future (Warnick *et al.* 2014). Attrition from mental health services has a high cost for individuals and clinicians, and reduces the ability for services to assess the effectiveness of specific interventions (Warnick *et al*. 2014). Interventions need to be tailored to the needs of individual women (Dennis 2005); more importantly the success of any intervention is dependent upon how well the woman and her family engage in services (Warnick *et al.* 2014).

## 1.4 Engaging women at risk of poor perinatal mental health

Pregnancy is a time when many women will engage with health services (Green *et al*. 2008; McDonald, Moore & Goldfeld 2012) and initiate positive lifestyle choices (Hall & van Teijlingen 2006; Hauck *et al.* 2008; Sword *et al.* 2009). Research suggests that a number of factors influence women, at risk for mental ill-health, and their decisions to access services during the perinatal period. They include: current mental health, symptom awareness, acceptance of postnatal depression and timeliness of care (Abrams, Dornig & Curran 2009; Sword *et al*. 2008); perception of the helpfulness of a service, service quality and sensitivity (Chisholm *et al*. 2004; Price & Cohen-Filipic 2013); perceived stigma of mental illness and mental health services (Bates & Stickley 2013; Foulkes 2011; Vogel *et al.* 2013); hesitance to disclose experiences such as abuse (Walsh, 2008); the belief that a trusting relationship can be developed with health professionals (Goldberg 2008); as well as the mother's concern that seeking help is putting her own needs above her infant's needs (Sampson *et al.* 2013).

Importantly, Abrams and colleagues (2009) identify that women in the perinatal period tend to normalise their symptoms of perinatal mood disorders to maintain the image of being a 'good mother'. The stigma for these women is associated with being labelled a 'bad mother', therefore women rely on self-help strategies and religious or spiritual practices (Abrams *et al*. 2009). King and colleagues (2014) propose three key elements to motivate engagement in therapy. These are: 1. hope, that the therapist and therefore therapy will be beneficial; 2. conviction, that the problem warrants intervention or treatment; and 3. confidence, within the individual, that the therapy and therapist can promote change.

Despite the growing literature on barriers and facilitators of engagement, engaging individuals in mental health services, for example, children and adolescents (Warnick *et al.* 2014) and women in the perinatal period (McGarry *et al*. 2009; Reay *et al*. 2011), remains problematic (Booth, Munsell & Doyle 2014). Barriers to engagement with mental health services need to be addressed, especially stigma, which can also result in discrimination and negative health implications for the individual and their family (Cleary *et al*. 2012).

## 1.5 Collaboration in perinatal and infant mental health services

Despite the implementation of the *SFE policy* (NSW DoH 2009) and other health related policies that promote integrated health systems, services remain fragmented within the current health care system (Psaila *et al*. 2014a). Therefore, even if women are prepared to engage in services, these services are often not readily available or accessible to all (Hayes 2010). There are increasing reports of the fragmentation of universal health services (for example general practitioners, CFH nursing services) for women and their families, specifically problems of communication in sharing and exchanging information. To address this, an integrated system is recommended with systems that support interprofessional collaboration (Psaila *et al*. 2014a).

There is limited literature on women's experiences of collaborative and integrative care for perinatal mental ill-health. A number of studies, however, have investigated women's experiences of integrated care models for perinatal substance misuse programs. The positive aspects that women report from attending these programs are multi-faceted and include: decreased stigma (Lefebvre *et al*. 2010); supportive and non-judgmental professionals (Hall & van Teijlingen 2006; Lefebvre *et al*. 2010); respectful, consistent and reliable communication (Hall & van Teijlingen 2006; Lefebvre *et al.* 2010; Sword *et al*. 2009); enhanced service engagement (Mayet *et al*. 2008); enhanced wellbeing (Sword *et al.* 2009); decreased substance use/continuation on opioid maintenance treatment (Hall & van Teijlingen 2006; Mayet *et al*. 2008; Sword *et al.* 2009); increased social support networks, increased insight, enhanced parenting capacity and maternal-child communication (Sword *et al.* 2009); decreased treatment for neonatal abstinence syndrome, increased spontaneous vaginal birth, increased initiation of breastfeeding and increased housing stability (Mayet *et al*. 2008).

An integrative literature review on collaboration and integrated services for perinatal mental health, published in the journal *Child and Adolescent Mental Health*, is presented in Chapter Two.

## 1.6 Women's experiences of perinatal and infant mental health services

There is a limited amount of literature that reports women's experiences of mental health services per se; however there is even less that reports women's experiences of PIMH services. Partnership and collaborative models of care for women and their families have, however, been described in many PIMH service aims (for example, Green *et al*. 2008). Women have reported that specific PIMH programs have given them increased skills and knowledge; however, the most important aspect for the women was the positive relationships they developed with their clinicians (Angarne-Lindberg & Wadsby 2013). Experiencing positive therapeutic relationships may also assist to break the intergenerational transmission of insecure attachment styles (Angarne-Lindberg & Wadsby 2013).

## 1.7 Summary

The existing literature identifies that mental health disorders cause significant maternal morbidity and mortality internationally, with resultant negative sequelae for the infant. New policy directives and health services are increasingly being developed to provide support to women at risk of poor perinatal mental health outcomes. Despite these initiatives, there is limited research reporting the most effective therapeutic interventions when working with women in the perinatal period. Relational-based interventions, specifically attachment-based parent-infant interventions may, however, benefit women and families who experience difficulties interacting with their infant. Irrespective of the intervention used, engagement in the therapeutic process is crucial if behaviour change is to occur. The challenge of overcoming the stigma of mental illness and mental health services is widely reported in the literature. Women in the perinatal period also have to overcome the perceived stigma of being a 'bad mother' if they seek help. Policy documents recommend collaboration and integrative care for PIMH services, however there is scant literature that describes what this looks like or how it is to be achieved. There is a more substantial literature base reporting outcomes for perinatal substance misuse programs that can help guide PIMH services. Women at risk of poor perinatal mental health require services to be effectively networked and collaborative. There is a limited amount of literature reporting women's experiences of specialist PIMH services, however the importance of positive relationships with clinicians is highlighted. It is, therefore, timely to explore specialist PIMH services in NSW. The findings from this study will add to the extant literature about these specialist mental health services of which little has been documented.

## 1.8 Aim of the study

The aim of this study is to explore and describe in-depth the role of clinicians, and the women who are referred to, as well as their experiences of, two specialist PIMH services in NSW. The findings will inform local, state and national policy and clinical practice development.

## 1.9 Research questions

1. What are the characteristics and risk factors of women who are referred to a specialist PIMH service?
2. What factors do PIMH clinicians, key stakeholders and women perceive enhance or disrupt engagement with the specialist PIMH service?
3. What interventions / treatments underpin the PIMH model of care?
4. How do PIMH clinicians work collaboratively with other service providers?
5. How do women interpret and experience the interventions provided by the specialist PIMH clinicians?

## 1.10 Significance of the study

Perinatal mental health has emerged as an important issue for health care delivery, however there is a dearth of literature about current services and what constitutes best practice from women's perspectives, as well as outcomes data. As such it is timely to explore in-depth the practices of clinicians who work in specialist PIMH services. This research will enhance our understanding of the role and services provided by clinicians who work in specialist PIMH services, for example, the engagement strategies, therapeutic interventions and collaborative practices used by clinicians when working with women who are at risk of perinatal mental ill-health. It will also describe the characteristics and risk factors of those women who are referred to a specialist PIMH service, and women's experiences of engaging with a PIMH service. The study contributes new knowledge to the growing field of PIMH services that will help inform policy and service development.

A convergent, embedded, mixed methods design was chosen for this study in order to address the complexities of perinatal mental ill-health, and to provide insights into specialist PIMH services. Mixed methods research designs provide unique opportunities to integrate both qualitative and quantitative methods of data collection and analyses to provide inferences and meta-inferences from research findings.

## 1.11 My research journey

I am a registered nurse and midwife with qualifications in child and family health nursing, lactation and research. I am also a mother of a young son, who was in infant school at the commencement of this project. I have been working with women and families for over 25 years in a variety of contexts including tertiary hospital and community settings. In 2009, I obtained a temporary position as a PIMH clinician in the local PIMH service. This was my first clinical role in mental health in an area where I enjoyed working: with women and families. My PIMH role was two-fold. One component was to work in collaboration with adult mental health services to provide support and care for women in the perinatal period who were current clients of the adult services. The other component was to co-facilitate a parenting program for parents who identified as having a mental illness. At the completion of the temporary position I then chose to learn more about PIMH and applied to commence a PhD. I was the successful recipient of an Australian Postgraduate Award for three years with a top-up contribution from the University of Western Sydney (UWS). To increase my skills in mental health nursing I also obtained a part-time position in a local adult mental health service. I reflect later in the thesis on my position and role in this research as it has inevitably influenced my approach to data collection, particularly the in-depth interviews, and the way in which I have interpreted the findings.

## 1.12 The structure of the thesis

Chapter One, the **Introduction**, has provided a rationale for the study and an overview of perinatal mental health and Attachment Theory, and has identified risk factors for poor perinatal mental health. I have highlighted the key gaps in the literature in regard to the strategies that clinicians use to engage women at risk of poor perinatal mental health, interventions that promote positive perinatal mental health, collaboration and integrative care in PIMH and women's experiences of PIMH services. The aims, significance and study questions are also addressed, as well as a personal reflection in undertaking the study as the beginning of my research journey.

In Chapter Two, I present a published paper that reports the findings of an integrative review of collaboration and integrative care in perinatal mental health. The review identifies that adult mental health clinicians are challenged when working with women in the perinatal period. It also highlights that women's voices are missing from the literature.

In Chapter Three, the **Methodology**, mixed methods is presented as the appropriate methodology for this study and theoretical pragmatism is described. The setting is introduced and the processes of data collection and analyses are described. A reflection on data collection continues my research journey.

In the following five chapters: Four, Five, Six, Seven and Eight I present the **Findings** from the study, addressing each of the research questions. Four of these chapters are presented as published papers. The style, structure and content of each paper accord with journal guidelines. In Chapters Five and Eight I present additional findings that have not yet been published.

- In Chapter Four, I discuss the findings in relation to research question 2: What factors do PIMH professionals, key stakeholders and women perceive enhance or disrupt engagement with the specialist PIMH service? The manuscript titled, *Engaging women at risk for poor perinatal mental health outcomes: A mixed methods study*, published in the *International Journal of Mental Health Nursing*.
- In Chapter Five, I discuss the findings in relation to research questions 1: What are the characteristics and risk factors of women referred to a specialist PIMH service? and 3: What interventions / treatments underpin the specialist PIMH service model? This chapter is divided into two parts. The first part presents the manuscript, *Therapeutic interventions in perinatal and infant mental health services: A mixed methods inquiry,* published in the journal *Issues in Mental Health Nursing,* and reports the findings from the quantitative and directed content analyses of the data. The second part of the chapter, *"To hold": Modelling a secure-base for women engaged with specialist perinatal and*

*infant mental health services*, reports the thematic analysis of the interviews with PIMH clinicians and includes illustrative text from the medical records.

- In Chapter Six, I present the findings in relation to research question 4: How do specialist PIMH clinicians collaborate with other service providers? The manuscript, *A mixed methods study of collaboration between perinatal and infant mental health and other service providers: Do they sit in silos?* Published in the journal *BMC Health Services Research.*
- In Chapter Seven, I present the findings in relation to research question 5: How do women interpret and experience the support provided by the specialist PIMH clinicians? The manuscript titled *"My special time": Australian women's experiences of accessing a specialist perinatal and infant mental health service* is published in the journal *Health and Social Care in the Community*.
- In Chapter Eight, I present the findings from the thematic analysis of the PIMH clinicians' interview data, *"To be held": Clinicians' experiences of working in a perinatal and infant mental health service*. This chapter reports the clinicians' experiences of working in a specialist PIMH service. These findings do not relate to any of the predetermined questions but underpin an important finding of the study and compliment the data from the perspective of the clinicians who work in specialist PIMH services.

In Chapter Nine, the **Discussion**, I provide an overview of the study findings and present the meta-inferences of those findings in relation to a Theory of Attachment Based Exploratory Interest Sharing (TABEIS) (Heard, Lake & McCluskey 2012). Knowledge translation, further research, the strengths and limitations of the study are also reported, as well as the conclusion to my research journey.

## 1.13 Conclusion

In this chapter, I have introduced the study and the importance of perinatal mental health for women, infants and families. A rationale for the study has been provided in relation to the limited literature with regard to engagement strategies, therapeutic interventions and collaborative care within PIMH service delivery, as well as the experiences and perspectives of women who engage with these specialist services. My reflection in the form of a personal research journey has commenced.

In Chapter Two, I present the published paper *Collaboration and integrated services for perinatal mental health: An integrative review*. This literature review of professionals' perceptions and experiences of collaborative care in the perinatal period provides further evidence and rationale for this study.

# CHAPTER 2: **COLLABORATION AND INTEGRATED SERVICES FOR PERINATAL MENTAL HEALTH: AN INTEGRATIVE REVIEW**

Myors, K.A., Schmied. V., Johnson, M. & Cleary, M. (2013). Collaboration and integrated services for perinatal mental health: An integrative review. *Child and Adolescent Mental Health*, *18* (1), 1-10. DOI:10.1111/j.1475-3588.2011.00639.x

## 2.1 Publication: Relevance to thesis

This paper is presented first in the series of published papers as it provides a background and review of the literature regarding clinicians' perceptions of collaboration and integrative practices when working with women with mental health problems during the perinatal period. The insights from this review identify that adult mental health clinicians are challenged, both professionally and personally, when working with women in the perinatal period. It also highlights that women's voices are missing from the literature.

Child and Adolescent Mental Health
a journal for all professionals working with children and young people
ACAMH
*Child and Adolescent Mental Health* Volume 18, No. 1, 2013, pp. 1–10
doi:10.1111/j.1475-3588.2011.00639.x

# Collaboration and integrated services for perinatal mental health: an integrative review

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**Background:** An integrative review was undertaken to synthesise the research related to professionals' perceptions and experiences of working in collaborative and integrated models of perinatal care for women with mental health problems. **Method:** A search of the databases CINAHL, Medline, PubMed, Psychinfo and Scopus was conducted. Studies were limited to English language papers published from 2000 to 2010. Fourteen papers were included in the review. **Results:** The overarching theme identified in the review related to the process of '*making it happen*'. Eight key elements were identified as central components of this process: funding and resources for collaboration; shared vision, aims and goals; pathways and guidelines; continuity of care; building relationships and trust; role clarity; training and education of staff and support to work in new ways. **Conclusion:** Perinatal mental health is an emerging field that is particularly challenging as it requires professionals to work across disciplines and timeframes, where there is a risk of dichotomising care, compounding existing barriers to service uptake. Professionals need resources and to feel supported to change clinical practice and work in more collaborative ways. The voices of women and families are missing in the literature.

**Key Practitioner Message:**

- Collaborative and integrated services in the perinatal period are purported to improve care for women and their families
- Professionals need additional resources and organisational support to be enabled to work closer with other services and agencies
- Women and families need to be included in future research

**Keywords:** Perinatal and infant mental health; collaboration; integration; integrative review

## Introduction

Poor mental health during pregnancy and in the year following birth can have a significant impact on the woman, her infant and family (Austin, 2003). Collaboration and integration across services is increasingly being proposed as the best approach to delivering services for women experiencing mental health problems in the perinatal period (Hayes, 2010; Horwath & Morrison, 2007; Schmied et al., 2010). Isolated services continue to be criticised by both management and consumers, calling for closer connections between professionals and agencies (Currid, 2004). Emerging evidence highlights that improved perinatal and infant mental health (PIMH) outcomes are likely if services can move to more collaborative approaches to care (e.g. Halbreich, 2005; Lefebvre et al., 2010; Stafford & Zeanah, 2008). However, this ideal may be difficult to achieve, given the varying structures, government bodies, diverse professional groups and funding streams for perinatal services. This article presents a unique review of contemporary literature relating to collaborative and integrated services from the perspective of health professionals who work with women and families in the perinatal period (conception to 2 years after birth; Austin, 2003).

## Background

Mental health disorders are the leading cause of maternal morbidity and mortality in both Australia and the United Kingdom (Hayes, 2010), with one in five mothers of full term infants experiencing a perinatal mental health problem (Priest, Austin, & Sullivan, 2005). Yet, many of these disorders are not diagnosed or treated (Buist et al., 2005). Mental health problems in pregnancy and following birth can have a significant impact on the mother–infant relationship and consequently on the social and emotional development of the infant (Misri & Kendrick, 2008).

The importance of the mother–infant relationship in promoting child well-being is well-known (Misri & Kendrick, 2008). Social, emotional and mental health problems, such as depression, anxiety, domestic violence, drug and/or alcohol misuse and lack of social support, in women during the perinatal period are major public health concerns (Priest et al., 2005) and

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are associated with poor outcomes for women (Buist & Bilszta, 2005) and their children (Miller, Shade, & Vasireddy, 2009; Stewart-Brown, Fletcher, & Wadsworth, 2005). In addition, growing research from neuroscience, molecular biology and social ecology demonstrates the significance of the early childhood years for long term well-being (McCain & Mustard, 1999; Shonkoff & Phillips, 2000; Silburn et al., 1996). Women with complex issues need a coordinated approach to care (Austin, 2003; Frayne, Nguyen, Allen, & Rampono, 2009), to promote positive maternal–infant bonds during the perinatal period (Misri & Kendrick, 2008), and to ameliorate any possible adverse outcomes. Services that fail to communicate and collaborate promote fragmented care delaying treatment for women, infants and families (Austin, 2003; Wooster, 2007).

Several definitions for collaboration and integration are used in the literature on health services. Collaboration, for the purposes of this review, is defined as coordinated care, both formal and informal, provided by professionals and agencies in consultation with each other (Allison, Gilliland, Mayhew, & Wilson, 2007; Horwath & Morrison, 2007; Leutz, 1999). Integration refers to the development of a new service or programme from resources that were previously allocated to individual services (Horwath & Morrison, 2007; Leutz, 1999). One of the difficulties within these definitions is that these terms are often used interchangeably. Some authors, however, believe that full integration of services, including funding, is the highest level of collaboration (Horwath & Morrison, 2007; Leutz, 1999).

The definitional problems are often resolved in the literature by the presentation of various models. Some examples of service models that may represent collaborative or integrated services include: a designated link worker (Allison et al., 2007), having a common manager across services (Allison et al., 2007), multidisciplinary managed and coordinated networks/steering committees (Sullivan, Raynor, & Oates, 2003; Waterhouse, 2009), perinatal multidisciplinary teams (Green et al., 2008; Miller et al., 2009), structured multidisciplinary peer supervision (Thomasgard, Warfield, & Williams, 2004), co-location of services (Callaly, von Treuer, Dodd, & Berk, 2010; Smith, Howell, Wang, Poschman, & Yonkers, 2009) and the inclusion of the non-government and voluntary sectors (Miller & Ahmed, 2000).

With the emerging focus on PIMH, it is timely to gain an understanding of collaborative and integrated care within this new health field. The authors have undertaken an integrative review of the literature, to specifically explore the perceptions and experiences of the professionals who work with women in the perinatal period.

## Methodology

### *Aim*

The aim of this literature review is to: identify professionals' perceptions and experiences of collaboration and integration, when working with women, infants and families in the perinatal period who experience mental health problems, and to synthesise the findings across studies.

### *Design*

The integrative review method was chosen for this study to include a broad range of empirical studies (both qualitative and quantitative; Whittemore, 2005; Whittemore & Knafl, 2005). The integrative review reexamines, critiques and synthesises findings from separate but related research to develop new frameworks or perspectives about a specific phenomenon or topic (Kirkevold, 1996; Torraco, 2005). An integrative review which addresses a new or emerging topic, as opposed to mature topics, provides an initial model, rather than recreating previous models (Torraco, 2005). Whittemore and Knafl's (2005) framework for conducting the research review was adhered to: problem identification, literature search, data evaluation, data analysis and presentation.

### *Search methods*

A literature search of electronic databases was conducted using the following databases: CINAHL, Medline, PubMed, Psychinfo and Scopus. The search strategy included combinations of relevant keywords: perinatal mental health or infant mental health, and collaboration, cooperation, coordinated, integrated services, integration, multidisciplinary, professionals, staff perceptions, systematic review, and women's experiences. Studies were limited to English language papers published from 2000 to 2010.

Six hundred and fifty-three papers were initially retrieved (Figure 1), this included a number of repeat publications and papers not directly related to collaboration/integration or PIMH care. Title and abstracts were read for relevance. A total of 62 papers were read in full. These 62 papers were reviewed by two authors to ensure that all relevant studies were included. The majority of these papers were discussion or opinion pieces or focused on describing models of collaborative or integrated care and were excluded. Finally, 14 empirical studies were identified for inclusion in the review. These reported professional's views of collaboration or integration and included a combination of qualitative and quantitative components to data collection. Collaboration or integration was not required to be the main focus of the study but was at least commented on by the professionals. Similarly, professionals did not have to work in specific PIMH services but had to have contact with women in the perinatal period, for example, adult mental health services.

Within most reviews an element of quality evaluation is undertaken often retaining only high quality papers

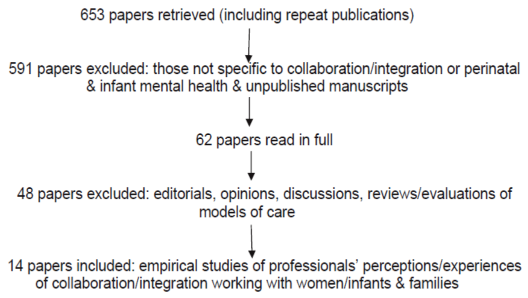

**Figure 1.** Flow chart of search strategy

based on a derived score (Whittemore & Knafl, 2005). Due to the limited number of relevant empirical studies found in the literature search all studies have been included in this review. The majority of the papers did not describe a theoretical or conceptual framework. Of the qualitative papers, only one specifically identified a methodological framework, in this case, grounded theory (Janssens, Peremans, & Deboutte, 2010). Other papers used relevant concepts such as attachment theory (Macdonald et al., 2005) or practice-based concepts such as 'partnership working' (Elliott, Bewley, Green, Hunter, & Hodgkiss, 2007; Freeman & Peck, 2006) to frame the focus of the study and interpret the findings. One paper (Hauck, Rock, Jackiewicz, & Jablensky, 2008, p. 385) conducted consultations to develop their own conceptual framework for a new model of care. This framework includes the notions of 'holistic approach', 'reproductive choice' and 'continuity of care'. Four papers were based on service evaluations (Brown, Mills, McCalmont, & Lees, 2009; Lees, Mills, & McCalmont, 2009; Rothera & Oates, 2008; Rowan & Bick, 2008). The first three cited papers above provide very little background information. There are limitations to the papers included in this integrative review, however, little research of high quality has examined collaborative and integrated services in PIMH.

The 14 studies (Table 1) included 6 from Australia, 7 from the United Kingdom and 1 from Belgium. Seven of the papers used qualitative methods of data collection-interviews and/or focus groups (Darlington, Feeney, & Rixon, 2005a; Elliott et al., 2007; Hauck et al., 2008; Janssens et al., 2010; Macdonald et al., 2005; McConachie & Whitford, 2009; Rothera & Oates, 2008). Two used analyses of written responses (Darlington & Feeney, 2008; Darlington, Feeney, & Rixon, 2004); two used quantitative methods of data collection (Darlington, Feeney, & Rixon, 2005b; Rowan & Bick, 2008); and three used a combination of both qualitative and quantitative methods of data collection (Brown et al., 2009; Freeman & Peck, 2006; Lees et al., 2009).

The professionals who participated in the studies included: adult mental health clinicians, child and family mental health clinicians, child protection workers, general adult psychiatrists, general practitioners, health service managers, health visitors, midwives, midwifery students, obstetricians, perinatal mental health specialists, and perinatal psychiatrists. One paper reported the services that were involved in the study not the professionals (Macdonald et al., 2005). A total number of participants recruited could not be determined as this finding was not reported in all papers. Of note, is that within the 11-year time frame of the literature search all of the studies were published from 2004 with over half (8) being published from 2008 onwards. This supports the assumption that collaboration and integration within PIMH services is indeed a new phenomena, worthy of further investigation.

According to Whittemore and Knafl (2005), to protect against bias and to enhance conclusions, data analysis needs to be explicit and systematic including an innovative synthesis of the evidence. Therefore, data analysis consisted of two authors examining the papers which met the inclusion criteria. As used within qualitative papers, a data extraction tool (Attride-Stirling, 2001) was used to identify the broad themes or categories relevant to collaboration and integration. Common findings were grouped together into categories and themes, which aimed to identify the key points in each paper. One main theme, '*making it happen*' emerged comprising eight key elements. The findings from the integrative review are presented by first discussing the system, then moving to the individual professional and to the relational aspects of their practice.

## Findings

In the papers included in this integrative review, there is an assumption that collaboration is useful and the main focus was on the process of '*making it (collaboration) happen*'. The papers reported two main benefits of collaboration; those for the professional and organisation, and those for the women, infants and families. The benefits for the professional and organisation included enhanced confidence and increased communication with other professionals (McConachie & Whitford, 2009, p. 873) and minimised service overlaps and wasted resources (Macdonald et al., 2005, p. 397).

The benefits for the women and families were reported as individualised client care (Rothera & Oates, 2008, p. 133; Darlington et al., 2005a, p. 246–247); flexible and innovative multidisciplinary services which provide a range of treatments or interventions (Elliott et al., 2007, p. 47; Freeman & Peck, 2006, p. 412; Darlington et al., 2005b, p. 1090); more thorough assessment and case planning (Darlington et al., 2004, p. 1185); increased choice for women (Hauck et al., 2008, p. 385) and increased coordinated interventions, avoiding distress to children and families (Darlington et al., 2005a, p. 246–247).

Despite the benefits of collaboration, for some women and families this may be difficult to achieve due to the often chaotic nature of mental illness (Darlington et al., 2005a). Also, in circumstances when the mental health diagnosis or level of child protection concern is unclear professionals experience greater difficulties in collaborating with other agencies (Darlington et al., 2004).

### *Making it happen*

In reviewing these studies, the theme '*making it happen*', is used by the authors of this paper to describe the process of implementing collaborative or integrated PIMH care identified in the 14 studies. From the data reported in these 14 studies, 8 key elements were necessary for '*making it happen*'. These included: funding and resources for collaboration; shared vision, aims and goals; pathways and guidelines; continuity of care; building relationships and trust; role clarity; training and education of staff; and support to work in new ways. The key elements are described with illustrative quotes taken from the results of the papers. In some instances, additional wording has been added in square brackets to aid interpretation.

*Funding and resources for collaboration.* One of the key elements reported in 12 of the studies was the need for adequate funding, resources and training. These studies reported that insufficient resources decreased professionals' ability to work collaboratively with other services.

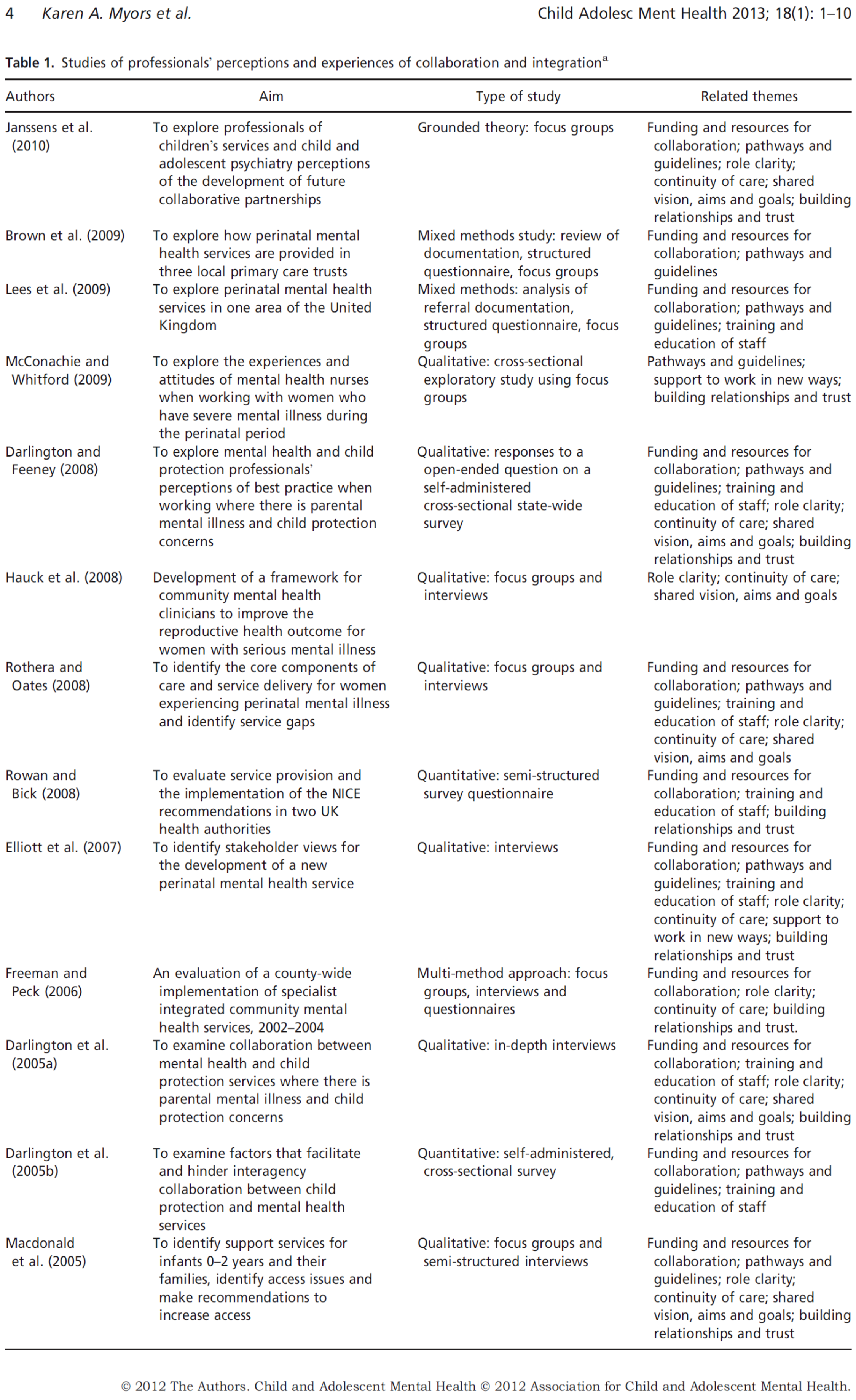

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**Table 1.** Studies of professionals' perceptions and experiences of collaboration and integration[a]

| Authors | Aim | Type of study | Related themes |
|---|---|---|---|
| Janssens et al. (2010) | To explore professionals of children's services and child and adolescent psychiatry perceptions of the development of future collaborative partnerships | Grounded theory: focus groups | Funding and resources for collaboration; pathways and guidelines; role clarity; continuity of care; shared vision, aims and goals; building relationships and trust |
| Brown et al. (2009) | To explore how perinatal mental health services are provided in three local primary care trusts | Mixed methods study: review of documentation, structured questionnaire, focus groups | Funding and resources for collaboration; pathways and guidelines |
| Lees et al. (2009) | To explore perinatal mental health services in one area of the United Kingdom | Mixed methods: analysis of referral documentation, structured questionnaire, focus groups | Funding and resources for collaboration; pathways and guidelines; training and education of staff |
| McConachie and Whitford (2009) | To explore the experiences and attitudes of mental health nurses when working with women who have severe mental illness during the perinatal period | Qualitative: cross-sectional exploratory study using focus groups | Pathways and guidelines; support to work in new ways; building relationships and trust |
| Darlington and Feeney (2008) | To explore mental health and child protection professionals' perceptions of best practice when working where there is parental mental illness and child protection concerns | Qualitative: responses to a open-ended question on a self-administered cross-sectional state-wide survey | Funding and resources for collaboration; pathways and guidelines; training and education of staff; role clarity; continuity of care; shared vision, aims and goals; building relationships and trust |
| Hauck et al. (2008) | Development of a framework for community mental health clinicians to improve the reproductive health outcome for women with serious mental illness | Qualitative: focus groups and interviews | Role clarity; continuity of care; shared vision, aims and goals |
| Rothera and Oates (2008) | To identify the core components of care and service delivery for women experiencing perinatal mental illness and identify service gaps | Qualitative: focus groups and interviews | Funding and resources for collaboration; pathways and guidelines; training and education of staff; role clarity; continuity of care; shared vision, aims and goals |
| Rowan and Bick (2008) | To evaluate service provision and the implementation of the NICE recommendations in two UK health authorities | Quantitative: semi-structured survey questionnaire | Funding and resources for collaboration; training and education of staff; building relationships and trust |
| Elliott et al. (2007) | To identify stakeholder views for the development of a new perinatal mental health service | Qualitative: interviews | Funding and resources for collaboration; pathways and guidelines; training and education of staff; role clarity; continuity of care; support to work in new ways; building relationships and trust |
| Freeman and Peck (2006) | An evaluation of a county-wide implementation of specialist integrated community mental health services, 2002–2004 | Multi-method approach: focus groups, interviews and questionnaires | Funding and resources for collaboration; role clarity; continuity of care; building relationships and trust. |
| Darlington et al. (2005a) | To examine collaboration between mental health and child protection services where there is parental mental illness and child protection concerns | Qualitative: in-depth interviews | Funding and resources for collaboration; training and education of staff; role clarity; continuity of care; shared vision, aims and goals; building relationships and trust |
| Darlington et al. (2005b) | To examine factors that facilitate and hinder interagency collaboration between child protection and mental health services | Quantitative: self-administered, cross-sectional survey | Funding and resources for collaboration; pathways and guidelines; training and education of staff |
| Macdonald et al. (2005) | To identify support services for infants 0–2 years and their families, identify access issues and make recommendations to increase access | Qualitative: focus groups and semi-structured interviews | Funding and resources for collaboration; pathways and guidelines; role clarity; continuity of care; shared vision, aims and goals; building relationships and trust |

**Table 1.** Continued

| Authors | Aim | Type of study | Related themes |
|---|---|---|---|
| Darlington et al. (2004) | To examine collaboration between mental health and child protection services and to determine if the uncertainty of parental mental illness and of child protection concerns impacts upon professional collaboration | Qualitative: analysis of written case studies | Funding and resources for collaboration; pathways and guidelines |

[a] An extended version of this table is available in the online appendix (Table S1).

*Human resources:* Increased funding for human resources (Brown et al., 2009; Darlington & Feeney, 2008; Darlington et al., 2004; Janssens et al., 2010; Lees et al., 2009; Rothera & Oates, 2008) was needed to expand teams (Darlington et al., 2004; Lees et al., 2009) due to high referral rates (Lees et al., 2009), and long waiting lists (Janssens et al., 2010; Lees et al., 2009) which resulted in slower response times (Rothera & Oates, 2008, p. 132), and prevented professionals from responding to women's needs effectively and efficiently (Brown et al., 2009, p. 39) was reported.

A lack of human resources also prevented professionals from supporting each other in providing joint home visits, due to geographical distances and high case loads (Darlington et al., 2004, p. 1187). Additional staff were required to provide increased time for professionals to deliver appropriate interventions (Macdonald et al., 2005, p. 396) and to work in more therapeutic ways, rather than a crisis driven focus (Darlington & Feeney, 2008, p. 195). Reducing time pressures (Darlington et al., 2005b, p. 1094), by employing more staff, would also allow professionals to work more collaboratively,

> Management of case loads to avoid overload and burnout which affects [our] ability to liaise with other agencies and affects [our] ability to engage in best practice (Mental health worker; Darlington & Feeney, 2008, p. 194).

High vacancy rates and the inability to retain staff impeded the implementation of a new integrated service and impacted negatively on professionals' job satisfaction (Freeman & Peck, 2006, p. 414–415).

*Practical resources:* Funding was also required for practical resources, such as improved office facilities, access to current information technology and increased access to vehicles (Darlington & Feeney, 2008, p. 194). Without appropriate infrastructure professionals described difficulties in engaging in ongoing communication and face to face meetings. Professionals also felt that increased funding was required to meet the demand for community mental health resources (Darlington et al., 2005b, p. 1094; Elliott et al., 2007, p. 46). A lack of dedicated PIMH resources (Rowan & Bick, 2008, p. 116) hindered collaborative partnerships and directly affected the services that agencies were able to provide (Darlington et al., 2005a, p. 243).

*Shared vision, aims and goals.* When collaboration did not occur there were often misunderstandings and uncertainty (Rothera & Oates, 2008, p. 133) about the care of pregnant and postpartum women and their families. These misunderstandings were more likely to arise when professionals were working from a framework of 'us and them', for example, mental health care systems versus non-mental health care systems and vice versa, and not looking at the whole picture,

> One of the arguments that Mental Health gave us when we said that, …, we'd removed the child and she was really upset and we think she's going to kill herself, is, 'Well, you're the ones that removed the child' and it was like we'd done something wrong, …, we wouldn't have removed the child unless … the child was at risk (Darlington et al., 2005a, p. 245).

To prevent the division of 'us and them' a shared vision (Janssens et al., 2010, p. 259) or 'joined up thinking' (Elliott et al., 2007, p. 46) needs to be embraced. This would prevent service gaps and ensure a smooth referral process (Elliott et al., 2007, p. 46). Similarly, to prevent dichotomised care, professionals need to focus on both the parent and the child (Macdonald et al., 2005, p. 396),

> I felt … like we came from two very different angles. They were very mum-focused, client-focused and we were very client-focused but on the child really … (Darlington et al., 2005a, p. 245).

When organisations and professionals stopped thinking in terms of 'us and them' the physical and psychological aspects of care and the welfare of the mother and infant were no longer mutually exclusive (Hauck et al., 2008, p. 385). Similarly, as professional relationships developed the supports for the families also increased,

> Through our interagency process, we have established quite strong relationships between [services], …, which then support the individual case management … Also … the senior staff from each service have good enough relationships to contact each other … and troubleshoot [if issues occur] (Child and youth mental health worker; Darlington et al., 2005a, p. 242).

When organisations and professionals have a shared vision, aims and goals they are enabled to work in more collaborative ways. This ensures that families who have complex needs receive the most appropriate supports and services and promote better outcomes in the long term (Darlington & Feeney, 2008, p. 194). However, due to the complexities of PIMH of working across disciplines and timeframes this may be challenging to achieve.

*Pathways and guidelines. Formal communication pathways:* Professionals reported that communication pathways needed to have formal structures, be clear and consistent (Brown et al., 2009; Darlington & Feeney, 2008; Elliott et al., 2007; Janssens et al., 2010; Lees et al., 2009; Macdonald et al., 2005) to promote collaboration and effective care. Without formal pathways, organisations were unable to track women who had been referred to specialist mental health services (Lees et al., 2009, p. 25). This effected the provision of seamless care (Brown et al., 2009).

When no formal structural procedures exist between services, collaboration becomes irregular and case specific (Janssens et al., 2010, p. 257),

> After liaising with MH [mental health] workers it was clear that a lot of information had not been shared and there were no formal procedures to ensure this (Darlington et al., 2004, p. 1185).

Formal communication pathways which professionals found helpful included interagency forums and joint training (Macdonald et al., 2005, p. 396). However, it was stressed by professionals that these meetings are the responsibility of the organisation, rather than being driven by individual workers (Darlington & Feeney, 2008, p. 193).

Despite the need for effective communication 'health professionals often failed to communicate important information to one another' (Rothera & Oates, 2008, p. 132), which can result in long term negative consequences,

> Too many fingers in the pie. Everyone thought everyone else was monitoring the situation. One Sunday night, one child dead (Darlington et al., 2004, p. 1186).

*Guidelines:* Managing confidentiality issues was also reported as a concern for professionals when working and sharing information with other agencies (Darlington & Feeney, 2008; Darlington et al., 2005b; Janssens et al., 2010; McConachie & Whitford, 2009). These concerns related to different policies (Darlington et al., 2005b, p. 1094), professional duties (Janssens et al., 2010, p. 261), fear of litigation and damage to the therapeutic relationships (McConachie & Whitford, 2009, p. 871). Professionals did not understand each other's confidentiality policies which created tensions within the collaborative process,

> It is very frustrating to contact mental health and not receive information due to confidentiality in the Mental Health Act (Child protection worker; Darlington & Feeney, 2008, p. 191).

Darlington et al. (2005b) state that 'substantial and important tensions are created by operating within a statuary framework that others do not understand' (p. 1094) which could be overcome by appropriate guidelines, training and education.

*Continuity of care.* Supporting continuity of care, such as a designated link worker, or an identified contact person (Darlington et al., 2005a; Elliott et al., 2007; Rothera & Oates, 2008) or a small team of caregivers (Hauck et al., 2008), was noted as facilitating collaborative work through improved communication. Having easily identifiable and consistent contact points can help ensure regular and timely communication (Darlington et al., 2005a, p. 241; Darlington & Feeney, 2008, p. 194). Similarly, continuity of care over a sufficient time-frame promoted uninterrupted treatment (Macdonald et al., 2005, p. 396).

*Building relationships and trust.* Relationships which promote partnerships and respect and value diverse expertise (Janssens et al., 2010, p. 257) are pivotal of collaborative care. However, these relationships are built over time.

*Building relationships:* Informal networking and information sharing (Macdonald et al., 2005, p. 396; Rowan & Bick, 2008, p. 117), especially if it enhances 'cultural' understanding (Darlington & Feeney, 2008, p. 191) about organisations, were identified as approaches to gaining knowledge and getting to know other professionals,

> maintaining communication throughout the life of a case, keeping all relevant agencies informed of what was happening, and, …, meeting together for … family meetings, regular case conferences, or at particular decision points (Darlington et al., 2005a, p. 241).

Co-location of services can also increase informal communication between services, enhance professional relationships and reduce feelings of isolation (Freeman & Peck, 2006, p. 412).

*Trust and respect:* Mutual trust and respect (Darlington & Feeney, 2008; Darlington et al., 2005a; Elliott et al., 2007; McConachie & Whitford, 2009) meant that agencies and workers did not have to agree with each other but that they could embrace conflict and different opinions without expecting all the answers (Darlington & Feeney, 2008, p. 192),

> just making the effort to stay in touch … when you are busy it can be quite easy to just let that fall through and have barriers come up and … having those joint meetings, … openly, with the client there so that they are very aware of my role and that we sometimes agree, sometimes disagree (Adult mental health worker; Darlington et al., 2005a, p. 241–242).

Having trusting professional relationships was reported to make the effort of collaboration easier (McConachie & Whitford, 2009, p. 872).

*Role clarity.* Many professionals reported that they were unclear about their roles and responsibilities (Rothera & Oates, 2008, p. 132) which impacted negatively on collaboration and patient care. Pregnant or postpartum women and their families with multiple and complex needs were at times transferred between services (Janssens et al., 2010, p. 258) as professionals were sometimes unsure of their role in difficult circumstances. Collaboration was reported to work well when agencies and professionals had separate and agreed upon roles and were clear about their boundaries (Darlington et al., 2005a, p. 242). Freeman and Peck (2006, p. 414) report increased role clarity for professionals when integrated community mental health services were implemented.

*Training and education of staff.* Further training was identified due to a lack of specialist PIMH services (Rowan & Bick, 2008, p. 117) and organisations needed to ensure that PIMH workers have an appropriate level of expertise and experience (Elliott et al., 2007, p. 47). Clinical mental health training (Rowan & Bick, 2008, p. 117) was also needed as many non-specialist PIMH healthcare workers reported that they lacked the knowledge and skills required to effectively work within PIMH (Rothera & Oates, 2008, p. 132).

Education also needed to include information about access and referral pathways to specialist (PIMH, adult mental health or child protection) services (Darlington & Feeney, 2008, p. 193; Rothera & Oates, 2008, p. 132; Rowan & Bick, 2008, p. 117), available resources (Darlington & Feeney, 2008, p. 193), and procedural information about other agencies (Darlington et al., 2005a, p. 242; Darlington et al., 2005b, p. 1094),

> … gaps in interagency processes include a lack of information about the other agency …, and gaps in the more complex information-sharing processes … (Darlington et al., 2005b, p. 1094).

Training and education not only needs to include clinical issues and information about other services and agencies but also the 'how to' of working in collaboration (Darlington et al., 2005b, p. 1094).

While appropriate funding needs to be allocated for training purposes, organisations also need a culture of providing training opportunities for their staff. Professionals reported that staff development was restricted and that they were unable to attend external conferences and courses (Lees et al., 2009, p. 25). Training was also needed to enhance professionals' confidence to expand their role and work with complex families and clients (Janssens et al., 2010, p. 259).

*Support to work in new ways.* While it is important for professionals to have a clear understanding of their role and work within their boundaries, health care is not static and services change. Therefore, organisations not only need to provide staff with training but also ongoing support to promote confidence in working in new and different ways. Client care is enhanced when professionals support each other and feel supported (Janssens et al., 2010, p. 259).

McConachie and Whitford (2009) identified that many professionals lacked confidence in working in PIMH,

> No I don't do mothers and babies, no seriously I know my limitations. I would not take that on. I would feel very uncomfortable (C1 community; p. 870);
>
> Caring for the woman is alright-it is the babies I don't like … it certainly poses a challenge … (C2 hospital; p. 870); and
>
> I think it is stressful … I feel responsible … my anxieties and worries go up right away (B4 community; p. 871).

These authors also report that professionals were reluctant to talk about suicide and infanticide, although they knew about these risks (McConachie & Whitford, 2009, p. 871). Professionals need ongoing support to enable them to manage their anxieties when working with women who have mental health problems (Elliott et al., 2007, p. 46). These quotes identify the fear and dread which some professionals experience when working with women and infants in the perinatal period. They also demonstrate that additional support is required for professionals to work effectively with families who have complex needs, particularly if they are to work collaboratively with other agencies.

The majority of professionals in this review spoke positively about increased collaboration with other professionals and agencies. Some professionals, however, identified constraints as to how far they wanted to collaborate. These professionals supported well-organised partnerships but rejected the development of a new integrated service from the resources of previous services. They identified their professional boundaries and asserted the need to maintain their autonomy (Janssens et al., 2010, p. 258–9). While these constraints were only identified in one of the reviewed papers, they are noteworthy and highlight the additional support and training that some professionals may need to change clinical practice.

## Discussion

In this integrative review of PIMH services, 14 empirical studies of professionals' perceptions and experiences of collaboration and integration were synthesised. We have used the term '*making it happen*' to describe the overarching components of collaboration identified in the studies reviewed. This theme related to the process of collaborative and integrated care and included eight key elements: funding and resources for collaboration; shared vision, aims and goals; pathways and guidelines; continuity of care; building relationships and trust; role clarity; training and education of staff; and support to work in new ways. These key elements are substantiated in the literature as they reflect the antecedents for collaborative practice which Petri (2010), in a concept analysis of interdisciplinary collaboration, identified as: interprofessional education, role awareness, interpersonal relationship skills, deliberate action, and support at both the individual and organisational level.

The majority of the professionals in this review reported that they were supportive of increased collaboration with other professionals, services and agencies, but need organisational support to achieve this. An initial injection of funds for staff, training and other support systems, may be required for integration to be successfully implemented and sustained (Leutz, 1999; Miller & Ahmed, 2000). Despite the organisational challenges, others have also reported that cultural attitudes of professionals can be the most difficult barrier to overcome (Callaly et al., 2010; Schmied et al., 2010). Even cooperation can create additional burdens for managers and clinicians as they need additional knowledge about other services (Leutz, 1999). There was only one paper in this review (Janssens et al., 2010) where professionals identified the degree of collaboration that they were willing to undertake. This reluctance to change clinical practice could be related to professionals' attitudes and unwillingness to work in unfamiliar ways, which may require ongoing support and education. Given the complexities of establishing integrated services and the lack of literature about the process of implementation it is interesting that most of the papers did not comment on the disadvantages of collaborative or integrated work.

Despite the reported benefits of collaborative and integrated care, there continues to be debate about the level of collaboration that is needed. Austin (2003) argues that intensive collaboration between primary health care professionals is essential as this is where the majority of women with perinatal mental health problems will present. Others disagree stating that the majority of women do not need tightly integrated perinatal services (Rodriguez & des Rivieres-Pigeon, 2007). These, and other authors argue that it is women and families who have multiple and complex issues that gain the most from intensely integrated services, to improve access, assessment and treatment (Rodriguez & des Rivieres-Pigeon, 2007; Sword, Busser, Ganann, McMillan, & Swinton, 2008) and prevent confusion and further disengagement by multiple uncoordinated services (Twomey, Soave, Gil, & Lester, 2005).

Furthermore, concerns that the process of integration will create 'issue silos' is identified by Fels Smyth, Goodman, and Glenn (2006). These 'silos' may in turn further isolate marginalised families. Fostering the relational aspect of care, and humanistic qualities and competence of professionals will support effective and equitable services (Allison et al., 2007; Rodriguez & des Rivieres-Pigeon, 2007), while assisting women, who are often reluctant to express their emotional and practical needs, to break their silence (Dennis & Chung-Lee, 2006). The stigma of mental illness is also a contributing factor to the silence (Livingston & Boyd, 2010), which is widely reported in the literature. The expectations and experiences of rejection cause people who are stigmatised to develop specific coping strategies, such as 'secrecy' and 'withdrawal' (Link, Struening, Rahav, Phelan, & Nuttbrock, 1997, p. 180).

When undertaking this literature search, it became evident that there is a dearth of literature on professionals' perceptions and experiences of collaborative and integrated care. However, more revealing was the lack of literature which included the voices of women and families experiencing perinatal mental health issues. Where women's voices were heard, these experiences related to perinatal substance misuse programmes, which predominantly reported positive outcomes for women and their children (Hall & van Teijlingen, 2006; Lefebvre et al., 2010; Mayet, Groshkova, Morgan, MacCormack, & Strang, 2008; Sword et al., 2009).

The findings of this review also identified that professionals did not link increased collaborative or integrated care with positive outcomes for the therapeutic relationship. An optimal relationship is based upon a partnership, with the clinician and client working together towards a common aim within a framework of mutual respect and trust (Davis, Day, & Bidmead, 2002). It may be that professionals working directly with women and families believe that high level communication skills form the basis of building effective relationships with clients and that these skills and this relationship must be present no matter whether the service is integrated or whether they work collaboratively with others. This issue is raised by Katz and Hetherington (2006) who argue that the relationship between a client and worker is the most important component of effecting change.

While all of the professionals in the studies worked with women and families in the perinatal period, PIMH was not the core role for many of them. Similarly, when anxiety was mentioned, it was in relation to the professionals' anxiety not the anxiety that many women and families may experience in the perinatal period. This may be due to the focus of the studies and the way professionals responded to questions or indeed may highlight the anxiety that the complexities of PIMH generate in professionals who have not been trained to work in specialist PIMH services and the amount of support these professionals require.

There are many challenges for governments, organisations and professionals alike, associated with collaborative and integrated care, which require leadership, local commitment and support (Callaly et al., 2010). Despite these challenges, this integrative review has identified that professionals are eager to work in more collaborative ways. It has also identified a number of key elements professionals reported as necessary for this process, suggesting a need to critically reflect on current practice. However, any enhanced service coordination and interdisciplinary collaboration must also include women and families (Lagan, Knights, Barton, & Boyce, 2009), which is where future research must focus.

## Limitations

A limitation of this paper is that not all studies may have been retrieved due to the selected keywords or the databases used. Only studies published in English were included and all studies were conducted in resource rich countries. Furthermore, as a broad range of papers are included in an integrative review, it excludes the depth of analysis which would occur for a meta-analysis or meta-synthesis. Unfortunately, there was insufficient literature to bring these findings together for a deeper analysis. However, as PIMH is an emerging health specialty it is timely to report on professionals' perceptions and experiences of collaborative and integrated care.

## Conclusion

In this review, the majority of professionals were supportive of increased collaboration with other professionals and services. The key elements within the theme – '*making it happen*' – demonstrate some of the processes necessary for professionals to be enabled to work in more collaborative ways. Specifically, professionals need resources and support to embrace change and challenge cultural attitudes. New services or models of care also need to promote the relational and humanistic qualities of care.

The eight key elements that professionals reported in this review represent a useful framework for increasing collaborative and integrated care between professionals and services/agencies. It must be recognised that these key elements may not be inclusive of all those necessary for successful collaboration, and represent the elements that professionals working with women, infants and families have identified as being necessary.

Perinatal and infant mental health is an emerging field that is particularly challenging as it requires health professionals to work across disciplines and time frames (encompassing both antenatal and postnatal periods), where there is a particular risk of dichotomising care, compounding existing barriers to service uptake. The lack of empirical papers exploring professionals' perceptions and experiences of collaboration warrants further research. Importantly, what is also missing in the literature are the voices of the women and families who experience these services.

## Supporting information

Additional Supporting Information may be found in the online version of this article:

**Table S1** Studies of professionals' perceptions and experiences of collaboration and integration – extended version

Please note: Wiley-Blackwell are not responsible for the content or functionality of any supporting materials supplied by the authors. Any queries (other than missing material) should be directed to the corresponding author for the article.

## Acknowledgements

Karen Myors was involved in all phases of drafting and writing the manuscript. Virginia Schmied was involved in deciding the study design, drafting of manuscript, critical revisions for important intellectual content and supervision. Maree Johnson and Michelle Cleary were involved in drafting of manuscript, critical revisions for important intellectual content and supervision. No funding was received for this paper and no other persons or parties contributed to this paper. The authors have declared that they have no competing or potential conflicts of interest.

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*Accepted for publication: 22 September 2011*

## 2.2 Conclusion

In this chapter, I have presented the published paper *Collaboration and integrated services for perinatal mental health: An integrative review*. It has provided a background to the issues of collaborative care in PIMH services, identified the challenges that adult mental health clinicians experience when working with women in the perinatal period, and the limited literature that reports women's experiences of mental health services (refer to Appendix 3 for a copy of the online Supporting Information).

In Chapter Three, I will outline the methodology and research methods used in this study. Specifically, I introduce mixed methods as the study design and pragmatism as the theoretical perspective that guides the study. I also report data collection and analysis techniques, discuss ethical considerations and rigor and continue my research journey as a personal reflection on methodological issues.

# CHAPTER 3: **METHODOLOGY AND RESEARCH METHODS**

## 3.1 Introduction

The aim of this study is to explore and describe in-depth two specialist PIMH services in NSW. Five questions are addressed that focus on the characteristics and risk factors of women referred to a PIMH service, engagement strategies of PIMH clinicians, therapeutic interventions used by PIMH clinicians, collaborative practices of PIMH clinicians and women service-users' experiences of engaging with a PIMH service.

In Chapter One, I provided an overview of the current literature and identified the service and research gaps. In Chapter Two, I presented the findings of an integrative review of professionals’ perceptions and experiences of working in collaborative and integrated models of perinatal care for women with mental health problems. In this chapter, I will describe the philosophical and theoretical underpinnings of this study, philosophical pragmatism and a mixed methods research design. The methods of data collection and analyses are discussed with a focus on data integration. Ethical considerations, reflexivity and a reflection on methodological issues continue my research journey.

Theoretical pragmatism informed the design of this study. A mixed methods research design was chosen to guide this study, as the combination of both quantitative and qualitative data methods provided the approach to gain the best understanding of the research purpose and questions (Hesse-Biber 2010; Ridenour & Newman 2009). A mixed methods research design is particularly salient to understand and address the complexities of health care delivery (Andrew & Halcomb 2009), and is increasingly being used in health care research. For example, Appleton and colleagues (2013) used a mixed methods design to evaluate how health visitors assess mother-infant interactions. Using a validated ratings scale, heath visitors rated video clips of mothers' interactions with their infant (quantitative data). The scales were then compared to a global rating scale. Interviews (qualitative data) were then conducted with the health visitors to explore how they rated the interactions, and why they rated them as they did. Through the use of mixed methods the authors identified that the health visitors had minimal knowledge of Attachment Theory or the developmental aspects of mother-infant relationships (Appleton *et al.* 2013).

As with all research, it is the broad purpose of the research that frames the research questions (Biesta 2010). Likewise, it is the research purpose and question/s that must guide the choice of methods (Ridenour & Newman 2009). The correct choice of methods can only be judged in relation to the specific research purposes and questions (Creswell & Plano Clark 2011) which provide insights into a researcher's worldview (Hesse-Biber 2010).

## 3.2 Mixed methods as methodology

Using the more traditional approach to research, a researcher aligns him/herself with a particular paradigm or world view (Creswell & Plano Clark 2011). In the 1990's, Crotty (1998), for example, argued that the researcher must take a stance, to position themself as either objectivist/positivist or constructionist/subjectivist. However more recently, there has been a trend towards merging paradigms, as occurs in mixed methods research (for example, Creswell 2009; Creswell & Plano Clark 2011; Halcomb, Andrew & Brannen 2009; Tashakkori & Teddlie 1998, 2010). Ridenour and Newman (2009) describe three paradigms: quantitative, qualitative and mixed methods, which has been coined, the 'third research paradigm' (Johnson & Onwuegbuzie 2004).

### 3.2.1 Theoretical pragmatism

The theoretical framework of pragmatism guided the design of this study. Pragmatism as a theoretical framework does not, however, refer to "everyday pragmatism" but "philosophical pragmatism" (Biesta 2010: 97). Biesta (2010) refers to everyday pragmatism as a pragmatic approach to research that is doing what works, as opposed to the philosophy of pragmatism proposed by John Dewey.

The philosophy of pragmatism originated in the USA around the 1870's. Charles Sanders Peirce (1839–1914) and William James (1842–1910) are noted as the early classical pragmatic philosophers of inquiry and truth. Peirce held the view that scientific inquiry would lead to an ultimate truth, and the relationship of that truth with the world (Hannes & Lockwood 2011). New discoveries were only possible by using systematic and rational processes such as abduction, developing research questions and assumptions; deduction, assessing the questions or assumptions; and induction, empirically testing the questions or assumptions (Asvoll 2014). Peirce cautioned about having rigid viewpoints as these interfere with scientific inquiry (Green 2014).

James expanded pragmatism from a purely scientific foundation to an inquiry about beliefs, particularly moral and religious beliefs, and asserted that there were multiple truths (Hannes & Lockwood 2011). All beliefs, scientific, religious, moral and ethical, should involve an ongoing process of testing to "establish their truth or their inadequacy" to further our knowledge about the complexities of the world in which we live (Green 2014: 79). James advises,

> Always hold your own beliefs hypothetically and with an open mind, while taking responsibility to formulate your beliefs in ways that account of the achievements of the various relevant sciences up to your own point in history; at the same time, realize [sic] and take your own risks in terms of the existential price and practical opportunity costs that you must pay to find out whether your hunches and the belief statements in which you currently express them are *true* [italics in text] (Green 2014: 80-81).

John Dewey (1859–1952), likewise, did not profess that inquiry was about absolute truths but that truth, like all knowledge, is temporary and embedded in our interactions with the world (Hall 2013). All inquiry is social in nature as our thoughts and ideas, as well as the research choices we make, are shaped by the society we live in and interact with (Morgan 2014). Therefore, scientific inquiry is about understanding social phenomena, or the problems that exist within society and must be problem-driven with an end result of promoting democracy. Philosophical pragmatism equates to social philosophy. Social inquiry, as an explanation of physical, biological or psychological phenomena, cannot be taken into account without the inclusion of the social impact (Frega 2014). Scientific inquiry is pluralistic and inclusive (Green 2014) and involves "courageous" and "thoughtful" empirical decisions to understand our lives in a consistent yet vulnerable world (Green 2014: 89).

Pragmatic social inquiry is practice driven and problem-oriented (Frega 2014), and is referred to by Biesta (2010: 112) as "action and reflection". For Dewey, action involves communities and communication, therefore any knowledge gained needs to be shared with society (Hall 2013) to improve the lives of others (Greene & Hall 2010).

Dewey did not profess that one type of knowledge was of a higher order than another, but that different kinds of knowledge result in the different ways scientific inquiry is applied (Biesta 2010). Knowledge can be either subjective, objective or a mixture of the two (Feilzer 2010). Dewey's pragmatism embraces all research methods as they seek to uncover the multiple truths that exist within society (Feilzer 2010).

Contemporary researchers have expanded the original concept of theoretical pragmatism and coined it “dialectical pragmatism” (Johnson & Gray 2010: 88). Some authors (for example, Greene & Hall 2010; Johnson & Gray 2010) argue that a dialectic viewpoint, that is the engagement of different perspectives to generate new insights and understandings (Greene & Hall 2010), encourages researchers to be creative in research designs that endeavour to improve the wellbeing of all through knowledge and social justice (Johnson & Gray 2010). The dialectical stance promotes political and social change and has been illustrated in participatory social research, when stakeholders are engaged through a continual process of building sustainable change (Nastasi, Hitchcock & Brown 2010). Other contemporary researchers have combined realism and pragmatism and have coined “pragmatic realism” (Maxwell & Mittapalli 2010: 152). The realist perspective believes in the existence of a real world that emphasises cause and effect as central to social science, that there are no universal truths but personal and community forms of truths that encapsulate the social fabric of the world (Maxwell & Mittapalli 2010).

Notwithstanding the developments of pragmatism as a theoretical perspective, criticism exists due to the lack of a consistent set of principles or beliefs (Kroos 2012). Many leading scholars of mixed methods research contribute different definitions to philosophical pragmatism, which has blurred its conceptual foundations (Kroos 2012). Denzin (2012: 83) argues that:

> The pragmatist focus is on the consequence of action, not on combining methodologies. And here the MMR [mixed methods research] discourse is of little help.

Denzin (2012: 83) continues, stating that theoretical pragmatism offers the researcher little guidance to assess the “interpretive, contextual level of experience” for the creation of meaning. Nor does it provide direction to address the social justice issues which are inherent within society and promote a moral and political stance (Denzin 2012).

Others disagree and argue that theoretical pragmatism and its later developments have a commonality in their inherent concern for the social fabric of communities and the endeavour to improve social justice (Nastasi, Hitchcock & Brown 2010). Despite the ongoing debate surrounding theoretical pragmatism, it remains the dominant world view for mixed methods research (Nastasi, Hitchcock & Brown 2010).

### *Pragmatism and mixed methods*

Theoretical pragmatism is therefore well suited for mixed methods research designs as it can encompass both qualitative and quantitative methods of data collection and analysis (Biesta 2010; Creswell & Plano Clark 2011). Qualitative and quantitative methods are not a dichotomy but an interactive continuum, where there is no divide, but a fluid continuum of research methods (Ridenour & Newman 2009).

The motivating purpose for qualitative designs is theory building, whereas for quantitative designs the intent is theory testing (Ridenour & Newman 2009). Therefore, the use of mixed methods not only allows the findings to be generalised to a population but also provides an understanding of the phenomenon to the individuals' experiences (Creswell 2009). It uses the strengths of both qualitative and quantitative data collection techniques and analyses for an enhanced and richer understanding of a problem (Creswell 2009; Hesse-Biber 2010; Ridenour & Newman 2009; Woolley 2009), and can therefore be regarded as complementary (Woolley 2009). A true mixed methods study is not simply a combination of two different types of data, but a planned combination of the data at a predetermined stage within the research process (Halcomb *et al.* 2009; Creswell & Plano Clark 2011).

As such, the integration of data is a pivotal point in mixed methods research (Kroll & Neri 2009) and needs to be purposefully planned from the conceptualisation of the study (Moran-Ellis *et al*. 2006; Yin 2006). Integration can occur at a number of levels: design, data collection, data analysis, interpretation and reporting (Creswell & Plano Clark 2011; Fetters, Curry & Creswell 2013), and there are multiple ways of integrating data (Bazeley & Kemp 2011). The key to integration, however, is that the qualitative and quantitative findings are enhanced (Bryman 2006) by the emergence of new data findings (Andrew, Salamonson & Halcomb 2008).

As with all research designs, it is important to understand the type of data that will meet the project's goals, and to have well-planned strategies for collecting, managing and analysing the data, and presenting the findings (Lieber 2009). Other important issues are time and available resources (Lieber 2009). With mixed methods research, an additional consideration is to ensure the integrity of a single study without it diverging and inadvertently becoming two or multiple, parallel studies (Yin 2006). With mixed methods research, thoughtful reflection also needs to be given to weighting or prioritising one type of data over another for answering research questions (Creswell 2009). There are three possible weighting options: equal priority, quantitative priority or qualitative priority (Creswell & Plano Clark 2011).

Theoretical pragmatism, with its emphasis on social inquiry and the use of research methods that best answer research questions, therefore, fits as an appropriate choice to guide this mixed methods study. The social phenomena in this study are women, transitioning through a vulnerable time in their lives (the perinatal period), who are also at risk of adverse outcomes due to mental ill-health and/or psychosocial adversity. The combination of quantitative and qualitative data has provided greater insights into the research questions. The quantitative data collected from the review of medical records provided specific information about the PIMH services, for example the types of therapeutic interventions clinicians used. The qualitative data collected from interviews provided rich data about PIMH clinicians' perspectives of their work and women's experiences of being engaged with a PIMH service. Mixed methods research designs are being used increasingly in health care research (for example, Appleton *et al*. 2013).

## 3.3 Study design

This study used a convergent, embedded, mixed method design (Creswell & Plano Clark 2011). Convergent designs (also known as concurrent or simultaneous) occur when both quantitative and qualitative data components are collected and analysed at the same time. The results are then integrated for interpretation (Collins 2010; Creswell & Plano Clark 2011). Embedded designs occur when additional data is required to support the main data component, for example as an explanation of quantitative data (Creswell & Plano Clark 2011).

This study involved reviewing medical records, transcribing textual illustrations from those medical records, and interviewing health professionals and women service-users. The design was convergent in that all of the data were collected simultaneously at each site; equal weighting was given to the two main data components of the medical record review-numeric data (quantitative) and the professionals' interview data (qualitative). A second qualitative component, women service-user data, was given less weighting. This does not imply that the views of the women were less important, but that the size and scope of the women's qualitative component was not as extensive as the qualitative component of the professionals' interviews. The qualitative embedded component consisted of textual illustrations transcribed from the medical records. This data provided illustrative examples of how I interpreted specific aspects written in the medical records, for example, the therapeutic interventions used by clinicians, and the type of contact between PIMH clinicians and other service providers.

Within this convergent, embedded, design all the data were analysed separately and then compared and contrasted, with regard to the research questions, (Driscoll *et al.* 2007; Tashakkori & Teddlie 2010) for the development of inferences and meta-inferences (Tashakkori & Teddlie 2010). Data integration was planned from conception of the study and occurred during the design, data analyses, discussion and reporting phases (see Figure 3.1 study design and Table 3.1 for a conceptualisation of the processes involved in the study).

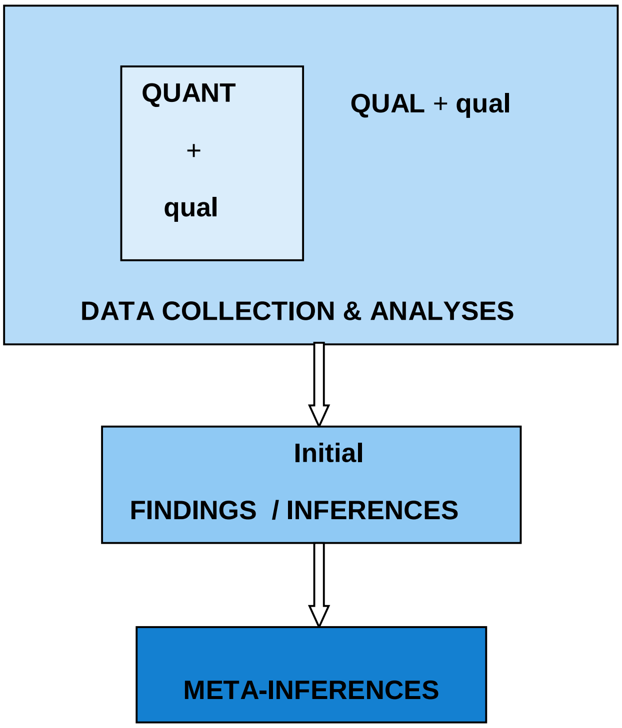

**Figure 3.1: Study design**

In mixed methods research a notation system has been developed to provide a shorthand method of conveying the study. Uppercase notation indicates priority or weighting over lower case notation, a plus sign indicates that the methods occurred concurrently and brackets indicate an embedded component (Creswell & Plano Clark 2011). The notation for this study is: QUAN (+ qual) + QUAL + qual.

## 3.4 Study setting

The study was conducted in two Area Health Services [(AHS), now Local Health Districts] in NSW, one area was Sydney metropolitan and the other was regional. These two sites were selected because the PIMH services had been implemented approximately 10 years prior to the commencement of the study; both were situated within the mental health service umbrella and employed a multidisciplinary team of nurses, psychologists and social workers. The main referral pathway was via a multidisciplinary case review meeting, which included maternity, social work, PIMH, adult mental health, and drug and alcohol services.

Site 1 provides health care to a population of approximately 370,000 people. It is a rapidly growing multicultural area with approximately 50% of the population having been born outside of Australia, and where approximately 75% of the population speak a language other than English at home (Australian Bureau of Statistics (ABS) 2011). It consists of one Level 6[6] maternity unit and one Level 4[7] maternity unit. Site 1 had 4847 births in 2013, with an additional 981 infants being born in a local private hospital (Centre for Epidemiology and Evidence 2012).

Site 2 provides health care services to a population of approximately 318,000 people. Three percent of the population are Aboriginal and Torres Strait Islander people, which is slightly above the NSW average of 2.5%. It is predominantly a white Caucasian population with approximately 80% of the population having been born in Australia and 91% of the population speaking only English at home (ABS 2011). It consists of one Level 5[8] maternity unit and a maternity unit that provides midwifery care only. Site 2 had 2496 births in 2013, with an additional 766 infants being born in a local private hospital (Centre for Epidemiology and Evidence 2012). Both sites have large areas of known socio-economic disadvantage, and as such received initial and ongoing funding to provide specialist PIMH services.

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[6] The hospital has the capacity to care for high risk births with both obstetric, anaesthetic registrars and operating suite staff on site 24hours.

[7] The hospital has the capacity to care for selected moderate risk births if >34 weeks gestation. Obstetricians, paediatricians and anaesthetists are available on-call 24 hours.

[8] The hospital has the capacity to care for selected high risk births.

## 3.5 Recruitment and participants

### 3.5.1 Medical record review

The medical records of women who were referred to two specialist PIMH services between January 2010 and December 2011 were reviewed. This two-year time-frame was chosen as it represented a relatively stable time within the PIMH services in relation to staff changes and service locations. Some medical records were not available to be reviewed, for example if they were being used by another team within the health service at the time of review.

### 3.5.2 Interviews

Purposeful sampling was used for the recruitment of participants. Purposeful sampling involves creating predetermined criteria for selecting participants who are best able to answer the research question/s (Creswell & Plano Clark 2011; McCann & Clark 2005). The participants in this study included clinicians who provided specialist PIMH services, and their managers, key stakeholders (midwives and social workers), who worked with women in the antenatal period and who were involved in the implementation of the *SFE Policy* (NSW DoH 2009) and/or the multidisciplinary case review meetings, and women who had engaged with one of the specialist PIMH services.

***Recruitment of health professionals***

I attended team meetings at both sites to inform PIMH clinicians of the study and to invite participation. Managers also sent invitations via email to capture any clinicians who were unable to attend the meetings. The PIMH managers were invited to participate in the study during individual meetings. Six PIMH clinicians (three from each site) and two PIMH managers (one from each site) consented to participate in semi-structured in-depth interviews.

Five key stakeholders (four midwives and one social worker) were contacted via email and invited to participate in semi-structured in-depth interviews. The email included written information about the study and my contact telephone number if further clarification was needed. All five stakeholders consented to participate.

***Recruitment of women service-users***

The initial recruitment involved the PIMH managers sending a letter of invitation to women who had been discharged from the service within the past six months

(Appendix 4). The letter included a return slip and a stamped self-addressed envelope for women to complete and post if they were interested in the study. Of the forty five letters that were sent out, only one response was received. An amendment to the original ethics approval was requested and granted for a second recruitment strategy (Appendix 5). The revised recruitment strategy involved the PIMH clinicians briefly informing women, who were soon to be discharged from the service, about the study. If women were interested, a consent to contact form (Appendix 6) was completed and then this was either posted to the university, or I was contacted to collect the forms in person. The other 10 women were recruited in this way.

When contact details were received, I contacted each woman by telephone, provided further information about the study and invited questions. I anticipated that many of the women may have experienced complex issues, therefore during this first telephone contact I informed the women that the study was not about their personal stories but their experience of being a client of a PIMH service. If the woman was interested in participating, a mutually convenient time and place was arranged for an interview. To avoid potentially compromising or interfering with any therapeutic interventions, women were only interviewed once they were discharged from their PIMH service.

## 3.6 Data collection

Data collection occurred between June 2011 and April 2012. Data were collected by reviewing 244 medical records of women who had been referred to the two PIMH services, from in-depth semi-structured interviews with 13 health professionals (eight PIMH professionals and five key stakeholders) and via semi-structured interviews with 11 women who had engaged with one of the PIMH services. The combination of the medical record review and semi-structured interviews allowed the data to be compared and contrasted. Specifically, it provided the opportunity to identify how and what the clinicians document in relation to their work, what the clinicians state that they do and how key stakeholders and women service-users perceive and experience the work of the PIMH clinicians.

### 3.6.1 Medical record review

A medical record review can be limited as it focuses mainly on a women’s care, however it is advantageous as it is uninhibited by sampling and selection bias, as the review was conducted on all available medical records (Wiebe, Chalmers & Yager 2012). The medical record review also provided the opportunity to numerically code or quantitise data (Creswell & Plano Clark 2011; Sandelowski, Voils & Knafl 2009) that was documented by the PIMH clinicians.

***Numeric data***

The medical record review-numeric data addresses research questions:

1. What are the characteristics and risk factors of women who are referred to a specialist PIMH service?
2. What factors do PIMH clinicians, key stakeholders and women perceive enhance or disrupt engagement with the specialist PIMH service?
3. What interventions / treatments underpin the PIMH model of care?
4. How do PIMH clinicians work collaboratively with other service providers?

The medical record review-numeric data is reported in the published papers in Chapters Four, Five A and Six.

A detailed review tool (Appendix 7) was developed to assist data collection and ensure that consistent data was obtained. The items in the tool were based on the antenatal screening tools that the midwives used at each site, the *SFE Policy* (NSW DoH 2009), the literature, and the expert clinical knowledge provided by my supervisors and other clinicians. My principal supervisor and I conducted a pilot review of 10 medical records to test the review tool and provide an initial examination of the medical records. Minor changes to the review tool were then made. The pilot review also provided an opportunity to determine which data was available to be extracted and how interventions were going to be recorded. Only interventions that were specifically written by a clinician in the medical record were recorded. When documentation lacked clarity, the intervention codes were checked with either MC, who has expertise in mental health, or VS, who has expertise in maternal and child health. Fourteen PIMH clinicians had documented in the 244 medical records. Three of these clinicians had left the service, and one was on leave at the time of the data collection.

Data collection involved reviewing 244 medical records of women who had been referred to a PIMH service between January 2010 and December 2011. Not all medical records were available to be reviewed, for example, some records were not currently in the clinical information department and were being used by another team in the health service.

***Textual data***

Textual data refers to either oral transcriptions or written documents (Wodak 2007). The textual data for this study were direct transcripts from medical records. The medical record review-textual data addresses research questions:

1. What are the characteristics and risk factors of women who are referred to a specialist PIMH service?
2. What factors do PIMH clinicians, key stakeholders and women perceive enhance or disrupt engagement with the specialist PIMH service?
3. What interventions / treatments underpin the PIMH model of care?
4. How do PIMH clinicians work collaboratively with other service providers?

The textual data is reported in the published papers in Chapters Four, Five A and Six.

The textual data from the 244 medical records were transcribed directly into a textual template on a laptop computer. The template was based on the research questions, and ensured consistency in recording the data (Appendix 8). These data gave illustrative examples of the quantitative data collected, such as descriptions of the interventions that the clinicians used, the referrals that were made, any contact with other service providers, letters to the women, and discharge summaries (refer to Chapters 4, 5, 6 & 8).

### 3.6.2 Interview data

***Health professionals***

The health professionals' interview data addresses research questions:

1. What are the characteristics and risk factors of women who are referred to a specialist PIMH service?
2. What factors do PIMH clinicians, key stakeholders and women perceive enhance or disrupt engagement with the specialist PIMH service?
3. What interventions / treatments underpin the PIMH model of care?
4. How do PIMH clinicians work collaboratively with other service providers?

The health professionals' interview data is reported in the published papers in Chapters Four, Five A, and Six. Chapters Five B and Eight report only the PIMH clinicians' interview data.

Thirteen health professionals participated in semi-structured in-depth interviews. All interviews with clinicians, managers and key stakeholders lasted between 60 and 90 minutes, were conducted at their place of work at a time convenient to them, and were digitally recorded. An interview guide was used to lead the interviews:

- PIMH clinicians: the clinician's professional background; the role and model of care of the PIMH service; engagement strategies; therapeutic interventions, collaboration with other service providers; their experiences as a PIMH clinician; the professional training needed to work in a PIMH service; and the support provided by management and colleagues. Additional questions were added to the guides as data collection proceeded, for example, to clarify documentation in the medical records (Appendix 9).
- PIMH managers: the history of the PIMH service; the model of care and how the service was developed; the demographics of the population that the PIMH team services; staff numbers employed and their professional background; support provided and challenges in providing the service; and collaboration with other services (Appendix 10).
- Key stakeholders: the history of the PIMH service; the current PIMH service model; the benefits of the PIMH service to women and families; any challenging aspects of the service; and collaboration with the PIMH service (Appendix 11).

The interview guides were used as an initial framework for the qualitative interviews. As the interviews proceeded, additional questions were included (O'Cathain 2009).

### *Women service-users*

The women service users' interview data addresses research questions:

2. What factors do PIMH clinicians, key stakeholders and women perceive enhance or disrupt engagement with the specialist PIMH service?
3. What interventions / treatments underpin the PIMH model of care?
4. How do PIMH clinicians work collaboratively with other service providers?
5. How do women interpret and experience the interventions provided by the specialist PIMH clinicians?

The women service-users' interview data is reported in the published papers in Chapters Four, Five A, and Six. Chapter Seven reports only the women service-user interview data.

Eleven women service-users participated in semi-structured interviews. Eight interviews were conducted at the women's family homes and three via telephone. The interviews lasted between 20 and 45 minutes and were digitally recorded. One interview lasted only 10 minutes due to both considerable interference from the telephone connection and the fact that another arrangement could not be made. One woman also became much more talkative once the digital recorder was turned off. This conversation was included as a summary at the end of the transcript.

The interview guide (Appendix 12) asked about the women's experiences of being referred to a PIMH service, their experience with the service, the number of PIMH clinicians they had contact with, the type of contact (for example, home visit or health centre appointment), any treatments or interventions, and their involvement with or referral to other services. At completion of the interviews, the women were given or posted a gift voucher of AU$20.00, which was linked to a number of major retail outlets, in order to thank them for their time.

## 3.7 Data analysis

Data analysis was an iterative process, moving between all data sets in an attempt to extract meaning and answer the research questions (Ridenour & Newman 2009). The process was circular and not linear, as I continually worked from one data set back to another data set to gain full understanding of the PIMH service (refer to Figure 6.1). This contrasts with the more linear approach advocated in other mixed methods designs, such as sequential designs.

### 3.7.1 Quantitative analysis

***Medical record-numeric data***

All numeric data from the medical record review tool were entered into the Statistical Package for the Social Sciences (SPSS) version 19 and 20 and analysed (two versions were used as analyses were conducted beyond the version 19 timeframe and the computer software had to be updated as per UWS and SPSS protocols). Some textual data from the medical records were quantitised or numerically coded for statistical analysis (Creswell & Plano Clark 2011; Sandelowski, Voils & Knafl 2009) (refer to section 3.7.4). The choice between various statistical tests in quantitative data analysis techniques was guided by the question/s asked and the type of data collected (Creswell & Plano Clark 2011) (refer to Tables 3.1 & 3.2).

Initially, descriptive analysis techniques were used to summarise and enhance understanding of the data (Onwuegbuzie & Combs 2010; Tashakkori & Teddlie 2010).

These included frequencies, percentages, means, standard deviations and ranges and were applied to the demographics and risk factors of the women referred, the engagement strategies and therapeutic interventions used by the PIMH clinicians, contact between PIMH clinicians and other service providers and discharge practices.

Second, inferential analyses were undertaken. Chi-square and independent t-tests were undertaken on the demographic and risk factor data to identify any relationships between these two data sets (Field 2009). The independent t-tests were identified as having a significant correlation if the $p$ value was $< 0.05$ (Field 2009).

### 3.7.2 Qualitative analysis

All of the qualitative data were entered into NVivo Version 8™ (QSR International Pty Ltd) (qualitative research data software) to assist with organisation and analyses.

#### *Medical record-textual data*

The textual data from the medical records were analysed using directed content analysis techniques (Hsieh & Shannon 2005). Directed content analysis is a more structured approach than other qualitative analysis procedures as it draws upon pre-existing concepts (Hsieh & Shannon 2005). In this study, the pre-existing concepts were based on the research questions, including engagement strategies, therapeutic interventions, collaboration with other services providers, and women's experiences of the PIMH service. The results of the analyses of the medical record-numeric data also informed these concepts. Data that could not be coded into the predetermined concepts were represented by a new code (Hsieh & Shannon 2005). In relation to the medical record-textual data, a new code was developed for the role of clinicians modelling a secure-base as part of their therapeutic interventions (refer to Chapter 5).

#### *Professionals' and women service-users' interviews*

All of the interviews with the professionals and women service-users were transcribed verbatim. Professional transcribers transcribed 22 interviews, and I transcribed two due to time constraints. All transcriptions were read in conjunction with the digital recordings to ensure that the text provided an accurate record of what the participants said, and any relevant corrections were made. I became immersed in the data by reading and re-reading the transcripts as the first step of qualitative analysis (Green *et al.* 2007). This is a reflexive and interactive process between the researcher, data collection, analysis and the development of patterns or themes (Altheide 2001; Braun & Clarke 2006; Emerson, Fretz & Shaw 2001).

The analyses of the professionals' and women service-user data occurred in two phases. Phase One involved directed content analysis techniques (Hsieh & Shannon 2005), as previously described. Two new codes were identified in the PIMH clinician data: the role of clinicians modelling a secure-base within the therapeutic interventions (refer to Chapter 5), and the clinicians' experiences of working in a PIMH service (refer to Chapter 8). All of the interview data were then analysed thematically (Braun & Clarke 2006; Green *et al.* 2007) within the codes that were generated from the directed content analysis: engagement strategies, therapeutic interventions, collaboration with other service providers, women's experiences of a PIMH service, and clinicians' experiences of working in a PIMH service. The thematic analysis constituted Phase Two of data analysis.

Thematic analysis is described as a tool that can provide a rich and detailed report of the data that captures important aspects in relation to the research question/s (Braun & Clarke 2006). The steps identified for undertaking a thematic analysis are varied. Braun and Clarke (2006) outline six: data familiarisation, generating codes, identifying initial themes, revising themes, describing and naming the themes, and writing the report. Despite these steps, thematic analysis is non-linear, but employs a time intensive iterative and recursive process (also refer to Chapters 6 & 8) of assessing the suitability of new data as it is analysed (Braun & Clarke 2006; Green *et al*. 2007). Refer to Figure 3.2 for a diagram of the processes of data analyses:

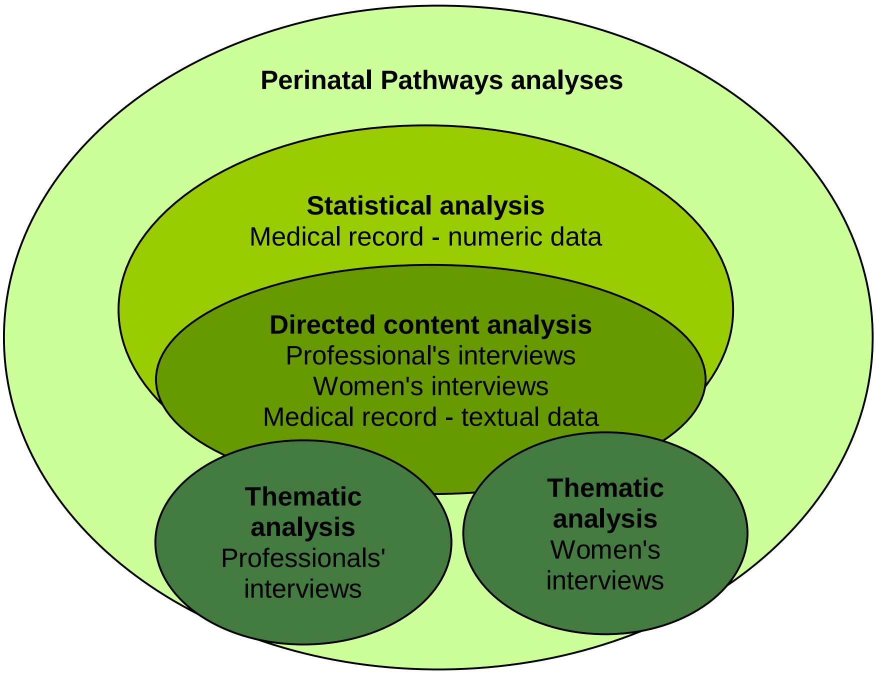

**Figure 3.2: Analyses of all data components**

**Table 3.1: Conceptualisation of the study design**

| **Procedures** | | **Products** | | **Procedures** | | **Products** |
|---|---|---|---|---|---|---|
| Develop medical record review tool | **QUAN data collection** | Numeric item scores | | Semi – structured interviews | **QUAL & qual data collection** | Transcripts |
| Review 244 medical records | | | | 13 professionals & 11 women service users purposively selected | | |
| | **QUAN data analysis** | | | | **QUAL & qual data analyses** | |
| **Procedures** | | **Products** | | **Procedures** | | **Products** |
| Descriptive & inferential statistics | | Means, SDs, Ranges, Percentages, Chi-Square, t-Test | | Content analysis | | Codes identified |
| **Procedures** | | **Products** | | Thematic analysis | | Themes identified |
| Review 244 medical records | **qual data collection** | Textual illustrations | | | | |
| **Procedures** | | **Products** | | | | |
| Content analysis | **qual data analysis** | Codes identified | | | | |
| | | | **Development inferences for each domain** * | | | |
| | **Procedures** | | | | **Products** | |
| | Compare & contrast results | | | | Manuscripts or chapters written for each domain | |
| | | | **Development of meta-inferences** | | | |
| | **Procedures** | | | | **Products** | |
| | Literature identified[#] - interpretation & development of the PIMH service | | | | Final discussion for thesis | |

⟲⟳ Denotes the embedded component, * engagement, therapeutic interventions, collaboration, [#] Heard *et al*. (2012)

### 3.7.3 Rigour and trustworthiness

Rigour and trustworthiness are important aspects of all scientific inquiry, and researchers need to demonstrate how rigour has been applied within a study (Finlay 2006). Within mixed methods research it is important to maintain a separation between the components of qualitative and quantitative data until the point of integration as Morse (2010: 348) asserts, "mixed methods are not data soup!"

***Quantitative data***

There are four well accepted criteria for quantitative research: *validity*, *reliability*, *replicability* and *generalisability* (Bryman, Becker & Sempik 2008). The quantitative data for this study was obtained from a review of medical records at both study sites.

The *validity*, specifically content validity, is achieved when a tool captures the data that it was designed to capture (Field 2009). The medical record review tool was developed in a systematic way and included the psychosocial assessment tools that were in use at both sites at the start of the study, NSW state level policy documents, current literature, and the opinion of expert clinicians and my supervisors (refer to Chapter 3 section 6.1). The captured data was appropriate as it answered the research questions requiring statistical analyses (research questions 1, 2, 3 & 4).

Likewise, *reliability* is achieved when the tool results are consistently produced (Field 2009). The medical record review tool was pilot tested by myself and my principal supervisor, discrepancies were clarified which resulted in minor changes to the tool, for example the living arrangements/accommodation of the women was deleted from the tool as this information was not available in the medical records (refer to Chapter 5). A large amount of information was collected (Thomas & Magilvy 2011) on the review tool, with 244 medical records reviewed covering a two-year time-frame of women referred to the PIMH services. When medical record documentation lacked clarity, the phrase or term was discussed with my supervisors and/or added to the interview guide for discussion with the next clinician participant (refer to Chapter 5). Ten medical records, as well as all data pertaining to therapeutic interventions, were coded by both myself and a member of my supervisory team. All data were double checked after being entered into SPSS to ensure accuracy.

*Replicability* is achieved when the study is described in sufficient detail (including population sample, situation and time points, if relevant) that it is able to be repeated by the same or other researchers with similar results achieved (Asendorpf *et al.* 2013). Conversely, the less transparent researchers are about their study designs the less replicable studies become (Asendorpf *et al.* 2013). Asendorpf and colleagues (2013) assert, “Replicability of findings is at the heart of any empirical science.” The processes of data collection and analyses of the medical record review have been sufficiently detailed to be replicated in a different study using a similar tool (refer to Chapter 3 section 6.1 & Chapters 4, 5 & 6).

*Generalisation* occurs when statistical results can be applied to not only the study sample but also the wider population from which the sample was drawn (Field 2009). The findings of this study however may not be generalisable to other PIMH services, as health services and teams are developed to meet local needs with different aims and resources. This study, however, was not designed to gather data that could be generalised to other settings, rather the study was designed to explore and describe in-depth two specialist PIMH services.

#### ***Qualitative data***

The criteria developed by Lincoln and Guba (1985) are generally accepted for qualitative research (Bryman *et al.* 2008). These include *credibility*, *transferability*, *dependability* and *confirmability* (Lincoln & Guba 1985).

*Credibility* is often demonstrated in qualitative research by asking participants or experts in the field to review the findings (Cooney 2011; Houghton *et al.* 2013). I used my supervisory team and my post-graduate student group colleagues as experts with whom I discussed the themes in relation to each research question, as well as the additional data relating to the clinicians' experiences (refer to Chapter 6). Credibility is also enhanced when data is gathered and compared from multiple sources relevant to the research questions or phenomenon being studied (Houghton *et al.* 2013). In this study, I gathered textual data from multiple sources which provided a more complete picture of the PIMH service (refer to Table 4.2). Confirmations and contrasts between data are also important components for credibility (Houghton *et al.* 2013). These are demonstrated in Chapter Five in relation to the therapeutic interventions.

The *transferability* of the findings relies upon thick description of the data to allow the readers to make informed decisions about data interpretation and whether it could be used in other settings (Houghton *et al.* 2013). In my published manuscripts and in this thesis, detailed descriptions of the research process and illustrations of raw data have been provided. The published manuscripts have also been subject to a peer-review process. Transferability is also dependent upon findings being meaningful in contexts outside of the study environment (Cooney 2011). The analysis of the data has presented a conceptual understanding of Attachment Theory within the PIMH service model, with the meta-inferences drawing upon a Theory of Attachment Based Exploratory Interest Sharing (Heard *et al.* 2012) (refer to Chapter 9). This suggests that the notions that I have identified have already been used in other works and in similar populations, therefore the concepts from this study are transferable to other similar contexts.

*Dependability* and *confirmability* are achieved by describing both the decisions made throughout the research process and how the interpretations of the data were arrived at (Cooney 2011; Houghton *et al.* 2013). Process decisions were documented in a note-book. NVivo was used to organise all qualitative data within the concepts derived from the directed content analysis. A spread of data was seen within each concept. (Refer to Chapter 3 section 7, Figure 6.1 and Chapter 8 for descriptions of the iterative process).

Saturation of sampling was achieved as no new information was seen in the data when participant recruitment ceased (Collins 2010; O'Reilly & Parker 2012). Reflexivity is also an important aspect of qualitative research rigour which provides an awareness of where the researcher is situated (Thomas & Magilvy 2011). Throughout this thesis and in all the published manuscripts, I have provided a reflexive account about how my previous experiences may impact on my subsequent decisions and how this hazard was avoided.

### *Mixing the data*

The mixing of data, or integration (described below), is an essential component of mixed methods research (Fetters *et al.* 2013). In this study, each data set and analysis were kept separate until the point of integration (Morse 2010). Integration allows inferences to be made by the combining of all data sets (Woolley 2009). Mixed methods matrices also assist integration and the identification of patterns in the data (Bazeley 2010). Matrices were developed (refer to Chapters 4 & 5 & Appendix 13) to demonstrate the relationship between data items and themes. Creswell and Plano Clark (2011: 267-268) have developed criteria to evaluate mixed methods research which I have used for comparison against this study (Table 3.2).

**Table 3.2: The application of mixed methods criteria in this study**

| Criterion | Study application |
|---|---|
| **Both quantitative and qualitative data are collected** | Quantitative data - medical record-numeric data<br>Qualitative data - participant interviews<br>- medical record-textual data |
| **Appropriate quantitative and qualitative data analysis techniques** | Quantitative data - descriptive statistics<br>- inferential statistics<br>Qualitative data - directed content analysis<br>- thematic analysis |
| **Integrates all sources of data to enhance understanding of the research problem** | Data have been compared and contrasted to enhance the findings. Matrices have been developed for engagement themes and the therapeutic interventions. The findings for each individual data component have been synthesised to form inferences. All inferences have been used to inform the meta-inferences in the Discussion. |
| **The mixed methods research design integrates all features of the study** | All components of the study have been used within the mixed methods design. |
| **The study is framed within philosophical assumptions** | The mixed methods design was guided by pragmatism. As the findings emerged Attachment Theory also provided a lens for interpreting the data. |
| **The final product uses terms consistent with mixed methods research** | Specific mixed methods terms such as integration, synthesis, inferences and meta-inferences have been used to convey the research. |

The *credibility* of all aspects of the data was confirmed after a feedback session was conducted at each study site. The study participants, and other members of the PIMH teams, supported the study findings (refer to Chapter 9 section 5).

### 3.7.4 Data integration

Data integration, the fusion of the quantitative and qualitative components of a study (O'Cathain, Murphy & Nicholl 2010), is integral in mixed methods research (Fetters *et al.* 2013). The degree of fit of data integration represents the coherence of the findings (Fetters *et al.* 2013). Integration occurred in this study during the design, data analyses, interpretation and reporting phases:

1. Integration at the design level occurred with the:

    - Convergent component. Both qualitative and quantitative data were collected simultaneously, which provided an opportunity for comparison of data, where data were analysed separately and then merged (Fetters *et al.* 2013);

    - Embedded component. The medical record-textual data were embedded or linked into the medical record-numeric data, which gave illustrative examples and greater insights into the quantitative numeric data;

    - Development of the medical record review tool (Appendix 7). This provided for the quantitising of the text. The quantitising or numeric coding of text transforms the text for statistical analysis (Creswell & Plano Clark 2011; Sandelowski, Voils & Knafl 2009).

2. Integration at the data analysis level occurred with the:

    - Quantitising of qualitative data for: the type of contact between a clinician and a woman service-user (for example home or centre visit), the age of infant when the mother was discharged from the PIMH service, how the woman's discharge occurred (for example, mutually agreed, the woman was lost to follow-up (refer to Chapter 4), the therapeutic interventions used by the PIMH clinicians (refer to Chapter 5), and collaboration between a PIMH clinician and another service provider (refer to Chapter 6).

3. Integration at the interpretation level occurred with the:
    - Comparison of all data (refer to Chapters 4, 5 & 6);
    - Identification of contrasts within the data (refer to Chapters 4 & 6). Comparing and contrasting the data allows for inferences to be made (Creswell & Plano Clark 2011) and finally meta-inferences (O'Cathain 2010; Onwuegbuzie & Coombs 2010), and these provided a more complete picture of the phenomena, capitalising on the mixed methods design (Woolley 2009) (refer to Chapter 9);
    - Development of matrices of engagement themes and therapeutic interventions (refer to Chapters 4 & 5 & Appendix 13). Data matrices provide a visual display of the data which enhances comparisons and interpretation (Creswell & Plano Clark 2011; Happ *et al.* 2006).
4. Integration at the reporting level occurred with the publication of three mixed methods papers from this study (refer to Chapters 4, 5 & 6) and the writing of this thesis. At the reporting level, narrative is used to weave the inferences and meta-inferences of both the qualitative and quantitative data (Fetters *et al.* 2013). The inferences and meta-inferences become greater than the sum of the individual parts (Woolley 2009), which are reported in detail in the Discussion, Chapter Nine. The 20 oral presentations on various aspects of the study also represent the reporting level of integration.

## 3.8 Ethical considerations

The ethical dimension of research is a fundamental aspect of the research governance process (Slowther, Boynton & Shaw 2006). Ethical considerations are important for mixed methods research designs as the researcher must ensure that informed consent has been given for all components of the data collection process (Hesse-Biber 2010). Women who are at risk of perinatal mental ill-health are a vulnerable population, as are any group with mental health issues, however the wellbeing of the infant is also an important consideration in this research (Miller 2009). Any harm to the mother, either perceived or real, may impact upon the mother-infant relationship, resulting in possible negative consequences for both the mother and the infant.

Ethical approval for this study was obtained from UWS and the Human Research Ethics committees at both data collection sites (Appendix 14). (The site specific Human Research Ethics committee letters of approval have not been included in the Appendices to maintain the anonymity of the sites and, therefore, the professionals who participated in the study).

### 3.8.1 Consent

Consent specifically refers to informed consent, which demands that: the participants have the right to be fully informed about the research, they can withdraw at any time, and no form of coercion will be used (Ryen 2007). Informed consent is a key function of all research due to the power imbalance between the researcher and the participant (Slowther *et al.* 2006). This power imbalance is more evident when participants experience a range of complex issues warranting reflection upon the principle of non-maleficence (Horsfall *et al*. 2007; Miller 2009). To ensure that informed consent is obtained, the information must be accurate and clear, there must be time for questions, time given for participant reflection, and the individual must be competent to give consent (Slowther *et al.* 2006).

All of the participants were informed, both verbally and in writing, about all aspects of the study; that they were free to withdraw at any time and that withdrawal would not affect their present or future relationship with their respective AHS or UWS. The participants were given opportunities to ask questions about the study, and questions were actively sought from the women service-users to ensure that they fully understood the study process. All of the participants had time to reflect upon the study before giving consent, as there were days and sometimes weeks between participants being informed of the study and being interviewed. The participant information sheets and consent forms were written in plain English; and all of the participants had a good understanding of English and were competent to give consent.

Consent was not sought from the 233 women whose medical records were reviewed and who did not participate in an interview. The Ethics committees were asked to waive consent for this, as it was anticipated that the risk to these women by being involved in the study was very low as all data were de-identified. It was also requested that consent be waived due to the potential benefits to the larger community in terms of understanding the types of services and interventions that meet the needs of women at risk of poor perinatal mental health, of which little is known. It would also have been difficult to contact and obtain consent from women who had been discharged from the service more than two years previously.

The PIMH managers were verbally informed of the study during the initial telephone call and the follow up meeting I had to discuss the study and request the participation of the service as part of each AHS Human Research Ethics process. Further verbal information was provided when they were given the participant information sheet (Appendix 15). Once the managers had read the information sheet and consent form (Appendix 16) they were asked to sign the consent form and were subsequently recruited into the study.

The PIMH clinicians were verbally informed of the study at a team meeting. Further verbal information was provided when they were given the participant information sheet (Appendix 15). Once the clinician had read the information sheet and consent form (Appendix 16) they were asked to sign the consent form and were subsequently recruited into the study.

The key stakeholders were verbally informed of the study prior to the arranged interview time when they were given the participant information sheet (Appendix 17). Once the key stakeholder had read the information sheet and consent form (Appendix 18) they were asked to sign the consent form and were subsequently recruited into the study.

The women service-users were verbally informed of the study when I made the initial telephone call to them, after they had indicated that they were interested in the study. If a woman indicated she was interested in participating, a time and place was arranged for the interview. Further verbal information was given to the women at the time of the interview. Written information was provided to the women in the form of a participant information sheet (Appendix 19). Once the women had read the information sheet and consent form (Appendix 20) they were asked to sign the consent form and were subsequently recruited into the study. As well as consenting to be involved in the interview process, the women service-users also consented to the review of their medical records while they were a client of a specialist PIMH team. Women who chose to participate in a telephone interview were posted the information sheet and consent form with a stamped self-addressed envelope prior to the interview. The women were not informed of the $20.00 gift voucher prior to the interviews so that it would not be seen as a coercive means of gaining consent.

All of the participant information sheets included the telephone number of the Executive Officer of the Human Research Ethics committee and the protocol number of the study in case a participant wanted to make a complaint or to enquire about ethics approval.

### 3.8.2 Confidentiality and anonymity

Researchers are obliged to protect the identity of the participants and the location/s of the research (Ryen 2007). All of the participants (including the medical record review data) were given codes or pseudonyms to protect their identity. These codes and pseudonyms were used on all data, in all of the presentations and in all of the published papers. The codes and pseudonyms are recorded on my personal computer, to which only I have access. Participants’ names were present on consent forms and digital recordings. These documents, along with the hard copies of transcripts, have been placed in a locked cabinet and will remain there for five years. Likewise, the specific AHS where the research was undertaken was not included in any of the presentations or papers.

The professional participants may perceive risks in the dissemination of the findings, as they may be concerned that their professional practice and their service are being scrutinised with potential negative consequences. At the time of the interviews I explained to the professionals that they may recognise themselves in illustrative quotes of interview or medical record textual data, and that it was unlikely that anyone else would recognise this text; although this was not entirely impossible due to the close nature of their work and the clinical reviews that the PIMH teams conduct. Specifically, the professional participants were informed that individual information would not be reported back to their managers or any other personnel in the health service.

### 3.8.3 Prevention of harm and promotion of benefit

Non-maleficence means that the researcher will do no harm (Ryen 2007). The obligation to doing no harm refers to the participants' as well as the researcher's responsibility for not spoiling the field so potential research participants are not dissuaded from participating in future research (Ryen 2007). All of the professionals were aware of support services available to them if needed, for example, their clinical supervisors and the Employee Assistance Programs, which are available in all health services in NSW.

The women service-users were specifically informed that the study was about their experience as a client of a specialist PIMH service, and not about their personal history. They were also informed that if they experienced any emotional discomfort due to the interview I could organise support through the local community health centre. When I perceived that a woman was beginning to tell me about her personal history, or any specific event not related to the PIMH service, I gently reminded her that she did not need to tell me this for the study, however if she wanted to continue I was happy to listen.

Beneficence means to do good to or benefit another (Miller 2009). Participants in this study were informed that they may not personally benefit from the study. However, part of my aim for conducting the study was that the dissemination of findings would inform health professional practice and service design, which may in turn benefit other women in the future.

### 3.8.4 Potential ethical dilemmas

Ethical dilemmas can also present themselves to the researcher, especially when the research involves vulnerable populations (Dockett *et al*. 2009), such as the women in this study. In NSW, all health professionals are mandatory reporters to child protection services. Therefore, in discussion with my supervisors, a statement on the women's participant information sheet included the wording, "In the event of any disclosed child protection concerns or illegal activity, the researcher is obligated to discuss this with the research team and make a report to the relevant authority" (refer to Appendix 19). No behaviour of concern was observed or discussed during data collection.

The place where the interview is conducted can have an impact on the information that is obtained. However, risks to the researcher also need to be considered (Fielding 2007). When a home visit was requested I followed the guidelines of the AHS for conducting home visits. This generally included obtaining information about who would be at home during the visit, if any pets would be present, the street visibility of the premises and the accessibility of parking. In many AHS, health workers are also directed to have a buddy (someone who is aware of the time and place of the home visit and who is contacted at the completion of the visit), and are also directed to carry a mobile phone on their person with emergency numbers entered. I arranged for my principal supervisor to be my buddy when a home visit was requested and I carried a mobile phone with emergency numbers entered.

## 3.9 Personal reflections on methodological issues

The clinical information department at one site was located at the bottom of the hospital, through security doors, down a long corridor, past the loading dock and mortuary. The room for reviewing medical records was located behind two locked doors. It was small, with five desks set along one wall. The medical records that were waiting to be reviewed or to be re-filed were arranged on the other two walls. There was only one telephone in the room, which was only able to make internal phone calls, and there was no mobile phone reception.

For convenience, I often reviewed medical records at this hospital in the evenings. Although my study was not about the women's personal stories, I had to read and concentrate on all that was written to ensure I did not miss any relevant data. Clinicians' documentation styles vary greatly in both the depth and breadth of what they write, and some of the medical records contained lengthy descriptions. One clinician at this site wrote lengthy narratives about the women in her care, including IPV. I clearly remember a description of a young woman who had an infant and a toddler and who was unsure of her safety with her ex-partner. One evening, she left her children at her mother's house for safety and went home alone in case her ex-partner came over to see her, as he had previously been very violent in the home.

At the completion of an evening visit to the clinical information department, I was always very keen to return home. If I had read any details about IPV, I thought about calling my principal supervisor on the way home to debrief, but I never did as it was already late and I did not want to prolong my evening. However, my experience of 25 years as a nurse and a midwife in a variety of clinical settings helped me to reflect and process my experience of reading detailed descriptions of women living in fear. After data collection had been completed, I was able to discuss this experience with my supervisors and I gave a reflective presentation at a research student meeting. This experience has taught me that reviewing or auditing medical records is not a benign activity. The implications for reviewing or auditing medical records, therefore, are that these should not be done alone or in isolation.

More importantly, this experience has provided me with an opportunity to reflect and empathise not only with the women who experience IPV and the support that they need, but also with the clinicians who strive to support the women. Vicarious trauma is described as progressive traumatisation by empathically engaging with an individual who is disclosing a traumatic event (Pack 2014). I wondered if and how the clinicians were adequately supported to work in such emotionally challenging environments.

## 3.10 Reflexivity

Reflexivity is necessary for all research, but particularly for qualitative research, as it is through the subjective lens of the researcher that knowledge is produced from encounters with individuals (Pink 2007). It is therefore imperative that qualitative researchers be aware of their own experiences, knowledge and assumptions that inform their interactions with participants and the interpretation of any data collected (Hesse-Biber 2010; Pink 2007). Reflexivity enhances rigour in qualitative research designs and should inform all stages of the research process (Delamont 2007).

As outlined in the Introduction of this thesis, I had previously worked as a PIMH clinician, albeit for a short period of 10 months, prior to commencing this study. None-the-less this experience has influenced my knowledge and assumptions of a PIMH service. Having some knowledge of the community to be researched can be an advantage; however it can also be viewed with scepticism due to the interpersonal dynamics that may impact the research (Walker, Read & Priest 2013). A close connection with other empirical researchers is important in keeping the researcher grounded (Gold 2001; Burns *et al.* 2012). Regular contact with my supervisors have kept me grounded in the data as they questioned any assumptions that I may have had. I have also provided personal reflections throughout this thesis in relation to the processes of conducting this study.

## 3.11 Conclusion

Mixed methods research designs combine both quantitative and qualitative methods of data collection and analyses which result in inferences and meta-inferences (Creswell & Plano Clark 2011; Tashakkori & Teddlie 2010). Integration is a key component of mixed methods research, and can occur at a number of levels (Fetters *et al.* 2013).

In this chapter, I have presented mixed methods as an appropriate methodology for this study. Pragmatism and the interactive continuum of quantitative and qualitative research designs have guided this study. Data collection, analysis, integration and ethical considerations have been discussed in detail. The application of rigour has been described as well as the role of reflexivity and personal research reflections.

In the following four chapters (4, 5, 6 & 7), I will describe the findings of this study. Specifically, in Chapter Four, I will present the published paper "*Engaging women at risk for poor perinatal mental health outcomes: A mixed methods study".* This paper reports the strategies that PIMH clinicians use to engage women with complex needs, answering research question two.

# CHAPTER 4: **ENGAGING WOMEN AT RISK FOR POOR PERINATAL MENTAL HEALTH OUTCOMES**

Myors, K.A., Johnson, M., Cleary, M. & Schmied, V. (2015). Engaging women at risk for poor perinatal mental health outcomes: A mixed methods study. *International Journal of Mental Health Nursing*, *24*: 241-252. DOI: 10.1111/inm.12109

## 4.1 Publication: Relevance to thesis

Chapter Four includes the publication, *"Engaging women at risk for poor perinatal mental health outcomes: A mixed methods study"*. The paper describes the strategies that PIMH clinicians use to engage women in the PIMH service who are identified as having complex needs in the perinatal period. Understanding how women at risk of poor perinatal mental health outcomes are engaged in PIMH services can assist clinicians and managers to promote effective engagement strategies and, thereby, support positive outcomes for women and their infants.

International Journal of
Mental Health Nursing

*International Journal of Mental Health Nursing* (2015) *24*, 241–252 doi: 10.1111/inm.12109

FEATURE ARTICLE

# Engaging women at risk for poor perinatal mental health outcomes: A mixed-methods study

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**ABSTRACT:** *Risk factors for poor perinatal mental health are well known. Psychosocial assessment and depression screening during the perinatal period aim to identify women at risk for poor perinatal outcomes. Early intervention programmes are known to improve the mental health outcomes of women and infants. Key to any intervention is initial and ongoing engagement in the therapeutic process. This mixed-methods study reports the proportion of women who engage/do not engage with services and their characteristics, as well as the strategies clinicians use to engage women. Data were collected by reviewing medical records, interviewing perinatal and infant mental health (PIMH) clinicians, their managers, key stakeholders, and women service users. Analyses identified that most (71.3%) women referred engaged with the PIMH service. Themes related to non-engagement are 'time to rethink' and 'stigma'. Themes reflecting the engagement strategies used by PIMH clinicians are initial engagement: 'back to basics' and 'building trust', therapeutic engagement: 'making myself useful', engagement at discharge: 'woman or clinician led', and models that facilitate engagement.*

**KEY WORDS:** *engagement, mental health service, mixed methods, perinatal and infant mental health, risk factor.*

## INTRODUCTION

Mother–infant interactions and the attachment relationship are crucial for an infant to develop optimal social and emotional health and well-being (Siegel 2001). Through positive interactions, the infant learns what to expect from mother and others, and the mother learns that her interactions with her infant are important (Fitton 2012). Stable and trusting relationships with primary caregivers lead infants to perceive their world as predictable and dependable, promote the development of empathy (Barrett & Cooper 2013), and foster a positive sense of self for the infant (Reyna & Pickler 2009). Mothers who have not experienced supportive relationships in their own families might need assistance to interact in synchrony and developmentally-appropriate ways with their infants (Reyna & Pickler 2009).

The perinatal period, conception to 12 months' postbirth (Austin *et al*. 2008), is a time when many women are at an increased risk for poor mental health outcomes (Austin *et al*. 2012), which can have negative consequences for the infant and family (Glasheen *et al*. 2010). There are known risk factors for poor perinatal mental health outcomes (Buist & Bilszta 2005), for example, idealistic expectations of motherhood, unsupportive partner and family (Knudson-Martin & Silverstein 2009), a history of depression (Lancaster *et al*. 2010), life stress, lack of social support, intimate partner violence (Austin *et al*. 2005; Schmied *et al*. 2013), and substance misuse (Ross & Dennis 2009).

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Accepted September 2014.

Pregnancy is a time when many women will engage with services (Green *et al.* 2008), and this can provide a strong motivation for change (Hall & van Teijlingen 2006; Sword *et al.* 2009). In previous studies, women mothering with mental health problems acknowledged that being a mother gave them a reason to seek treatment and recover, as their children inspired hope (Tuval-Mashiachi *et al.* 2013), provided them with an identity (Wilson 2007), and facilitated positive life choices (Montgomery *et al.* 2006). Mental illness itself, however, can be a barrier to engagement, as depression compromises energy levels, increases fatigue, reduces concentration, and promotes low self-esteem (Grote *et al.* 2007).

## Policy and service context

Australian and international literature has identified a trend where increasing numbers of children are experiencing poor outcomes (Australian Research Alliance for Children and Youth 2013, Hancock *et al.* 2013; Waylen & Stewart-Brown 2009). In response to this growing evidence, the New South Wales (NSW, Australia) government introduced the 'Supporting Families Early' policy (New South Wales Department of Health 2009). This policy provides a framework of promotion, prevention, early intervention, and treatment for mothers, infants, and their families. Psychosocial assessment and depression screening in the antenatal and early postnatal periods aims to identify women at risk for poor perinatal mental health. The needs of women identified with risk factors are discussed at multidisciplinary case review meetings, and if necessary, referral to specialized services is initiated. The risk factors are categorized into three levels: (i) level 1: no risks identified; (ii) level 2: social issues, such as poor support networks; and (iii) level 3: complex issues, such as maternal mental illness (New South Wales Department of Health 2009).

Women with complex needs require a coordinated approach to care, encompassing early planning and intervention (Frayne *et al.* 2009; Myors *et al.* 2013) with intensive individualized programmes (Dennis 2005). Engagement is critical for the success of any programme; however, many women do not engage easily in services (Miller *et al.* 2009), often preferring to rely on their own resources and social supports (Reay *et al.* 2011). Women at risk for poor perinatal outcomes often do not have resources or supports readily available to them (Macomber 2006; Wilkinson & Marmot 2003).

There is research on women's engagement in services, such as adult mental health and drug and alcohol services (e.g. Crawford *et al.* 2009; Grote *et al.* 2007; Johns *et al.* 2009); however, there is limited research about how clinicians engage women identified with complex needs in the perinatal period. The present study has drawn on the work of Kim *et al.* (2012) who describe engagement as a continuum from initial contact through treatment until mutual discharge, with active participation by both the clinician and the client.

The data reported in this paper come from a larger mixed-methods study examining specialist perinatal and infant mental health (PIMH) services. The research questions addressed in this paper are: (i) What are the characteristics of women who engage in PIMH services?; (ii) What are the reasons that women do not engage in PIMH services?; and (iii) What factors do PIMH clinicians, other professionals, and women service users perceive to enhance or disrupt engagement with the specialist PIMH service?

Women's experiences of engaging with a PIMH service have been reported elsewhere (Myors *et al.* 2014a).

## METHODS

A convergent, embedded, mixed-methods design guided the study to provide a richer understanding of specialist PIMH services (Creswell & Plano Clark 2011). Both quantitative and qualitative data were collected with equal weighting given to the medical record numeric data and the qualitative data from professional's interviews. Lesser weighting was given to the qualitative data from interviews with women service users and the medical record textual data (the embedded component).

To enhance the understanding of mixed-methods studies, a notation system was developed where QUAN represents quantitative, QUAL represents qualitative, uppercase indicates priority or weighting over lower case, '+' indicates that the methods occurred concurrently/convergently, and brackets indicate an embedded component (Creswell & Plano Clark 2011). The notation for this study is: QUAN (+qual) + QUAL + qual: MEDICAL RECORD NUMERIC DATA (+medical record textual data) + PROFESSIONAL'S INTERVIEWS + women's interviews.

Ethics approval was obtained from the relevant area health services (now local health districts) and the University of Western Sydney, Sydney, NSW, Australia. All participants consented to having the interview digitally recorded. The women service users also consented to have their medical record reviewed. All participants have been de-identified by using codes (P = PIMH and S = key stakeholder) and pseudonyms.

## Sample and recruitment

The study was conducted in two specialist PIMH services in NSW that employed a multidisciplinary team of health professionals. Engagement with the women commenced in the antenatal period, with discharge planned by 12 months' post-birth; however, one team had a greater capacity to engage women beyond the infant's first birthday.

Six PIMH clinicians, two PIMH managers, and five key stakeholders (4 midwives and 1 social worker) participated in in-depth, semistructured interviews. A purposive sample of 11 women who had engaged with a specialist PIMH team was invited to participate in the study. Detailed recruitment processes are described elsewhere (Myors *et al*. 2014a,b).

The clinicians interviewed were nurses, social workers, and psychologists, and had been working as a PIMH clinician between 2 and 8 years. The managers and key stakeholders had been involved in the PIMH service between 2 and 12 years. The 11 women service users had been discharged from the PIMH service when they were interviewed. Saturation of qualitative data was achieved, that is, no new information was seen in the data when participant recruitment ceased (Collins 2010).

## Data collection

A 2-year timeframe, January 2010–December 2011, was chosen to review the medical records. This timeframe represented a stable period within the PIMH services after recent service model changes. A total of 244 medical records were available to be reviewed. A detailed review tool was developed to ensure consistency of data collected from the medical records. Direct transcriptions of textual data from the medical records were entered into a Word document and consisted of quotes illustrating clinical practice.

The interviews were conducted between June 2011 and April 2012. All interviews were guided by an interview schedule, and lasted between 50 and 90 min (professionals) or 10 and 40 min (women service users). The schedules included prompts related to service aims/model of care, referral processes, engagement strategies, interventions, collaboration with other services, barriers/challenges in providing the service, and experiences of the service. The interviews with professionals were conducted at their work place, and the interviews with women service users were either conducted in their homes ($n = 8$) or over the telephone ($n = 3$). At completion of the interview, the women were given or posted a gift voucher ($A20.00) to thank them for their time.

## Data analysis

The medical record numeric data were analysed using the Statistical Package for the Social Sciences versions 19 & 20 (SPSS, Chicago, IL, USA). Descriptive analysis techniques were used to describe the characteristics of the women service users. Textual data, for example, the type of contact (centre appointment or home visit) between the clinician and the woman, were 'quantitized' to demonstrate frequencies of engagement strategies. The 'quantitizing' or numeric coding of textual data provides a description of the phenomena and can counteract bias by enhancing analytical reliability (Bazeley 2010, p. 443). Directed content analysis (Hsieh & Shannon 2005) of all the qualitative data was guided by the research questions and quantitative analyses. Thematic analysis (Braun & Clarke 2006; Green *et al*. 2007) was used to analyse data collected from interviews with professionals and the women service users. All qualitative data were organized using NVivo (QSR, Melbourne, Victoria, Australia). Data integration was planned from conception and occurred during the design, data analyses, and discussion phases of the study.

## FINDINGS

These findings report the characteristics of the women who were referred to, and those who engaged with, a PIMH service, the reasons why women did not engage ('time to rethink' and 'stigma'), and themes of engagement (initial engagement: 'back to basics' and 'building trust', therapeutic engagement: 'making myself useful', engagement at discharge: 'woman or clinician led', and models that facilitate engagement). In some quotes, additional wording has been added in parentheses to aid understanding.

### Characteristics of the women referred to the PIMH services

The average age of the women was 28 years (standard deviation (SD) = 5.9). The majority (77.5%) were born in an English-speaking country and were partnered (73.4%). A total of 140 (57.3%) women had children prior to the referral, and 116 (47.5) had experienced a previous pregnancy or infant loss. The women were identified as having complex psychosocial issues, with 72.4% having three or more level 2 risk factors and 54.1% having at least one level 3 risk factor. The majority of women (84.8%) were referred via the midwives in the antenatal clinic, 29 (11.9%) were referred antenatally by another service, for example, the mental health crisis team, and eight (3.3%) were referred post-natally, for example, by their general practitioner or self-referred.

**TABLE 1:** *Characteristics of women referred*

| | Referred<br>*n* = 244<br>*n* (%) | Engaged<br>*n* = 174<br>*n* (%) | Non-engaged<br>*n* = 70<br>*n* (%) | $\chi^2$ (*P*-value) |
|---|---|---|---|---|
| Country of birth | | | | |
| English speaking | 189 (77.5) | 135 (78.9) | 54 (78.3) | 0.014 (0.906) |
| Non-English speaking | 51 (20.9) | 36 (21.1) | 15 (21.7) | |
| Missing | 4 (1.6) | 3 (1.7) | 1 (1.4) | |
| Relationship status | | | | |
| Partnered | 179 (73.4) | 135 (78.0) | 44 (64.7) | 4.538 (0.033)* |
| Unpartnered | 62 (25.4) | 38 (22.0) | 24 (35.3) | |
| Missing | 3 (1.2) | 1 (0.6) | 2 (2.9) | |
| Parity | | | | |
| 1st pregnancy | 98 (40.2) | 69 (40.6) | 29 (42.6) | 0.085 (0.771) |
| 1–3 children | 125 (51.2) | 91 (53.5) | 34 (50.0) | 0.243 (0.622) |
| 4+ children | 15 (6.1) | 10 (5.9) | 5 (7.4) | 0.178 (0.673) |
| Missing | 6 (2.5) | 4 (2.3) | 2 (2.9) | |
| Pregnancy loss† | 106 (43.4) | 77 (44.3) | 29 (41.4) | 0.162 (0.687) |
| Infant loss‡ | 10 (4.1) | 9 (5.2) | 1 (1.4) | 1.780 (0.182) |
| Risk factors | | | | |
| Low level 2 (1&2) | 40 (16.4) | 31 (17.8) | 9 (12.9) | 0.896 (0.344) |
| High level 2 (3+) | 177 (72.4) | 124 (71.3) | 53 (75.7) | 0.496 (0.481) |
| Level 3 (any) | 132 (54.1) | 90 (51.7) | 42 (60.0) | 1.377 (0.241) |
| High level 2 & level 3 | 204 (83.6) | 143 (82.2) | 61 (87.1) | 0.896 (0.344) |
| Child abuse/neglect | 83 (34) | 62 (35.6) | 21 (30) | 0.705 (0.401) |
| Adult sexual assault | 12 (4.9) | 10 (5.7) | 2 (2.9) | 0.892 (0.345) |
| Self-harm§ | 55 (22.5) | 38 (21.8) | 17 (24.3) | 0.171 (0.679) |
| Previous PIMH client | | | | |
| Yes | 20 (8.2) | 14 (8.0) | 6 (8.6) | 0.018 (0.892) |
| No | 224 (91.8) | 160 (92.0) | 64 (91.4) | |
| | Mean (SD) | Mean (SD) | Mean (SD) | *t* (*P*-value) |
| Age (years) | 27.7 (5.9) | 28.1 (6.2) | 26.6 (5.2) | 1.765 (0.079) |

*Significant at <0.05. †Miscarriage, termination of pregnancy, foetal death in utero. ‡Stillbirth, neonatal death, sudden infant death syndrome. §Deliberate self-harm, suicide ideation, suicide attempts. PIMH, perinatal and infant mental health; SD, standard deviation.

Of the 244 medical records reviewed, 174 (71.3%) women had engaged with the PIMH service. Being partnered was the only significant difference between the women who engaged and those who did not engage (28.7%), with the women who engaged being more likely to have a partner ($\chi^2 = 4.538$, $P = 0.033$) (Table 1).

*Non-engagement: 'time to rethink' and 'stigma'*

Of the 244 medical records reviewed 70 (28.7%) women did not engage with a PIMH service. Nine (3.7%) women could not be contacted by a clinician and were referred back to the antenatal clinic. The time lag between the antenatal screening process and being contacted by a PIMH clinician was recognized by PIMH clinicians and key stakeholders as a reason why women chose not to engage:

> Women will often consent at the time of booking in and then . . . PIMH might ring them and they (have) changed their minds . . . they've had time to go from feeling vulnerable to getting out and going, 'Oh no, I don't want anything', and wondering . . . 'Oh god . . . why did I tell them that?' (S3)

The PIMH clinicians reported that there was nothing that could be done to improve the process and decrease the time lag:

> (It) might take us 2 or 3 weeks . . . to actually call them. I don't necessarily think we can do anything to change that. (P2)

In contrast, key stakeholders believed that the process could improve by making the multidisciplinary case review a referral meeting, not just a discussion meeting:

> That meeting won't take a referral, it's just a discussion meeting, and then it needs to go back . . . to the midwife, who then will ring the woman back and ask her if she'd

> like a referral, and then eventually someone will ring you . . . it's a really poor process. (S4)

Stigma of mental illness was another reason reported by clinicians for why women did not engage, especially women who 'have been through the revolving door of the mental health system would not see (the referral) as a positive' (P7), as documented in this medical record (MR):

> (Client) clearly stating she is annoyed re referral to (mental health) & said she did not give consent. She said she did have mental health issues in the past & has seen (a) private psychologist. . . . (Client) given (information) that she could re refer to PIMHS – she made it very clear that she would not be doing that. . . . No further plan for (follow up) by PIMH. (MR234)

Clinicians used a variety of strategies to counteract the stigma. For example, one clinician highlighted 'that we're actually about the baby' (P2), and another clinician does not call the service 'Perinatal and Infant Mental Health', instead referring to it as 'the perinatal service' and 'that I work with the midwives' (P3). Conversely, other clinicians believed that mental health services could be

> 'destigmatized . . . by having these sorts of services in it. . . . If we hide mental health because we think people don't want the stigma, then aren't we just . . . perpetuating the image, or the negative stereotypes?' (P7).

## Engagement strategies used by PIMH clinicians

Clinicians used a range of strategies to engage women identified as having complex needs. Four broad themes were identified in the data: initial engagement: 'back to basics' and 'building trust', therapeutic engagement: 'making myself useful', engagement at discharge: 'woman or clinician led', and models that facilitate engagement. Exemplars of integrated qualitative data related to the engagement themes are represented in Table 2.

Clinicians reported that the aim of the service was to promote positive mother–infant relationships as women want,

> 'to do the best for their babies. Even the ones who were really unwell with substance abuse or mental health issues, at the base of it, they really want the best for the babies. . . . So it's easy to work on that' (P5).

The concept of engaging women by focusing on the therapeutic and mother–infant relationship was woven through all stages of the engagement continuum.

### *Theme 1: Initial engagement: 'back to basics' and 'building trust'*

Of the 244 medical records reviewed, 161 (65.9%) women were able to be contacted on the first telephone call made by the clinician. Nine women did not receive initial telephone contact, as the clinician arranged with the midwife to meet the woman in the antenatal clinic. Eighteen women received a higher number of telephone calls (5–13) before contact was made, indicating a commitment by the clinician to make contact. When contact was made, clinicians were mindful that it might have been a month since the booking visit and referral and determined that it was best to take 'it back to basics of . . . initial engagement on the phone, is this a good time? Does this work?' (P6). Also, not 'rushing' the process was important, as 'some (women) were happy to jump on it straight away and others wanted time to think about it' (P6).

Clinicians reported that their initial contact with women was important to engagement, and described being 'responsive', 'available', 'client led', and making women 'feel heard'. One clinician stated 'being chatty [laughs] . . . I'm really quite relaxed and aim to be non-judgmental' (P5). The ability to home visit was preferred by some clinicians for the initial assessment, as many women felt more comfortable in their own homes, as Nancy stated: 'I was more relaxed in my own environment'.

Building trust was about being 'open' and 'transparent', especially in the early stages (Table 2). One clinician commented:

> When I'd meet women and say that I work for mental health, I'd ask . . . what that meant to them, and how they felt about that. (P6)

Clinicians were also mindful of language, 'using language around mood, energy, enjoyment . . . just normalizing it' (P6). Empathy also assisted initial engagement as clinicians asked questions, such as:

> Is there something that scares you about coming? . . . Have you been worrying about it?' . . . (so that women) could see, even before she'd met me, that maybe I could understand how she felt. (P2)

A trusting relationship also meant talking about '(the) limits of confidentiality at the beginning' (P2), for example, referral to child protection services, as documented in the following medical record:

> Presented as anxious. . . . Worried about discussing (mental health) & trauma (history) today & who I told the information of last week. Confidentiality, team supervision & mandatory reporting explained. (MR006)

Trust was important, as many women were concerned about being judged:

> (Client) reported that her main concern was being able to be a good mother to all the children once the baby arrives

**TABLE 2:** *Engagement themes and data source*

| Theme | Data source | | |
|---|---|---|---|
| *n* = 174 | Medical record – textual data | Professionals | Women service users† |
| Initial engagement: 'back to basics' | Letter: You have given indication that you would like contact and support from PIMHS. I have phoned today but was unable to get through to you. So as to provide you with information as quickly as possible I am posting a PIMHS brochure to you which will give you information about our team and other contact numbers as well. (MR047) | Taking it back to basics of initial engagement on the phone, is this a good time? Does this work? . . . Are there kids around now or can I call back later? (P6)<br>That first phone call's really critical. (P1) | It was very flexible, depending on me too, sometimes I wasn't very good at going out, and they would (fit) in with that, but the home service was the best, that they could come here. (Patricia) |
| 'building trust' | (Client) expressed that she doesn't feel that comfortable talking to me, but would like to. We will make regular 2/52 appointments for time & space to get to know each other. (MR035) | The consistency, the reliability, honesty and transparency . . . being quite up front really – what we're doing – what I'm thinking . . . sharing your experience of whatever's going on in therapy sometimes. (P3) | But also the appointments and length between appointments was open to me saying whether I needed something sooner than what was previously going to be fortnightly or monthly or something. Also it was open for me to call her in between meeting, so all those things were great. (Tabitha) |
| Therapeutic engagement: 'making myself useful' | (Phone call) to (acting nursing unit manager) postnatal ward. Discussed case & (client's) request for her husband to stay overnight. (Manager) advised that it is likely that this can be accommodated however, not guaranteed. (MR110) | About making myself useful to them . . . people aren't going to stay with a service that they don't perceive as useful. (P7)<br>Holistic approach, in that someone who's homeless is not going to enter into very deep discussion about relationships with their baby. You need to meet the basic needs first. (P1)<br>There's a lot of great. qualities within the team members. They're very passionate and they're very good with what they do and their knowledge base. The service. is really holistic, it looks at all of those things that can impact on a family . . . My sense is that the families feel well supported. (S3) | I also stayed in (family support service) for a week, and (the clinician) came to see me once there. (Melissa)<br>She also helped me into programmes to help (me) feel more confident with my parenting. (Carol) |
| Home visits | Initial (appointment) arranged for (date) at family home due to transport issues. (MR154) | (Home visits) shift the power base so there's a more equal start to be taken, whereas if they're having to come into a centre, it changes things. (P7) | I was more relaxed in my own environment . . . you didn't have to have that warm up bit at the beginning of a session . . . if I had one or two of the children home, we always arranged it around rest time . . . so it was very convenient at home. (Nancy) |
| Centre appointments | | You could still access health centres and there was enough around . . . (but) some of the health centres aren't very aware, if they don't have child and family health there or they don't have mental health . . . they weren't always very welcoming to clients. (P6) | (Centre rooms have to be) child friendly, especially if there were other children (and) to be in a familiar room all the time is better for you than to have to chop and change rooms. (Sharon) |
| Engagement at discharge: 'woman or clinician led' | Invited (client) to come in for an appointment, offered a further (phone call). (Client) declined. She is ready to be discharged. (MR005)<br>Over the last few months I have attempted to contact (client) but have been unsuccessful. She has regular (follow up with private psychiatrist), therefore I will discharge the file. (MR007)<br>Has had some anxiety about finishing (with) service as (baby) is coming up to 12/12. Discussed some options such as joint sessions (with sexual assault service) so she could move on with them. (MR043) | There is certainly a large percentage of these families that would benefit from a 2-year intervention, rather than a 12 month. (P7)<br>Some, once they knew they were coming up for discharge, they would discharge themselves early . . . (I'd) just follow up with the letter . . . I didn't take it personally, but I took it that's where they were at. (P6)<br>One of the things that comes back in the feedback is that a lot of women say that they wish (the service) could have gone on a lot longer. (P5)<br>For those women that you keep on past the perinatal period with no subsequent children – keeping that positive relational model, rather than possibly again being a relationship that didn't last. (P3) | (The sessions) kind of dropped off, as I felt more and more confident and comfortable and the medication kicked in and I was able to not feel the heavy stress that I was feeling. (Cathie)<br>All up, I have known her almost 4 years, and this time around, she has been around for just over 2 years. (Carol)<br>I've needed the help through all three of my pregnancies and birth . . . it only seems to be during the beginning of the birth, so it's within the first 3 months that things are really up and down, and then after that they seem to stabilize a bit. (Melissa) |

†Pseudonyms used. MR, medical record. P, PIMH; PIMHS, perinatal and infant mental health service; S, key stakeholder.

> . . . spoke to (client) about being a 'good enough' parent. (MR139)

The initial assessment processes, conducted by the midwives and the PIMH clinicians, were described as negative by some clinicians:

> (They are) so focused on the weaknesses or vulnerabilities or what's lacking for them – the risk factors. (P1)

To counteract the perceived negativity, clinicians promoted women's strengths:

> (Many women have) never been told that they're doing anything good . . . I had one mum who I said to her . . . that her baby adored her, and she was the most important thing in his whole world, and she just lost it and burst into tears. Because nobody had ever told her that she was that important. (P5)

*Theme 2: Therapeutic engagement: 'making myself useful'*

An average of five (SD = 8.5) home visits were made to 102 (58.6%) women, and seven (SD = 12.2) centre appointments were made with 154 (88.5%) women. Eighty-two (47.1%) women received both home visits and centre appointments. While more centre appointments were conducted overall, all clinicians reported there were times when home visits were 'a huge benefit to engaging families' (P5) (Table 2). Of the 11 women interviewed, most stated that they preferred home visits. One woman responded that she preferred centre appointments, because she lived with her extended family and could not talk openly at home.

As the therapeutic relationship developed and women talked more freely about their concerns, clinicians responded that being 'useful' and having a 'holistic approach' assisted ongoing engagement. Some clinicians described this approach within a case-management model as 'you need to meet the basic needs first' (P1). The developing therapeutic relationship also meant,

> 'not being scared to upset them in some way. . . . It can be hard . . . to have to tell someone something that you know they're not going to want to hear' (P2)

as described in the following medical record:

> Described (relationship) as domestic violence – she was shocked & overwhelmed by this idea. Plan in place. (MR112)

During difficult situations, it was important to support the woman and help ensure her safety by 'seeing them through whatever it is they need to do' (P3).

Clinicians reported being mindful of not imposing their own thoughts or ideas, and emphasized the need for therapeutic interventions to be 'client led':

> I might have my own thoughts about the work that might need to be done, but that doesn't necessarily mean that's what they want to do . . . eventually you get to the places you want to go. (P3)

**TABLE 3:** *Discharge practices*

| Time of discharge | *n* = 174 (%) |
|---|---|
| Antenatal period | 19 (10.9) |
| <3 months' post-birth | 48 (27.6) |
| 3–6 months' post-birth | 37 (21.3) |
| 6–9 months' post-birth | 30 (17.2) |
| 9–12 months' post-birth | 5 (2.9) |
| >12 months' post-birth | 35 (20.1) |
| **Reason for discharge** | ***n* = 174 (%)** |
| Mutual/negotiated | 74 (42.5) |
| Referred to another service | 45 (25.9) |
| Unable to be contacted/lost to care | 31 (17.8) |
| Moved out of area | 12 (6.9) |
| No further follow up by clinician | 8 (4.6) |
| Self-discharge | 2 (1.1) |
| Neonatal death | 1 (0.6) |
| Clinician left the service | 1 (0.6) |

*Theme 3: Engagement at discharge: 'woman or clinician led'*

Women were engaged with a PIMH service for an average of 45 weeks (SD = 32.7). Sixty-seven (38.5%) women were discharged from the PIMH service before their infant was 3 months old, and 72 (41.4%) women were discharged when their infant was between 3 and 12 months. The main reasons for being discharged in the antenatal period was for a referral to another service (*n* = 6), three of which were to culturally-specific services, and four women moved out of the area. The main reasons for discharge from birth to 3 months were mutual agreement (*n* = 23), unable to be contacted (*n* = 9), and referred to another service (*n* = 7). Thirty-five (20.1%) women were discharged after their infant's first birthday. Twenty-two (12.6%) women were with the service for longer than 18 months.

Overall, the majority (*n* = 131, 75.3%) of women were discharged from the service after mutual agreement between the woman and the clinician. Of these women, 45 (25.9%) were referred to another service, and 12 (6.9%) moved out of the area. Thirty-three (18.9%) women were discharged because they were lost to follow up or self-discharged without support from the clinician (Table 3).

Clinicians reported that some women would prematurely disengage from the service when they knew that discharge was pending. Clinicians indicated that when a woman's tolerance to distress, anxiety, or mood had decreased to a 'comfortable' level that they could 'manage', some women would self-discharge. Lack of trust was also a possible reason for self-discharge, as the following clinician commented:

> (The women) have to be able to trust that the clinician can support them in what they're going through . . . what they feel (could be) so big and frightening, that they either don't trust themselves . . . or the supports they've got to be able to handle it. (P6)

A change in case manager was reported to prompt women to self-discharge or negotiate an early discharge:

> It takes such a long time to establish a relationship. People don't want to go then elsewhere and tell their story all over again. (P3)

> We've become the attachment figure for the family . . . and if your attachment figure suddenly walked out and said, 'I'm not going to be your mum anymore, here's another mother, have fun', it'd be a bit uncomfortable . . . what we do is so relationship dependent. . . . We work with the women and their families through relationship. (P7)

For some women, the discharge process was clinician led due to the 12-month post-birth timeframe and limited capacity within the team to extent engagement. This was potentially devastating for women:

> (Client) aware of my need to discharge her from PIMH. (Client) distressed +++ at finalisation of services – teary, sobbing, appeared to disassociate – speech slurred, face immobile. Assisted with breath coaching and grounding exercise to reorientate. (Client) returned to normal appearance, speech and motor (movements) but remained labile in her mood. . . . (Client) acknowledging that she did not want support to stop and was anxious as to how she would manage. Advised I would be discussing supports and making referral as agreed today and need for her to be more open to accepting alternate supports. (Client) stated she was safe, no disassociation, no suicidal thoughts at completion of session. (MR218)

Clinicians reported that it would be beneficial 'to be able to offer a longer term intervention' (P7) of 2 years or more, because at 12 months, some women are 'only just getting to trust you enough, to be able to do the work' (P7). Women also reported that they would have preferred a longer service. Some women were able to have an extended service, as Patricia said, 'they did extend my service slightly . . . based on circumstances', but others were not.

*Theme 4: Models that facilitate engagement*

Most clinicians talked about their work within a case-management model and saw it as a way of facilitating engagement, being an 'advocate . . . scaffolding for the client what they need to do' (P2). Clinicians and managers identified that 'negotiating the system takes a huge amount of perseverance and . . . these parents don't always have the skills . . . to get . . . through the maze' (P4). Being an advocate meant 'helping (women) develop the skills to be their own advocate . . . linking them in with other services . . . finding out what needs . . . they might have' (P5), as documented in the following medical record:

> (Phone call) to . . . (Department of Housing). Advised (client's) been very unwell & stressed. Encouraged them to give her special consideration re: rent payment. (MR112)

Other clinicians responded that 'some sessions are purely therapy and . . . some sessions have minimal therapy and they're more about the case management . . .' (P3). One clinician particularly found case management to be a difficult and emotive term to discuss:

> I hate case management, because I think families manage themselves. . . . If they need something from a service . . . then I'm the one that facilitates that or helps them to know how to facilitate it themselves. (P6)

Case management as a term also caused some confusion among clinicians; for example, 'Which case-management model are we talking about.?' (P7) and 'I think there's (sic) different definitions of case management, and I don't know what they all are' (P5). Another clinician explained that 'therapy is part of case management, but it's not case management' (P7), adding that,

> 'most of the practitioners within the team would see themselves as the expanded version of case manager, not the narrow version of case manager, which is that you don't provide any therapy' (P7).

Clinicians predominantly talked about working in a case-management model; however, the medical record review identified the diverse interventions that the clinicians use to work therapeutically with women (Myors *et al*. 2014b) and promote engagement.

## DISCUSSION

Defining engagement as a continuum from initial contact to discharge (Kim *et al*. 2012), this mixed-methods study has identified the characteristics of the women who were referred to, and then engaged with, a specialist PIMH service, and the strategies that clinicians use to engage women with complex needs. The women in the present study had multiple and complex risk factors associated with poor perinatal outcomes; however, the majority of women (71.3%) engaged with a PIMH service. There were no significant differences in the risk factors of the women who engaged and those who did not, indicating that women with all levels of risk are willing to engage with services. Another important finding in this study is that a high proportion of women (65.9%) were contacted on the first attempted telephone call by a PIMH clinician. This is in contrast to some studies where making initial contact with a client has been problematic and resulted in non-engagement (e.g. Kim *et al*. 2010).

## Engagement barriers and facilitators

The time lag between the antenatal assessment by the midwife and contact by a PIMH clinician was identified as a barrier to initial engagement. Systems that promote consistent and clear assessment and decision-making processes, timely referral, and availability of appointments within days and not weeks enhance care-seeking behaviours of women at risk of perinatal mental ill health (Beyondblue 2011; Myors *et al*. 2013).

Stigma is a well-documented barrier to engagement in mental health services (Bates & Stickley 2013; Vogel *et al*. 2013), including concerns about the prescription of psychiatric medications (Alvidrez *et al*. 2010) and shame for women with traumatic backgrounds (Talbot & Gamble 2008). To counteract stigma, clinicians focus on the infant and the mother–infant relationship and are mindful of the language they use, especially during initial contact with women.

To facilitate engagement, clinicians are also 'woman led', which means that, at times, much of their work involves case management. Clinicians have reported that the term 'case management' is demoralizing and confusing; however, this term is used widely in the literature (e.g. Castle 2013; Dadich *et al*. 2013). Clinicians are also conscious to offer choice, are flexible about the model and location of service delivery, and focus on women's strengths. Flexible models of care (Gibbons *et al*. 2010), choice (Laugharne & Priebe 2006), and focusing on the relational strengths of women promotes engagement and empowerment, and enhances the therapeutic relationship (Wisdom *et al*. 2009).

Clinicians also view advocacy as synonymous with case management. Advocacy is needed, as women with perinatal mental ill health often have poor support networks and are ill-equipped to deal with child protection services (Lagan *et al*. 2009). Advocacy also promotes empowerment and skill development when working with trauma survivors (Elliott *et al*. 2005). A good knowledge of child protection systems and a close working relationship between mother–infant and mental health services is needed to meet the needs of marginalized women in the perinatal period (Lagan *et al*. 2009). Women who do not feel that their needs are being met are more likely to disengage (Jack *et al*. 2005).

## Discharge practices

The early postnatal period can be demanding for many mothers, especially for mothers experiencing additional challenges (Barkin *et al*. 2010). Likewise, the first 3 months can be a critical time for relapse in women who have previously experienced mental illness (Frayne *et al*. 2009). Surprisingly, a significant proportion of women (27.6%) were discharged from the PIMH service before their infants were 3 months old.

A recent study on maternal mortality in NSW identified a peak in deaths 9–12 months' post-birth for women with a mental health diagnosis (Thornton *et al*. 2013). This is of concern, as 115 (66.1%) of the women were discharged before 9 months' post-birth (not including antenatal discharges). The prescribed discharge time for the PIMH service is either before or by the infant's first birthday; however, 20.1% of the women were discharged after this timeframe. Some women wanted longer engagement with the service; however, not all women were able to continue with the service. The present study has identified an ad hoc and reactive approach to discharge depending on service capacity, with potential negative consequences for women and their infants. Services that do not have formal time limits are reported to have higher retention rates (Crawford *et al*. 2009) and might decrease the number of women who are 'lost to care'.

## Further research

Further research is needed on engagement, its meaning, and how it is conceptualized and understood by service users and clinicians. Some authors recommend . . . specific strategies during the early engagement period to identify barriers to care and ongoing treatment. Talbot and Gamble (2008) advocate an engagement analysis that focuses on an individual's functioning and social supports. The engagement analysis draws on interpersonal psychotherapy, underpinned by attachment theory (Bowlby 1958), and emphasizes how the mother–infant relationship affects all other interpersonal relationships.

Alternatively, Grote *et al*. (2007) recommend highlighting a woman's strengths, especially her ability for positive change, and developed an engagement interview. The engagement interview draws on ethnographic and motivational interviewing to understand the clients' stories from their cultural perspective, and identify their motivations for change.

Clinicians in the present study highlighted both their relationship with the woman, within an attachment theory framework, and women's strengths (Wisdom *et al.* 2009). Using a specific engagement strategy might further promote women's engagement by identifying risks for disengagement early in the engagement continuum.

### Strengths and limitations

There are few studies in the literature that report the characteristics of women who engage with specialist PIMH services and the strategies clinicians use to engage women. As such, this is an important study that adds to the growing literature base of these specialist services. The medical records reviewed in the present study represent a small group of women who received services at two specific sites in NSW, and are not necessarily representative of the population requiring this service. Only a small number of professionals and women were interviewed; however, saturation was achieved.

## CONCLUSION

The mental health of the mother during the perinatal period has a significant impact on maternal and infant well-being. Strategies that effectively engage women who are at risk for poor perinatal outcomes are essential to prevent negative long-term sequelae. The stigma of mental illness and mental health services, as well as the number of women who disengage from services prematurely, is a concern for mental health clinicians and services alike. Focusing on the mother–infant relationship, being 'woman led', and having a holistic approach are strategies that PIMH clinicians use to promote engagement. Clinicians and services need to review discharge practices in light of recent literature to not place women and their infants at further risk for poor perinatal outcomes.

## ACKNOWLEDGEMENTS

The authors acknowledge and thank the women and the professionals who generously gave their time to participate in this study, as well as the support provided to KM by an Australian postgraduate award.

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## 4.2 Conclusion

In Chapter Four, I have presented the first chapter reporting the findings of this mixed methods study as a published paper, "*Engaging women at risk for poor perinatal mental health outcomes: A mixed methods study"*. The main strategies that PIMH clinicians use to engage women in the perinatal period who have complex needs in specialist PIMH services have been described. In Chapter Five I will present the second chapter on the findings of the study about the therapeutic interventions that PIMH clinicians use when working with women at risk of poor perinatal mental health outcomes.

# CHAPTER 5: **THERAPEUTIC INTERVENTIONS IN PERINATAL AND INFANT MENTAL HEALTH SERVICES**

## 5.1 Introduction

Chapter Five is divided into two parts. In the first part I present the published manuscript, "*Therapeutic interventions in perinatal and infant mental health services: A mixed methods inquiry*". In this paper, the data from the quantitative analysis of the interventions that PIMH clinicians documented in the medical records are presented. Data from the directed content analysis of the interviews, and textual illustrations from the medical records pertaining to therapeutic interventions, are also included.

In the second part of the chapter, I report the therapeutic interventions that PIMH clinicians use from the thematic analysis of the clinician interview data. In this data, the clinicians spoke about their broader role, with a specific focus on their relationship with the mother and the attachment between the infant and the mother.

## 5.2 Part A - Publication

Myors, K.A., Schmied. V., Johnson, M. & Cleary, M. (2014). Therapeutic interventions in perinatal and infant mental health services: A mixed methods inquiry. *Issues in Mental Health Nursing, 35:* 372-385. DOI: 10.3109/01612840.2013.873100

*Issues in Mental Health Nursing*, 35:372–385, 2014
Copyright © 2014 Informa Healthcare USA, Inc.
ISSN: 0161-2840 print / 1096-4673 online
DOI: 10.3109/01612840.2013.873100

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# Therapeutic Interventions in Perinatal and Infant Mental Health Services: A Mixed Methods Inquiry

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**Perinatal mental health disorders potentially have long-term negative sequelae for women, their infants and their families. Multidisciplinary perinatal and infant mental health (PIMH) services are an emerging specialty in mental health designed to improve mother-infant outcomes. This mixed methods study explored the characteristics of women referred to a specialist PIMH service and the therapeutic interventions that PIMH clinicians use. Women referred to the service were identified with multiple and complex risk factors. Perinatal and infant mental health clinicians use a range of interventions, dependent upon their training, such as family of origin work/genograms, non-directive counseling, and strategies to manage anxiety and depression. Clinicians also emphasized the therapeutic relationship and the interventions they use within an attachment-based framework, which warrants further research.**

Pregnancy is a time of increased emotional and social vulnerability, a state of transition and identity reassessment. Many new mothers have doubts about their ability to be a "good" parent, uncertainties about the support they will receive from their partner and others, and often have fears of repeating negative patterns of mothering that they had received (Hammonds, 2012), with many women revisiting past anxieties, traumas, and disappointments (Frayne, Nguyen, Allen, & Rampono, 2009). This can be distressing for any woman, but even more so for women who have mental health problems or poor social supports (Blegen, Hummelvoll, & Severinsson, 2012). Likewise, the postnatal period can be a critical time for relapse in women who have previously experienced mental illness (Frayne et al., 2009). Therefore pregnancy and birth, a time usually considered as being natural and happy, can be negatively affected by the experience of mental ill-health (Wilkinson & Mulcahy, 2010).

Perinatal mental health problems have a significant impact on women, children, and families (Hauck et al., 2013). Research in the UK identified that, potentially, the most modifiable determinant for improved child outcomes is maternal health, particularly depression. These authors argue that policies that focus on parental health are likely to have a greater impact on childhood trajectories than those which focus on reducing childhood poverty alone (Waylen & Stewart-Brown, 2009). Women with complex health and social issues need effective care pathways, such as early planning and intervention programs to improve women's emotional well-being before and after birth and prevent mental health problems in the perinatal period (beyondblue, 2008; Myors et al., 2013a), from conception until 12 months post-birth (Austin, Priest, & Sullivan, 2008b).

## IDENTIFICATION OF RISK FACTORS

Emerging evidence has shaped policy in Australia at both the national and state levels. The *NSW Supporting Families Early Policy* (New South Wales Department of Health [NSW DOH], 2009), known as Safe Start, has outlined a model of perinatal care consisting of psychosocial assessment and depression screening with routine care in the early antenatal and postnatal periods. The psychosocial assessment is divided into three levels of risk: Level 1: no vulnerabilities detected; Level 2: predominantly social issues, such as an unemployed partner, unstable housing, and lack of social support, are present; and Level 3: complex risk factors, such as maternal mental illness or substance use, are present. Women identified with multiple Level 2 or any Level 3 risk factors are referred to a multidisciplinary

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The authors acknowledge and thank the women and the professionals who generously gave their time to participate in this study.

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case discussion meeting where referral to more specialized services, for example, drug and alcohol treatment, is determined (NSW DOH, 2009). Some health areas have discreet specialist perinatal and infant mental health (PIMH) services. These multidisciplinary teams provide individualized care for women and their families who are identified as at risk for poor perinatal mental health outcomes.

Perinatal and infant mental health services are an emerging specialist area in mental health, of which little has been researched or documented. Specialist PIMH services are needed as many health professionals such as midwives, health visitors (Rothera & Oates, 2011), and adult mental health nurses (McConachie & Whitford, 2009) lack confidence in working with pregnant or postpartum women who have mental health problems. Early assessment, clear pathways to care, and prompt interventions are necessary to ameliorate any risk for poor perinatal mental health outcomes (Hayes, 2010).

Interventions that have been found to be helpful for women who are at risk of experiencing perinatal mood disorders or are currently experiencing a perinatal mood disorder include counseling techniques (Lumley, Austin, & Mitchell, 2004), such as, cognitive behavioral therapy (CBT), interpersonal psychotherapy (IPT), psychodynamic therapy, and non-directive counseling as well as interventions that promote positive mother-infant interactions (beyondblue, 2011). Any service or intervention, however, needs to incorporate intensive, individualized programs (Dennis, 2005). Perinatal and infant mental health services are unique in mental health as clinicians focus on both the mother and the infant, specifically the mother-infant relationship (Dolman, Jones, & Howard, 2013).

The research questions addressed in this article are:

1. What are the characteristics of women who are referred to a specialist PIMH service?
2. What therapeutic interventions do PIMH clinicians use when working with women who have been identified as being at risk for poor perinatal mental health?

There is a dearth of literature about PIMH services in general; less is known about the interventions or treatments that underpin the PIMH model of care. As far as we have been able to ascertain, this is the first Australian study to address these questions in regard to these specialist services.

## METHODS

### Setting and Design

The setting for this study was two specialist PIMH services (one metropolitan, the other regional) in New South Wales (NSW), Australia. Both services have been in place for over ten years, are situated within mental health, and have a multidisciplinary team of nurses, psychologists, social workers, and psychiatrists. The services are community-based and have referral pathways to more acute services, for example, acute mental health assessment teams, if needed. Regular 13-week clinical reviews of clients (NSW DOH, 2003) and monthly group clinical supervision are conducted to support these clinicians who are working with women with complex needs.

A convergent embedded mixed methods design (Creswell & Plano Clark, 2011) was chosen to provide a more comprehensive understanding of PIMH services, as it draws upon all aspects of data to find the best understanding of the research questions (Creswell, 2009; O'Cathain, 2009). Ridenour and Newman's (2009) worldview of an interactive continuum of qualitative and quantitative research has guided the study from conceptualization through analysis and interpretation of results.

The study design was convergent as all data were collected simultaneously at each site and equal weighting was given to the two main data components of the medical record review—numeric data (quantitative) and the professional's interviews (qualitative). Lesser weighting was given to the women service-users data (qualitative). The design also employed an embedded component. These data, textual data transcribed from the medical records, have both helped illustrate the interventions provided by clinicians as well as elaborate on the nature and categories of interventions. Within this mixed methods design all the data were analyzed separately, compared, and any contrasts were identified (Onwuegbuzie & Combs, 2010). While integration has been planned from conception of the study, the main areas of integration are in the analysis and discussion.

### Sample and Recruitment

#### *Medical Records*

The medical records of 244 women who were referred to two specialist PIMH services between January 2010 and December 2011 were reviewed. Not all medical records were available to be reviewed; for example, some records were not currently in the clinical information department and were being used by another team within the health service.

#### *Professionals' Interviews*

All PIMH clinicians and their managers were invited to participate in the study. The researcher (KM) attended team meetings to inform clinicians about the study and invite their participation. Service managers also sent invitations via e-mail.

Five key stakeholders were purposively selected to participate in semi-structured in-depth interviews due to their involvement in the implementation of the Safe Start Policy (NSW DOH, 2009) or the multidisciplinary case discussions or both.

#### *Women's Interviews*

Women who were close to discharge were informed of the study by the PIMH clinician and given a Consent to Contact form. Interested women completed the form and were followed up with a phone call by KM. Further recruitment details are reported elsewhere (Myors et al., 2013b).

TABLE 1
Interview Guides: Broad Themes

- PIMH Clinicians
  - Professional background
  - Service aims
  - Engagement practices
  - Issue of stigma
  - Interventions used
  - Model of care
  - Integration/collaborative practices
  - Experiences—positive and negative
  - Professional training needed
  - Support provided by management, colleagues
- PIMH Managers
  - History of the PIMH service
  - Model of care and how it was developed
  - Demographics of the population that PIMH services
  - Staff numbers employed and their professional background
  - Barriers or challenges in providing the service
  - Collaboration with other services
- Key Stakeholders
  - History of the PIMH service
  - The current PIMH service model
  - Benefits of the PIMH service to women and families
  - Less positive aspects of the service
  - Collaboration with the PIMH service
- Women Service-Users
  - Referral to the PIMH service
  - Experience with the service—positive and less positive
  - Number of clinicians in contact with
  - Type of contact (e.g., venue)
  - Treatments or interventions
  - Involvement/referral to other services

## Data Collection

### *Medical Record Review: Numeric Data*

A detailed review tool was developed to assist with data collection and ensured that consistent data were obtained. This tool was developed from the antenatal screening tools that the midwives used at each site as well as the *NSW Supporting Families Early Policy* (NSW DOH, 2009). Ten medical records were reviewed by KM and VS to pilot test the review tool. Minor changes to the review tool were then made. The review also provided an opportunity to confirm the type of data that was available for extraction and determine how interventions were going to be recorded. Only interventions that were specifically written by a clinician in the medical record were recorded, for example, CBT, mindfulness, referrals to other services. When documentation lacked clarity, the intervention codes were checked with either MC, who has expertise in mental health, or VS, who has expertise in maternal and child health. Fourteen PIMH clinicians had entered documentation in the 244 medical records. Three clinicians had left the service and one was on leave at the time of data collection.

### *Medical Record Review: Textual Data*

Textual data from the medical records were transcribed directly into a Word document. These data gave illustrations of the quantitative data collected, such as the interventions used and referrals made.

### *Professionals' Interviews*

Six PIMH clinicians, two PIMH managers, and five key stakeholders consented to participate in semi-structured in-depth interviews. The interviews lasted between 50 and 90 minutes (PIMH clinicians and managers) and 60 and 70 minutes (key stakeholders). All of the interviews were conducted at the professional's place of work at a time convenient to them.

### *Women's Interviews*

A total of 11 women consented to being interviewed and to having the interview recorded and their medical records reviewed. Eight interviews were conducted at the woman's home and three via telephone. The interviews lasted between 10 and 40 minutes. At completion of the interviews, the women were given or posted a gift voucher of AU$20.00 to thank them for their time.

An interview guide was used for all the interviews (Table 1). Additional questions were added to the guides as data collection proceeded, for example, to clarify documentation in the medical records.

## Ethical Approval and Procedures

Ethical approval was obtained from the relevant health services (later local health district) and the University of Western Sydney. All participants were informed, both verbally and in writing, that they were free to withdraw from the study at any time. All data has been de-identified, and pseudonyms and codes have been used for quotes from the qualitative data.

## Data Analyses

The data analyses followed an iterative process, moving between all data sets in an attempt to make meaning and answer the research questions. This is a circular process, as analysis continually moves from one data set to another to gain full understanding of the phenomena (Ridenour & Newman, 2009).

This contrasts with a more linear approach advocated in other mixed methods designs such as a sequential design. Initial data analyses was undertaken by KM and then discussed with all authors until agreement was reached.

### *Medical Record Review*

Numeric data from the medical records were entered into and analyzed using the Statistical Package for the Social Sciences (SPSS) versions 19 and 20. Descriptive analyses techniques were used to summarize (means, frequencies, and percentages) and enhance understanding of the data (Onwuegbuzie & Combs, 2010). The individual interventions also were coded into five broad themes to assist analysis. Textual data from the medical records were organised into categories reflecting the type of intervention, for example, family of origin work/genograms, non-directive counseling, and so forth.

### *Professionals' and Women's Interviews*

All the interviews were digitally recorded and transcribed verbatim. The qualitative data were analyzed in two phases. Phase one, content analyses (Hsieh & Shannon, 2005), was conducted where the research questions and quantitative analyses provided a framework in which the interview data were coded and organized using NVivo (qualitative data analysis software). Phase two, thematic analyses (Braun & Clarke, 2006), was conducted using a process of data immersion, data coding, creating categories, and identifying themes (Green et al., 2007). The data from the thematic analyses of the women's interviews are reported elsewhere (Myors et al., 2013b).

## Data Integration

All data relating to the description of interventions provided, either in the medical records or discussed by professionals and women service-users, were synthesized in a matrix (Bazeley, 2010) to demonstrate how inferences or conclusions were drawn (Creswell & Plano Clark, 2011) (Table 2). The following provides an example of how data relating to the same intervention across the datasets have been integrated, for example, Intervention: Parent-Infant Therapy was reflected in the

- Medical Record: Numeric Data: $n = 62$ (25.4%)
- Medical Record: Textual Data: Week 1 COS-P [Circle of Security Program]. [Client's] level of insight good with relation to her understanding of the basis of the "circle." Pleased to hear about "good enough parenting."' (MR225)
- Professional's Interview: "Lately [I have been using] a lot of Circle of Security . . . that's very good in getting them to understand their children's needs." (P3)
- Woman's Interviews: "She bought videos and things around . . . Circle of Security, that was really good." (Tanya)

Some qualitative findings from the professionals' interviews are presented separately. The first instance describes the vulnerabilities of the women as perceived by the clinicians. The second instance highlights a contrast between the interventions recorded in the medical records and the emphasis on the mother-infant relationship or attachment that the clinicians spoke about. This disparity prompted further thematic analysis, which will be reported elsewhere.

## Rigour and Trustworthiness

The medical records reviewed covered a two-year timeframe and all available records were reviewed. The review tool was developed by KM, discussed with all authors, and piloted tested by two authors (KM and VS). The initial analysis of the qualitative data was undertaken by KM. This was reviewed by VS and then discussed and confirmed by all authors. The data components have been kept separate until the point of integration (Morse, 2010), analyses, and discussion. The matrix was reviewed by a group of mixed methods researchers with positive feedback provided on this approach (P. Bazeley, personal communication, October 9, 2013).

Saturation of qualitative data was achieved; that is, no new information was seen in the data when participant recruitment ceased (Collins, 2010). Reflexivity also is an important component of qualitative data analyses (de Laine, 1997). As such, it is important to acknowledge that KM previously worked as a PIMH clinician. Reflexivity helps the researcher understand their own assumptions and how these may impact on the project (Hesse-Biber, 2010). Constant contact with the co-authors has kept KM grounded in the data to ensure that the findings are representative of the data collected.

## RESULTS

## Profile of the Women

A total of 244 medical records were reviewed representing 47% of the total number of women who were referred to the two services within the two-year time period. The majority (84.8%) of women were referred via the midwives in the antenatal clinic, 29 (11.9%) were referred antenatally by other services, and eight (3.3%) women were referred postnatally, for example, by their general practitioner or self-referred. The women ranged in age from 16 to 45 years (Mean = 27.7, *SD* = 5.9). The majority (77.5%) were born in an English-speaking country and were partnered (73.4%). For 40.2% of the women it was their first pregnancy, with a further 51.2% having between one and three children, and 6.1% having four or more children.

## Profile of the Professionals

The clinicians interviewed held bachelor degrees in nursing, social work, or psychology, and four clinicians had undertaken post-graduate training in PIMH. All of the clinicians had undertaken post-registration training in therapeutic interventions,

TABLE 2
Synthesis of Data on Interventions from All Sources

| | Data Source | | | |
|---|---|---|---|---|
| Intervention† | Medical Record: Numeric Data $N = 244$ (%) | Medical Record: Textual Data | Professionals' Interviews | Women's Interviews‡ |
| Family of origin (FOO) work (including genograms) | $n = 161$ (66.0) | Discussed FOO intrusive attempts to "support" [client] in looking after the baby, not realising their "undermining" of [client's] mothering. Assertiveness encouraged. (MR053) | The genogram's really important . . . so getting a family tree, an understanding of where all that fits. (P2) | I didn't realize myself but that a lot of my issues are from . . . past experiences and childhood and all that sort of stuff. (Nancy) |
| Non-directive counseling | $n = 156$ (63.9) | [Client] feels like there is no one around her. We discussed how she "wishes" things were different. (MR053) | Supportive counseling . . . it'll be driven by the client and what's happening for them at the time. (P1) | It was just, basically, talking about the things that I wanted to talk about. (Mary) |
| Strategies for managing anxiety & depression: | $n = 100$ (41.0) | Gave [client] the relaxation CD to try. Also gave [client] the anxiety monitoring sheet. (MR005) | Breathing . . . or progressive muscle relaxation, those really practical things, if their anxiety . . . is out of control. (P3) | . . . working on techniques to cope and manage . . . day to day and with anxiety and stress. (Patricia) |
| - normalizing | $n = 14$ (5.7) | Reports that last night was OK but is feeling very tired today. Reflected that this was understandable having had baby for the week. Her husband will be home on the weekend and I encouraged [client] to get him to help with the baby so perhaps she can rest. (MR015) | | . . . while I see it as stress now . . . and that a lot of women feel that way . . . making me see how it's okay to be a little upset or stressed, but then to recognize it and then be able to move on from it. (Cathie) |
| - mindfulness | $n = 13$ (5.3) | Talked through series of mindfulness exercises. Will practice mindful breathing over the next week. (MR240) | Mindfulness is . . .being purposefully aware of what's happening in your body, at any one time. (P5) | |
| - CBT | $n = 10$ (4.0) | Engaged in CBT focusing on managing negative cognitions in relation to how she saw herself as a person/potential mother and obsessional thinking around finances. (MR001) | A bit of CBT . . . around the anxiety. (P6) | |

| | | | | |
|---|---|---|---|---|
| Referrals to other services | $n = 69$ (28.3) | [Client] requested counseling from a Vietnamese speaking worker and she has been referred to [other service] for follow up. She has also been given the contact details of [name] community centre who provide a Vietnamese family worker. (MR054) | Referring them to other services for more practical type support, or social, to reduce their social isolation. (P7) | She helped me into a few . . . programs to help me feel more confident with my parenting. (Carol) |
| Advocacy | $n = 67$ (27.5) | [Letter] I am writing to support the request for [client] requesting financial assistance to support childcare arrangement for her second and third daughters. [Client] has been a patient of our service since [date] and I have been treating her for depressive symptoms. To date, she continues to experience ongoing psychological distress exhibiting thoughts of wanting to harm herself and I believe that her children should be placed in childcare as an opportunity to allow her psychological well-being to improve. (MR028) | I often write Housing advocacy letters and get my clients on the Housing list. (P7) | She . . . went through the hospital system and did a complaint for me . . . no one responded to her or myself, but the fact that she was proactive and really tried to help seek justice in the situation . . . that helped me emotionally. (Nancy) |
| Parent-infant focus: | $n = 70$ (28.7) | Primary concern is the mother/infant relationship. Does not have this baby in mind, just wants it to be born. Does not think about this baby the way she does/did the others e.g., played music, spoke with them, prepared for them. (MR022) | . . . getting them to understand their children's needs. (P3) | |
| - parent-infant therapy | $n = 62$ (25.4) | Week 1 COS-P. [Client's] level of insight good with relation to her understanding of the basis of the "circle." Pleased to hear about "good enough parenting." (MR225) | Lately a lot of Circle of Security . . . that's very good in getting them to understand their children's needs. (P3) | She bought videos and things around . . . Circle of Security, that was really good. (Tanya) |

*(Continued on next page)*

TABLE 2
Synthesis of Data on Interventions from All Sources *(Continued)*

| | Data Source | | | |
|---|---|---|---|---|
| Intervention[†] | Medical Record: Numeric Data $N = 244$ (%) | Medical Record: Textual Data | Professionals' Interviews | Women's Interviews[‡] |
| - parent-infant therapy with videotaping | $n = 7$ (2.9) | We will try and see each other more often and will do some video work to build their [relationship]. Took videotape of [client] and [baby]. (MR065) | I've had DVDs of parents themselves . . . we've done filming and then I've brought that in the next session. (P3) | |
| - sleep & settling | $n = 14$ (5.7) | Seems possible that [client] does not know what to do with her baby but does not want to appear "incompetent." Asked to try some settling techniques for baby and to write down what she is doing with her. (MR004) | | |
| - infant development | $n = 4$ (1.6) | [Baby] is not yet walking at 17 months, needs [pediatric] review. Not saying words. Discussed with [client] who agreed for referral to speech pathology. (MR003) | there's lots of . . . education around developmental needs of infants . . . just giving them actual information. (P3) | [Clinician] sent home a fair bit of literature . . . about . . . bonding with the baby and things like that. (Cathie) |

[†] Multiple interventions were used for each woman.
[‡] Pseudonyms used.

for example, mindfulness (Guardino, Schetter, Bower, Lu, & Smalley, 2013) and CBT (Leddy, Anderson, & Schulkin, 2013), five clinicians had completed training in attachment-based interventions, and five had undertaken specific training to work with clients with trauma histories. The clinicians had been working in the PIMH service between two and eight years. The managers and key stakeholders had been involved in the PIMH service between 2 and 12 years.

### Identified Risk Factors of the Women

The majority of women were identified as having complex psychosocial issues, with 72.4% having three or more Level 2 risk factors and 54% having at least one Level 3 risk factor. One hundred and six women (43.4%) had experienced a pregnancy loss and ten (4%) had experienced an infant loss. Eighty three (34%) women identified as having experienced childhood trauma and 12 (4.9%) women were sexually assaulted as an adult. Fifty-five (22.5%) women disclosed previous self-harm during the antenatal screening process whereas 77 (31.6%) women disclosed self-harm during the assessment process by the PIMH clinician. Self-harm for the purposes of this study is defined as deliberate self-harm, suicide ideation, or suicide attempt (Table 3). The 11 women service-users were similar in age, with a similar spread of Level 2 and Level 3 risk factors to the women in the 244 medical records reviewed.

The interview data highlighted that the clinicians were cognizant of the complex needs of the women referred to the service and the need for sensitivity, as one clinician described:

> one of the reasons families look really isolated in the notes is because they are. Their psychosocial vulnerabilities put them to a point of excluding themselves, add to that their vulnerabilities have probably meant and precipitated a mental health issue, which isolates them internally even more. So, they're sitting in a very isolated place and the last thing they need is to have lots of people prying into their personal business when they've actually isolated themselves and their family of origin … issues have isolated them anyway. (P6)

The level of social and emotional needs identified by clinicians influenced the way in which they worked with the women and the interventions they used.

### Interventions Provided By Clinicians

A diverse mix of interventions were identified through the medical record review. Individual interventions were coded and placed into broad themes to assist analyses: mental health assessment (*n* = 175), mental health psycho-therapeutic intervention (*n* = 165), care coordination (*n* = 137), parent-infant focus (*n* = 70), child protection (*n* = 69), family intervention (*n* = 61), and education—other (*n* = 20) (Table 4).

The review identified that, in general, women received many of these interventions. An example of the diverse range of interventions received by one woman is described in Figure 1.

TABLE 3
Characteristics of Women Referred

| Demographics | Sample *N* = 244<br>*n* (%) |
|---|---|
| Age (years) Range *M* (*SD*) | 16–45 (27.7) (5.9) |
| Parity | |
| 1st pregnancy | 98 (40.2) |
| 1–3 children | 125 (51.2) |
| 4+ children | 15 (6.1) |
| Missing | 6 (2.5) |
| Marital Status | |
| Partnered | 179 (73.4) |
| Unpartnered | 62 (25.4) |
| Missing | 3 (1.2) |
| Country of Birth | |
| English speaking | 189 (77.5) |
| Non-English speaking | 51 (20.9) |
| Missing | 4 (1.6) |
| **Risk Factors** | **Sample *N* = 244<br>*n* (%)** |
| Low Level 2 (1 & 2) | 40 (16.4) |
| High Level 2 (3+) | 177 (72.4) |
| Level 3 (any) | 132 (54.1) |
| High Level 2 & Level 3 | 204 (83.6) |
| Pregnancy loss[1] | 106 (43.4) |
| Infant loss[2] | 10 (4.0) |
| Childhood trauma | 83 (34.0) |
| Adult sexual assault | 12 (4.9) |
| Self-harm[3] | 55 (22.5)[4] |
| Self-harm[3] | 77 (31.6)[5] |
| Previous PIMH client | |
| Yes | 20 (8.2) |
| No | 224 (91.8) |

[1] Termination of pregnancy, miscarriage, fetal death in utero.
[2] Stillbirth, neonatal death.
[3] Deliberate self harm, suicide ideation, suicide attempt.
[4] From midwives psychosocial assessment.
[5] From PIMH clinician's assessment.

Of the 244 medical records reviewed, the most frequently used interventions were family of origin work (including genograms) (*n* = 161), non-directive counseling (*n* = 156), strategies for managing anxiety and depression (*n* = 100), referrals to other services (*n* = 69), and advocacy (*n* = 67). Strategies for managing anxiety and depression incorporated a number of individual techniques, such as scaling questions (*n* = 39), challenging negative thoughts (*n* = 15), normalizing (*n* = 14), mindfulness (*n* = 13) and CBT (*n* = 10). Parent-infant focus, that is, any mention about the infant, was only reported in 70 (28.6%) of the records reviewed. Formalized parent-infant therapy, for example, the Circle of Security Program, an early intervention

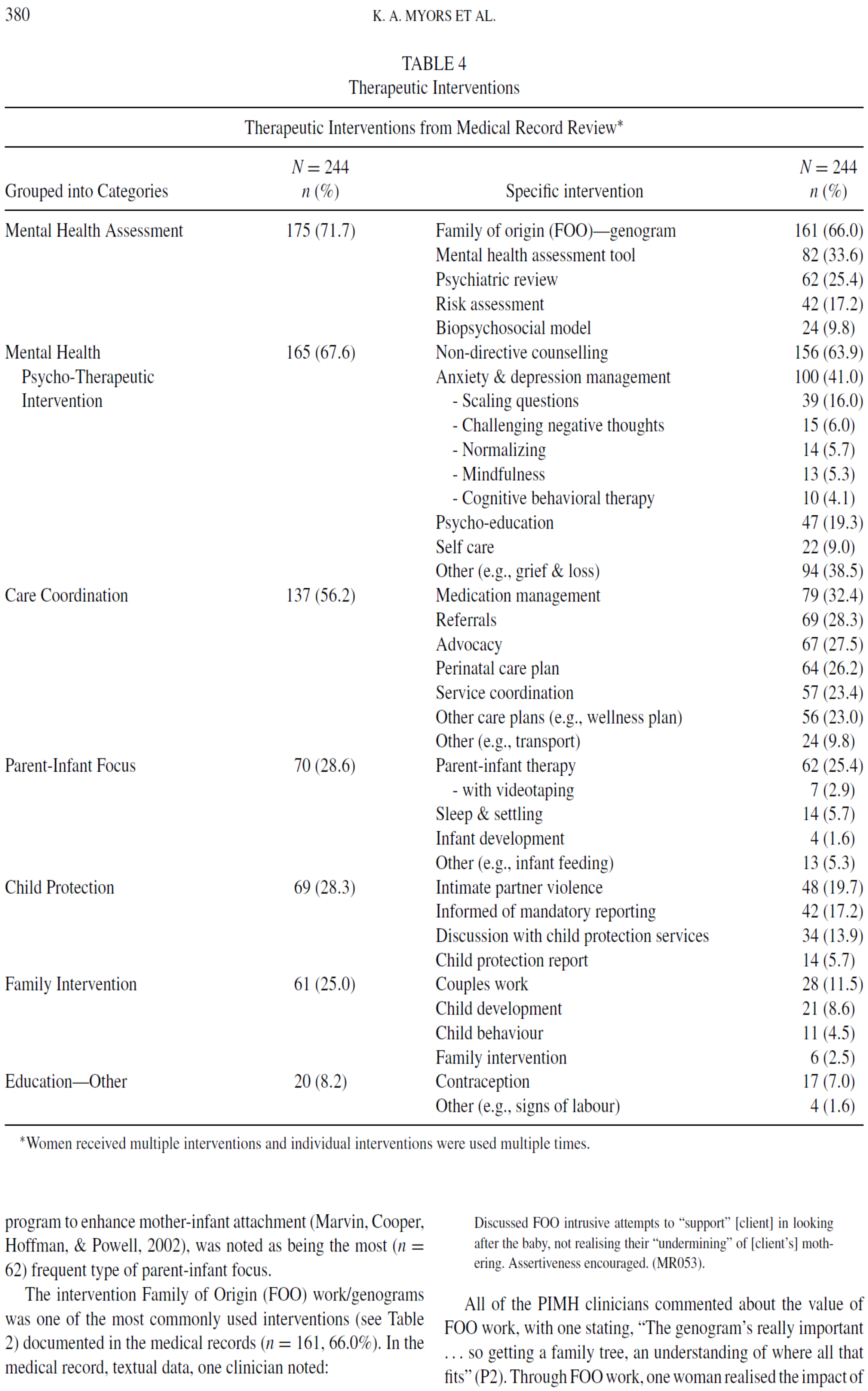

TABLE 4
Therapeutic Interventions

Therapeutic Interventions from Medical Record Review*

| Grouped into Categories | *N* = 244 *n* (%) | Specific intervention | *N* = 244 *n* (%) |
|---|---|---|---|
| Mental Health Assessment | 175 (71.7) | Family of origin (FOO)—genogram | 161 (66.0) |
| | | Mental health assessment tool | 82 (33.6) |
| | | Psychiatric review | 62 (25.4) |
| | | Risk assessment | 42 (17.2) |
| | | Biopsychosocial model | 24 (9.8) |
| Mental Health Psycho-Therapeutic Intervention | 165 (67.6) | Non-directive counselling | 156 (63.9) |
| | | Anxiety & depression management | 100 (41.0) |
| | | - Scaling questions | 39 (16.0) |
| | | - Challenging negative thoughts | 15 (6.0) |
| | | - Normalizing | 14 (5.7) |
| | | - Mindfulness | 13 (5.3) |
| | | - Cognitive behavioral therapy | 10 (4.1) |
| | | Psycho-education | 47 (19.3) |
| | | Self care | 22 (9.0) |
| | | Other (e.g., grief & loss) | 94 (38.5) |
| Care Coordination | 137 (56.2) | Medication management | 79 (32.4) |
| | | Referrals | 69 (28.3) |
| | | Advocacy | 67 (27.5) |
| | | Perinatal care plan | 64 (26.2) |
| | | Service coordination | 57 (23.4) |
| | | Other care plans (e.g., wellness plan) | 56 (23.0) |
| | | Other (e.g., transport) | 24 (9.8) |
| Parent-Infant Focus | 70 (28.6) | Parent-infant therapy | 62 (25.4) |
| | | - with videotaping | 7 (2.9) |
| | | Sleep & settling | 14 (5.7) |
| | | Infant development | 4 (1.6) |
| | | Other (e.g., infant feeding) | 13 (5.3) |
| Child Protection | 69 (28.3) | Intimate partner violence | 48 (19.7) |
| | | Informed of mandatory reporting | 42 (17.2) |
| | | Discussion with child protection services | 34 (13.9) |
| | | Child protection report | 14 (5.7) |
| Family Intervention | 61 (25.0) | Couples work | 28 (11.5) |
| | | Child development | 21 (8.6) |
| | | Child behaviour | 11 (4.5) |
| | | Family intervention | 6 (2.5) |
| Education—Other | 20 (8.2) | Contraception | 17 (7.0) |
| | | Other (e.g., signs of labour) | 4 (1.6) |

*Women received multiple interventions and individual interventions were used multiple times.

program to enhance mother-infant attachment (Marvin, Cooper, Hoffman, & Powell, 2002), was noted as being the most (*n* = 62) frequent type of parent-infant focus.

The intervention Family of Origin (FOO) work/genograms was one of the most commonly used interventions (see Table 2) documented in the medical records (*n* = 161, 66.0%). In the medical record, textual data, one clinician noted:

> Discussed FOO intrusive attempts to "support" [client] in looking after the baby, not realising their "undermining" of [client's] mothering. Assertiveness encouraged. (MR053).

All of the PIMH clinicians commented about the value of FOO work, with one stating, "The genogram's really important . . . so getting a family tree, an understanding of where all that fits" (P2). Through FOO work, one woman realised the impact of

Patricia, 24 years old at the time of the interview, was from an English-speaking background, partnered, and had three living children. Her interview was conducted in her home and lasted approximately 30 minutes. Patricia's referral to the PIMH service came from the midwife in the antenatal clinic due to the following risk factors: current-high antenatal Edinburgh Depression Scale (Cox, Holden, & Sagovsky, 1987), anxiety, mental health problem (not specified), relationship issues, poor support network, financial stress and past-postnatal depression, depression, anxiety, neonatal death, deliberate self-harm, suicide ideation.

Patricia was a client of the PIMH service for 56 weeks and was supported by two female PIMH clinicians due to staff changes. The medical record review indicated that Patricia received the following interventions: seven psychiatric reviews, medication management, FOO work, non-directive counseling, strategies to manage anxiety and depression, parent-infant therapy, advocacy, perinatal care plan (recommendations/ requests for when a women goes into hospital to give birth), referral to other services, transport assistance, baby care plan (a plan for the baby if the mother is admitted to hospital, usually a mental health unit), the completion of risk assessments, discussion of a safety plan (to keep a client safe from self-harming), discussion about intimate partner violence, discussion about the clinician being a mandatory reporter to child protection services, and contact with and a report made to child protection services due to intimate partner violence.

FIGURE 1. A Case Study.

her family and past experiences stating, "I didn't realize myself but that a lot of my issues are from . . . past experiences and childhood and all that sort of stuff" (Nancy).

## Professionals' and Women's Interpretation of the Interventions

The clinicians reported that they all had a different approach and would use interventions they had been trained in. As one clinician stated, "Clinicians have their own preferences about what they like to work with . . . and their own beliefs" (P5). This autonomy was reinforced by a manager who stated, "The clinicians have got . . . within their professional capacity of being able to work with a client how they see as the most appropriate" (P4). The key stakeholders had difficulty articulating what the clinicians did but indicated that they broadly understood that the service

> is based in the evidence of . . . long term mental health outcomes for . . . infants with . . . emotionally unavailable parents, so with a very large focus on attachment and disordered attachment and the problems that that can cause in the long term . . . that's been the underpinning of the reasons for the psycho-social assessment and screening from the outset. (S3)

In contrast to the data from the medical record review, clinicians reported that their main focus was to enhance the mother-infant relationship or attachment stating "[Our aim is to provide] optimal mental health for the mother, which, in turn, gives optimal mental health for the baby, so always the focus on the mother and infant relationship" (P2). The relational aspect of care was emphasized due to the isolation of the women, their perceived vulnerability and that "a lot of people that we see have experienced some sort of trauma in their own childhood" (P4), which can disrupt mother-infant attachment. The clinicians, therefore, focused on attachment theory, "that we all exist in relationships and it's how we form those relationships that assist us in having positive mental health" (P7). Through relationship, "being dependable, available and consistent" (P2) and understanding attachment theory, the clinicians aim to "stop that intergenerational transmission of mental health issues" (P5) from the mother to the infant.

The women service-users had difficulty in articulating what interventions were used (see Table 2) however the therapeutic relationship was key as these women stated,

> So it was almost like it was someone who became a friend, but they didn't know anyone that I knew, so there was no issue saying to her what was really going on . . . it's very personal things that you share, so it was someone that was, I suppose, all for me . . . I knew it was confidential, that I could trust with working through some of my stuff and being supported. (Tabitha)

> She gave me time. So everything, the first appointment I had with her, I was explaining what was wrong with me, with no interruptions . . . She made me feel important. (Andrea)

## DISCUSSION

This convergent embedded mixed methods study has identified the characteristics and risk factors of women who are referred to a specialist PIMH service. This is an important study as it confirms, for the first time, that the women using specialist PIMH services have a high level of need, that the referrals are appropriate, and that women with many of the complex risk factors identified would not be well-supported in the universal maternity or child and family health services in Australia. Notably, 34% of the women experienced childhood trauma and 5% had experienced sexual assault as an adult. Women who experience childhood trauma, particularly child sexual assault, are predisposed to more severe and long-term postpartum depression with a significant impact on their parenting capacity, often resulting in an impaired mother-infant relationship (Buist, 1998; Buist & Janson, 2001).

Deliberate self-harm, reported by 55 (23%) of the women, also is associated with a past history of childhood trauma (Mangnall & Yurkovich, 2008), which negatively impacts an individual's attachment models (Hsu, Chen, & Lung, 2013). Trauma is often referred to as complex trauma if it has been perpetrated in environments where individuals have minimal control, for example, by childhood caregivers or through intimate partner violence or when the trauma is prolonged and repeated, (Cloitre et al., 2011, Greeson et al., 2011, Hughes, 2003). It is, therefore, important to examine the interventions offered by the PIMH clinicians in view of the complex trauma that many of the women experienced. Due to the large number of interventions that the clinicians used, only the main interventions used will be discussed. This includes FOO work (genograms), non-directive counseling, strategies for managing anxiety and depression, referrals to other services, and advocacy. These interventions, per se, are not new. What this study does contribute, however, is an understanding of how specialist PIMH clinicians apply a range of interventions to women in the perinatal period who have a history of complex trauma. More research, especially in regard to effectiveness and outcomes, is required.

### Psychosocial Assessment and Referral

The risk factors reported were identified by the midwives during the antenatal screening process. Women are informed of the screening process when screening occurs; however, research indicates that midwives have varying degrees of proficiency in the antenatal psychosocial screening process, which may impact on how comfortable women feel about disclosing details of past trauma (Rollans, Schmied, Kemp, & Meade, 2013). It is therefore possible that these women may have had other risk factors that they chose not to reveal during the initial screening process when they were referred to the PIMH service. Indeed, the antenatal psychosocial assessment identified that 55 (23%) of the women disclosed deliberate self-harm whereas the assessment conducted by the PIMH clinicians identified that 77 (32%) of the women had self-harmed. Similarly, an audit of women with a significant mental health history, for example, psychiatric admission or puerperal psychosis, identified that over 50% of women referred to a specialist perinatal mental health team had a history of deliberate self-harm (Healey et al., 2013).

### Interventions Used by Clinicians

Complex trauma is often a familial experience (Hsu et al., 2013) related to the transgenerational transmission of trauma (Siegel, 2001). Genograms are visual diagrams of familial relationships. Genograms help clarify complex personal histories and identify patterns of attachment between family members. The visual design promotes distance and assists clients in telling emotionally overwhelming stories (Chrzastowski 2011; Goodman, 2013). PIMH clinicians used FOO and genograms to focus on how a woman's personal history and her current system of support may impact not only on the woman, but on the development of her infant as well.

Non-directive counseling is described as being attuned to and flexibly responding to the client's needs. It promotes the therapeutic relationship and assists clients in healing from trauma (Danzer, 2011). As such, non-directive counseling may assist when important decisions have to be made, for example, inpatient admission. In addition, psychodynamic therapies such as non-directive counseling have been shown to be potentially effective treatments for postnatal depression (PND), however further research is needed (Dennis & Hodnett, 2007). The clinicians in this study focused on the therapeutic relationship and were "client led" in their approach.

Individuals who have experienced complex trauma often report high levels of anxiety and depression, such as affect regulation and behavioral control (Becker-Weidman, 2009). Cognitive behavioral therapy aims to change thought processes and their resultant emotional and behavioral reactions, in order to promote emotional resilience and decrease maladaptive coping strategies (Leddy et al., 2013). Individual (Milgrom et al., 2011) and group (Austin et al., 2008a) CBT have been found to be an effective treatment for women experiencing perinatal depression and anxiety.

In this study, CBT was only documented in ten (4%) of the medical records reviewed as a strategy to manage an anxious or depressive mood, however four of the six clinicians specifically mentioned CBT as a therapeutic intervention they use. This incongruence may reflect the high profile of CBT in the literature, prompting clinician recall when asked about interventions although the use of CBT as an intervention was not highly reflected in the medical record data.

Advocacy is a crucial role for clinicians who are working with women during the perinatal period, to enable women to maintain their parenting and individual rights (Lagan, Knights, Barton, & Boyce, 2009). Women with mental health problems and a history of complex trauma often lack resources to manage the dual role of ill-health and motherhood (Lagan et al., 2009).

The clinicians frequently advocated for the women in their care, to promote the best outcome for the woman and infant.

### Attachment Focus

Trauma by an attachment figure results in an incongruence of chronological age and developmental age and the development of maladaptive functioning (Becker-Weidman, 2009), such as poor affect and impulse regulation (Hughes, 2003). Individuals who have experienced a disruption in the development of a secure-attachment also experience decreased self-efficacy (Hughes, 2003) and difficulty developing and maintaining interpersonal relations (Siegel, 2001). The clinicians in this study identified that many of their clients had experienced complex trauma and therefore saw their primary role was to provide women with a "secure base," a "safe" environment, and the experience of "being held."

In this context, some of the clinicians were hesitant about referring the women to other services or individual professionals as they believed that they may not have the capacity to emotionally "hold" or provide the "secure base" that the PIMH clinician perceived the woman needed. The clinicians also emphasized modeling a secure relationship, "being dependable, available, and consistent," with the woman as one of their main therapeutic interventions. While the focus on the therapeutic relationship is far from new, the focus of modeling a secure relationship or attachment to enhance the mother-infant relationship could explain why the clinicians used minimal formalized parent-infant therapies.

Understanding the negative childhood experiences of women and working with them in an attachment focus may help to overcome the transgenerational transference of poor relationships and maladaptive coping mechanisms. A secure attachment between an infant and his or her primary caregiver, where the primary caregiver shows that she is attuned or "in sync" with the infant, teaches the infant about the initial significant relationship that will influence all subsequent relationships (Fitton, 2012). Attunement also promotes emotional regulation for the infant (Siegel, 2001). Attachment, therefore, is the basis for infant development that will impact an individual's life trajectory as he or she learns to interact with the social environment (Fitton 2012).

### Confirmation and Contrasts

Mixed methods research provides the opportunity to both confirm or complement data from different sources and identify contrasts within the data as well (Bryman, 2006). The initial content analyses of the qualitative data confirmed the interventions identified by the descriptive analyses of the quantitative medical record review data. More detailed analyses of the qualitative data however identified contrasting views about the interventions initially described. The interview data identified that the clinicians focused on the mother-infant relationship and that their main intervention was to model a secure attachment. This focus was not evident in the medical record documentation. This additional finding provides a more complete picture of the interventions that clinicians use in their work, highlighting that attachment work is somewhat invisible and difficult to articulate and document.

### Implications for Practice and Further Research

The results of this study indicate that PIMH clinicians predominantly used FOO work and non-directive counseling as opposed to interventions with a higher level of evidence, such as CBT (beyondblue, 2011), when working with women who are at risk for poor perinatal mental health. Psychodynamic therapies focus on the relationship between the client and the clinician (Bliss & Rasmussen, 2013), where the therapeutic relationship acts as a vehicle for change (Mishna, Van Wert, & Asakara, 2013) and have shown to be potentially effective treatments for depression (Dennis & Hodnett, 2007, Hunot, Churchill, Teixeira, & Silva de Lima, 2010). Women identified with complex needs have reported that the therapeutic relationship is key to them remaining engaged with a service (Myors et al., 2013b); the use of psychodynamic therapies with this group of women requires further research.

Clinicians also emphasized the therapeutic and mother-infant relationship within an attachment model. While a large body of literature promotes the development of a trusting relationship (e.g., Lefebvre et al., 2010; Mills et al., 2012), less is known about the impact of clinicians modeling a secure-attachment for mothers to emulate for their infants. Further research is needed to identify the nuances that clinicians use when modeling a secure attachment and whether women identified with complex needs are able to comprehend these nuances and translate them into practice by promoting a secure attachment with their infants.

Documentation in the medical records did not reflect what the clinicians identified as their main intervention, the mother-infant relationship and modeling a secure attachment. The subtlety of modeling a secure attachment may make it difficult to document in clinical records. However, if this important aspect of PIMH clinicians' work is to become visible, this documentation difficulty needs to be overcome.

Perinatal and infant mental health services employ a multidisciplinary team of health professionals with varying postgraduate qualifications and training. Further research is needed to identify if one type of intervention is more effective than another and what leads to better outcomes for women. In the absence of evidence, clinicians will continue to use an eclectic range of interventions, dependent upon their training. Likewise, all of the clinicians talked about attachment theory as underpinning their work. However, not all of the clinicians could clearly articulate how they used attachment theory within their work. Therefore, consideration needs to be given to identifying the specific skills and qualifications that clinicians need to work in this specialist area as well as the skill mix within a service.

## Strengths and Limitations

There are few studies in the literature that report the characteristics of women referred to specialist PIMH services and the therapeutic interventions that clinicians use. Specifically this study has identified the specific risk factors of women referred to specialist PIMH services; the interventions that PIMH clinician use; how PIMH clinicians view their main intervention within attachment theory by modeling a secure-relationship; and that clinical documentation does not reflect the complexities of the clinician's work. As such, this is an important study that adds to the growing literature base of these specialist services.

There are limitations to the findings of this study. The medical records reviewed in this study represent a small group of women who received services at two sites in NSW and are not necessarily representative of the population requiring this service. Only interventions that were clearly documented in the medical records were recorded on the review tool, other interventions may have been used but not recorded if they were not able to be identified by the researcher. Only a small number of professionals and women were interviewed however saturation was achieved.

## CONCLUSION

Perinatal mental health disorders potentially have long-term negative sequelae for women, their infants, and the women's families. The findings of this study have identified that women referred to PIMH services have multiple risk factors and a history of complex trauma and that PIMH clinicians use a wide range of interventions depending upon their professional background and training. Many of these interventions have a limited evidence base; however, it is well known that the therapeutic relationship is key to any intervention, especially if behavior change is to be gained. Importantly, the study identified the attachment focus of the clinicians which was not evident in the medical records. As PIMH is an emerging specialty area, further research is needed to determine the most effective interventions when working with women with complex needs.

***Declaration of interest*:** The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

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## 5.3 Part B - "To Hold": Modelling a secure-base for women engaged with specialist perinatal and infant mental health services

### Introduction

In this second part of Chapter Five, I report on the thematic analysis of the clinicians' interview data with regard to the therapeutic interventions that they use. As detailed in Chapter Three, six clinicians were interviewed across the two study sites. In these interviews clinicians were asked to describe in detail the interventions, therapies or approaches they used when working with women and families, for example, "What services or interventions do you provide/use for the women you see?"

These data were analysed thematically (refer to Chapter 3). One main theme, "modelling a secure-base", and three supporting themes, "enhancing reflective capacity", "enhancing emotional regulation" and "enhancing empathy" were drawn from the data. Illustrative examples from the medical record textual data have also been included. In some instances, additional wording has been added in square brackets to aid interpretation. Pseudonyms have been used to protect the identity of the women service-users; the professionals and medical records are represented by code numbers (P = PIMH professional, S = key stakeholder, MR = medical record).

### Modelling a secure-base

The perinatal period was seen as a "window of opportunity" (P2) by clinicians to enable them to work with women who were identified with complex needs. All of the clinicians reported that their service was based upon Attachment Theory and, therefore, their aim was to model being a secure-base for the women, as one clinician stated, "you need to hold these women" (P3) emotionally. The clinicians described the secure-base as, "being predictable, available, consistent, clear about saying what we mean and meaning what we say" (P2). The importance of modelling a secure-base was emphasised by clinicians as they reported that many of the women had experienced previous negative life events, including childhood trauma, and therefore may not have experienced positive relationships to draw upon, as described by one clinician:

> By modelling a secure attachment the aim is that the mothers can take that model and then use it with her own infant ... It's usually very different from any relationship that the mothers we see have ever had. (P2)

The clinicians also hoped that by modelling a positive relationship with the women they may be able to stop the ongoing trajectory of poor relationships within families:

> ... what we're trying to do is stop that intergenerational transmission of mental health issues. And so the way you do that is by working with the relationship. ... babies ... don't grow and develop by themselves. They ... have a relationship with someone else ... that's the relationship that puts them on the pathway to where they're going to go and how they're going to do it ... So ... it's about relationship ... (P5)

While the main aim for modelling a secure-base was to enhance the mother-infant relationship, clinicians also used modelling to demonstrate a supportive adult relationship, which the mother could use with her other adult relationships as well:

> ... the relationship becomes a model of a way of relating that [the mother] ... could take outside of our therapy and be able to do that with other people and get support from others. (P3)

One clinician summarised modelling a secure-base in terms of "being held" and "being with", as described below,

> I think a lot of these women have not had the experience of being held ... [for] a lot of these woman I think nobody has been with them in their experience. Or as small children they [were] emotionally abandoned by their parents, so they've ... suffered alone in a lot of their feelings. So it's ... having that experience of being held and somebody being with you in whatever your experience is. (P3)

When the key stakeholders (midwives and a social worker) were asked about the PIMH service model of care they did not articulate it in terms of Attachment Theory, however they all acknowledged that the PIMH clinicians worked within a relationship-based model. As described below:

> ... to establish a relationship that's a trusting relationship, that's not going to abandon [the women], and that is going to see them through their tough times and ... support them ... (S3)

Modelling a secure-base was documented twice in the medical records for example,

> (Client) feeling guilty because thinks she hasn't been available for her children. I discussed with (client) the importance of modelling behaviour that informs the children that she is available & can support them. (MR024)

Participating clinicians identified and described three key aspects that comprise or characterise the concept of modelling a secure-base: enhancing reflective capacity, enhancing emotional regulation and enhancing empathy.

### *Enhancing reflective capacity*

Enhancing the reflective capacity of the mother was about the mother being able to reflect upon her past life experiences and how these experiences may impact on her current emotions and behaviours:

> The idea of mentalising or reflective capacity ... to be able to think about how the other person's feeling and also to link the past to the present ... that's what I do for the patient in the therapy. Eventually you see that people can do it for themselves. (P2)

Enhancing reflective capacity was also about the mother learning, through the clinician's modelling, to be able to reflect back or "mirror" what the baby may be experiencing:

> You're enhancing their mentalising. So just as a parent needs to reflect back to the baby what it's feeling by words or facial expressions ... to be like a mirror for the baby ... as a therapist ... we're doing that for the parent. So reflecting back to the parent their experience because sometimes they can't make sense of it. So you mentalise for the parent who then hopefully can do it for themselves and the baby. (P3)

By increasing "maternal-reflective functioning, so that [the mother is] ... in a better place to be able ... [to] connect with her infant" (P7), the mother-infant relationship is also enriched. Enhancing the reflective capacity of the mother was documented four times in the medical records. For example,

> (Father of baby) [not living together] came over the weekend. (Baby) "played up" a lot while he was there. Reflected on (baby's) experience of the house changing & having to "share" her mum. (MR011)

and

> During the play session, described feeling fed up, fatigued and unhappy when playing [with] the children. I asked (client) about her experiences of play – after [her mother's] death [she] was cared for by two different families and as a child had to do household tasks. Play was forbidden and if caught playing [she] was punished. As a child [she] frequently felt tired, fatigued and "fed up". [She had] few positive experiences of comfort and nurture from adults, often no food. [She] describes still feeling jumpy & scared [with] loud noises/shouting, etc. We discussed how past childhood feelings/experiences may impact/get in the way of how she interacts and experiences her sons. (MR072)

### *Enhancing emotional regulation*

Clinicians also talked about the emotional state of the women and how their role is to support the mother to be emotionally stable and consistent with her infant,

> [part of our therapy is] working towards getting the woman so that she is in a really good space with her mental health, so that she can be available for her baby, and have an ongoing positive relationship with her baby. (P5)

One clinician reflected on the assessment processes conducted by the midwives (the antenatal psychosocial assessment) and the PIMH clinicians. She expressed concern that both processes focus on the negative aspects of a woman's life, with minimal documentation about positive factors or resilience,

> Our assessment can leave [the woman] quite down. If you talk to everyone about all their issues in their life, it can make it seem all pretty overwhelming. So I try to end every session with something protective, like the strengths they have ... – and how well they're doing – but it's got to be genuine ... I don't like people to walk away feeling down, because it's a negative experience for them. You have to somehow get them to walk away with hope. (P1)

Enhancing emotional regulation was documented eight times in the medical records. For example,

> [Discussed with] (client) that she needs to act like a container to provide the strength for her children but also contain her negative sense of self & not to allow it to spill over. (MR014)

and

> We discussed (client's) cycle of thinking leading to thoughts of deliberate self harm [sic]. Feels [negative] thoughts about herself. Weight gain, feels alone, thinks about cutting. Finds distraction helpful. Worries about being unable to stop the baby crying, not knowing how to soothe her baby. We discussed how (client) finds it difficult to manage her own emotions so understandably having to be with a crying baby will present challenges. (MR113)

### *Enhancing empathy*

Enhancing empathy was similar, but was described with subtle differences, to reflective capacity. Reflective capacity referred to the mother being a "mirror" for the infant's emotions as well as the mother's ability to reflect about her past experiences and how they may continue to influence her thoughts and behaviours. Empathy is about thinking about the baby from his/her experiences and perspectives,

> Empathy building ... [is] about getting them to look at what the baby might be experiencing, so ... during pregnancy what the baby might experience, and then what the baby might experience once they're born and how that might be different and how to get them to emulate, for the baby, that experience once they've been born ... (P5)

One clinician stated that enhancing empathy is a crucial therapeutic intervention that PIMH clinicians use:

> So getting [the mother] to think about things from the baby's point of view is probably the biggest intervention we do ... Highlighting the child and that they've got their own perspective and feelings on the world already. (P2)

Enhancing empathy was documented four times in the medical records. For example,

> (Client) reported that despite feeling calmer in herself, she does get frustrated with (baby) when he cries. Further exploration revealed that (client) felt like having space at times and when (baby) cried she felt overwhelmed with responsibility ... Discussed in terms of adjustment and learning to compromise. How (baby) might be feeling on certain occasions (i.e. when crying after being out shopping for hours) was addressed. (Client) identified that he might feel tired, hungry, frustrated and need certain things from her. Praise and encouragement provided for identifying same. (MR088)

It is also noteworthy that the clinician documented her role in taking a strength-based approach, providing positive feedback to the woman.

One clinician reflected on a satisfying aspect of their work when women were able to be reflective and empathic when discussing their infants,

> Seeing these women develop relationships with their babies that you know wouldn't have happened without the intervention from the team. We know that they wouldn't have developed that level of insight and that level of empathy to be able to sit and say "Oh wow I wonder how she thinks about it", meaning the baby ... and that's probably the most satisfying part of my job, is to see them develop that empathy and that insight ... (P5)

The women service-users were also asked about the interventions that they received as a client of a PIMH service. Most of the women were unable to clearly articulate what the clinicians did, it was clear however that the focus of the relationship between the woman and the clinician was paramount (refer to Chapter 7).

## 5.4 Conclusion

In this chapter, I have presented the therapeutic interventions that PIMH clinicians use in two parts. In the first part, I reported the findings from the quantitative and directed content analyses of the data. This was presented in the manuscript, "*Therapeutic interventions in perinatal and infant mental health services: A mixed methods inquiry*". In the second part of the chapter, I presented the findings from a thematic analysis of the PIMH clinicians' interview data with illustrative quotes taken from documentation in the medical records. The importance of the application of attachment-based work is discussed in detail in Chapter Nine, the Discussion.

Chapter Six includes the publication, *"A mixed methods study of collaboration between perinatal and infant mental health clinicians and other service providers: Do they sit in silos?*" In this paper, I report the collaborative practices between PIMH clinicians and other service providers. While the next chapter discusses collaboration, it is important to understand women's experiences of the therapeutic interventions used by the PIMH clinicians, which is addressed in Chapter Seven.

# CHAPTER 6: **A MIXED METHODS STUDY OF COLLABORATION BETWEEN PERINATAL AND INFANT MENTAL HEALTH CLINICIANS AND OTHER SERVICE PROVIDERS: DO THEY SIT IN SILOS?**

Myors, K.A., Cleary, M., Johnson, M. & Schmied, V. (2015). A mixed methods study of collaboration between perinatal and infant mental health clinicians and other service providers: Do they sit in silos? *BMC Health Services Research*, *15*: 316. DOI: 10.1186/s12913-015-0977y

## 6.1 Publication: Relevance to thesis

Chapter Six includes the paper, "*A mixed methods study of collaboration between perinatal and infant mental health clinicians and other service providers: Do they sit in silos?*" In this paper, I report the collaborative practices between PIMH clinicians and other service providers who work with women during the antenatal period. Collaboration is an important aspect of clinical work as it streamlines information and referral pathways (Psaila *et al.* 2014a), enhances outcomes for individuals (Schmied *et al.* 2010) and is increasingly being written into service policies (for example, NSW DoH 2009).

Myors *et al. BMC Health Services Research* (2015) 15:316
DOI 10.1186/s12913-015-0977-y

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# A mixed methods study of collaboration between perinatal and infant mental health clinicians and other service providers: Do they sit in silos?

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## Abstract

**Background:** Women at risk of poor perinatal mental health benefit from coordinated approaches to care. Perinatal and infant mental health (PIMH) services have been established to support women with social and emotional needs. This paper examines the nature and extent of collaboration within two PIMH services in Australia.

**Methods:** A convergent, embedded, mixed methods design was used. Two hundred and forty four medical records were reviewed, 13 professionals (six PIMH clinicians, two PIMH service managers, and five key stakeholders) and 11 women service-users participated in semi-structured interviews.

**Results:** Three broad themes were drawn from the data, Theme 1: *We don't sit in silos … but they do,* Theme 2: *We need to enhance communication*, and Theme 3: *Collaboration is hard work*. Perinatal and infant mental health clinicians believe they work collaboratively with other service providers. Key stakeholders and documentation in the medical records reveal that collaboration is nominal.

**Conclusions:** Professionals believe that collaboration is essential for women with complex needs. Perinatal and infant mental health clinicians are skilled at building relationships with women, however further support is needed to build trusting relationships with other service providers. Women service-users also need to be involved in the collaborative process to become equal partners in their care.

## Introduction

Service integration and collaborative care are considered essential to promote continuity within and across health and other services [1], and to foster a shared vision of health care delivery [2]. The aim of collaboration is to facilitate continuity of care and information exchange between service providers [3], and service providers and clients [4].

Traditionally, adult mental health services focus on the adult whereas child and adolescent mental health services focus on the child or young person. There are few services which consider both the parent and the infant or child or their relationship. Due to the complexities of the perinatal period, conception to 12 months post birth [5], specialist perinatal and infant mental health (PIMH) services have been developed. To work effectively within a family-centred approach, these specialist PIMH services need to network and collaborate with the broader services that provide care for women with complex needs [6].

## Background

Maternal social and emotional distress in pregnancy can have negative consequences for the unborn infant [7]. Likewise, families where parental functioning is compromised, for example a mental illness, can impact directly on infant wellbeing and result in long term negative trajectories [8]. Screening, identification of perinatal mental health problems, and pathways to care are needed for early intervention and the development of comprehensive management plans [9].

With growing evidence linking women's wellbeing during the perinatal period to infant wellbeing, the *Supporting Families Early Policy* [10] was developed in

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NSW, Australia. The policy provides a framework for universal psychosocial risk assessment and depression screening for women during the perinatal period with links to specialist services if physical or mental health risks are identified [10]. The risks are divided into three levels: Level 1—no vulnerabilities detected; Level 2—predominantly social issues such as social isolation; and Level 3—complex risk factors such as maternal mental illness. Women identified with multiple Level 2 or any Level 3 risk factor are referred to a multidisciplinary case review meeting where referral to more specialised services, for example PIMH, is determined [10]. Underpinning the policy are the concepts of service integration, integrated care planning and active collaboration [10].

### Integration and collaboration

The terms integration, collaboration, coordination, cooperation, and multidisciplinary care are often used interchangeably by health professionals. They are similar in that they indicate working with other professionals and services; they differ in the amount of interactivity between the services [11]. All levels of collaboration aim for continuity of information, relationships, either with an individual or a service, and management of care [12]. Integration, however, is often described as the highest level of collaboration [13], where services are re-organised to make them more efficient, accessible and continuous [14]. Collaboration can therefore be described as working together with other services from a lower level - cooperation, coordination; or a higher level - integration [13].

Collaboration is needed if health services are to be effective and equitable for individuals and families with complex needs [15], especially multi-service users [14]. Integrative and collaborative models of care have been found to increase service use and improve health outcomes. Bai and colleagues [16] conducted a longitudinal analysis (36 months) of 1613 children (two years and older), who had mental health problems, within 75 child welfare agencies in the United States of America. They identified that enhanced interagency relationships resulted in increased mental health service use and improved mental health outcomes for the child. Likewise, a meta-synthesis of services for women suffering from substance use issues identified that integrated services promoted recovery, personal growth and enhanced relationships with their children and significant others [17]. Alternatively, services which do not communicate effectively or collaborate with other professionals and services limit continuity of care and decrease service use by women and families [18]. An integrative literature review also identified that health professionals are willing to work collaboratively with other services but require organisational support to achieve this [19].

To understand the level of collaboration between services, D'Amour and colleagues [20] developed a "typology of collaboration". The typology was based upon a study of perinatal services in four regions in Canada. The study identified that the region which had the highest level of interagency cooperation had increased service performance, was more accessible and had higher levels of continuity of care [21]. The typologies are:

- Active collaboration - the highest level - partnerships have been developed and are sustainable despite changes within healthcare systems. Goals have been developed and supported by policies. Trust is evident as all parties understand their own and each other's roles and responsibilities. A strong working relationship can often lead to inter-professional and inter-organisational innovation.
- Developing collaboration - collaborative practices have commenced but remain unstable especially when faced with change. Goals, leadership and policies are still being negotiated which may result in some conflict. Roles and responsibilities are still divided. Services are less efficient but change is occurring.
- Potential collaboration - collaboration does not exist and is blocked by ongoing conflict. Negotiations breakdown with resultant loss of accessibility and continuity. Conflict needs to be overcome before collaboration can occur [20].

### Study aim

The aim of this paper is to report the collaborative practices between PIMH clinicians and other service providers from the perspective of PIMH clinicians and managers, key stakeholders, women service-users and documentation in medical records. These data come from a larger mixed methods study examining specialist PIMH services. Other companion papers have been published from this study reporting women service-users' experiences of engaging with a PIMH service [22], the interventions PIMH clinicians use [23] and the strategies PIMH clinicians draw upon to engage women with complex needs [24].

## Methods

This study used a convergent, embedded, mixed methods design [25] and was conducted in NSW, Australia between June 2011 and April 2012. The design was convergent in that all data were collected at both sites simultaneously. Equal weighting was given to the medical record—numeric data (quantitative) and the professional's interviews (qualitative). Less weighting was given to the women service-user data and the medical record—textual data.

Ethics approval was obtained from the Human Research Ethics Committees of Sydney Local Health District and the University of Western Sydney. All participants were informed, both verbally and in writing that they were free to withdraw from the study at any time with no consequences. All data were de-identified. Pseudonyms and codes have been used for quotes from the qualitative data.

### Setting

The study was conducted in two specialist PIMH services (one metropolitan, the other regional) in NSW, Australia. Both services employed a multidisciplinary team of nurses, psychologists, social workers and psychiatrists. The main referral pathway was via multidisciplinary case review meetings which included services such as maternity, social work and PIMH.

### Participants and data collection

#### *Professionals*

All PIMH clinicians from both sites were informed about the study by the first author who attended team meetings. Six PIMH clinicians (three from each site) and two managers (one from each site) consented to participate in semi-structured, in-depth interviews. The interviews lasted between 50 and 90 min. The PIMH clinician's interview schedule asked about the service model of care and their role, how they engage women with complex needs, the interventions they use, collaboration with other services and their experiences as a PIMH clinician. The managers were asked about the history of the PIMH service, the model of care, supports and challenges in providing the service and collaboration with other services.

Five key stakeholders (four midwives and one social worker) were purposively selected to participate in semi-structured, in-depth interviews due to their involvement in the implementation of the *NSW Supporting Families Early Policy* [10] or the multidisciplinary case reviews or both. All five stakeholders consented. The interviews lasted between 60 and 70 min. The interview schedule asked about the PIMH service and its model of care, collaboration with the PIMH team and women's experience of the PIMH service, if known. All of the interviews with the professionals were conducted at their place of work.

#### *Women service-users*

A purposive sample of women service-users who had engaged with a specialist PIMH service were invited to participate in the study. A total of 11 women consented to being interviewed, having the interview recorded and having their medical records reviewed. Eight women were interviewed in their family home and three via telephone. The interviews lasted between 10 and 40 min. The interview schedule asked about the referral process, the involvement of other services, the interventions or treatments that were used and the women's overall experience of the PIMH service. At completion of the interviews the women were given or posted a gift voucher of AU$20.00 to thank them for their time. The women were interviewed after discharge from the PIMH service. (Refer to [23] for the interview guides).

#### *Medical record review*

All available (244) medical records of women who were referred to the two specialist PIMH services between January 2010 and December 2011 were reviewed. A detailed review tool was developed to assist the process and ensure that consistent data were obtained. This tool was developed from the antenatal screening tools that the midwives used at each site, the literature including the *NSW Supporting Families Early Policy* [10] and clinical experts.

Textual data from the medical records were transcribed directly into a word document on a laptop computer. These data gave illustrative examples of the quantitative data collected, for example, illustrations of contact between PIMH clinicians and other service providers.

### Data analyses

Textual data collected on the medical record review tool were quantitised, or coded numerically, for statistical analyses. The quantitising of data counteracts bias and enhances reliability [26]. Quantitative data were then entered into the Statistical Package for the Social Sciences (SPSS) versions 19 and 20, and analysed.

Qualitative analyses occurred in two phases. Phase one - content analyses [27] of all qualitative data were guided by the research questions (for example, engagement strategies, therapeutic interventions, collaboration with other service providers) and quantitative analyses; and Phase two – thematic analyses [28, 29] of the professionals' and women service-user interview data.

All qualitative data were organised using NVivo. The analyses of all data used an iterative and circular process [30], where the researcher (KM) moved from one data source to another to fully answer the research question (Fig. 1). The integration of the data occurred during the design, data analyses, interpretation and discussion phases of the study.

Reflexivity or critical self-awareness is an important component of qualitative research [31]. Therefore, it is relevant to acknowledge that KM had previously worked as a PIMH clinician prior to conducting this study. Any potential bias was addressed by KM meeting regularly

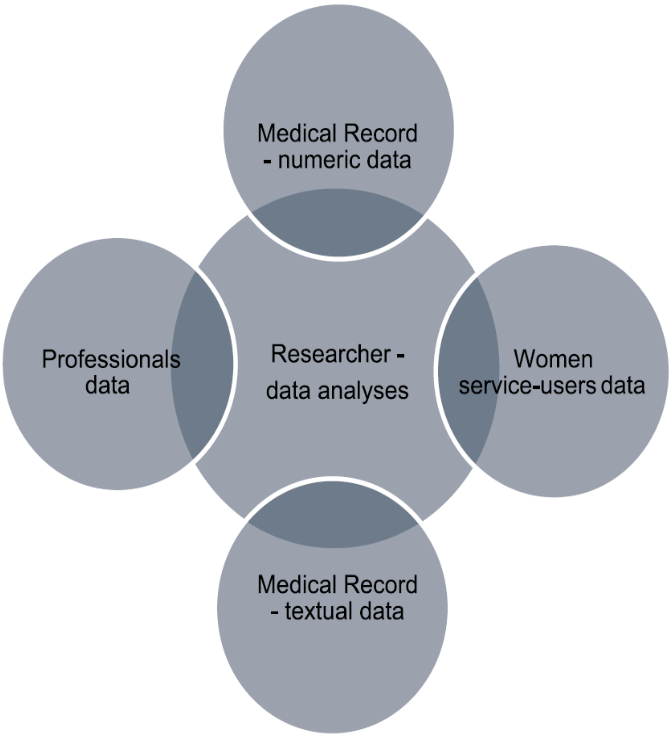

**Fig. 1** The iterative process of data analyses

with her supervisors to discuss issues related to recruitment, data collection and data analyses, and these were documented in research notes.

## Results

These findings report the profile of the professionals and women service-users, the role of the PIMH service from the perspective of PIMH clinicians, and three themes and sub-themes that were drawn from the data about the collaborative practices of the PIMH clinicians.

### Profile of the professionals

The clinicians interviewed hold bachelor degrees in nursing, social work or psychology. Four of the clinicians had undertaken post graduate training in infant mental health and all of the clinicians had undertaken post registration training in therapeutic interventions, such as attachment-based group programs and working with clients with trauma histories. The clinicians had been working in the PIMH service between two and eight years. The managers and key stakeholders had been involved in the PIMH service between two and 12 years.

### Profile of the women

The women ranged in age from 16 to 45 years (Mean = 27.7, SD = 5.9). The majority (77.5 %) were born in an English speaking country and were partnered (73.4 %). Most women (96.7 %) were referred antenatally to the PIMH service and eight (3.3 %) women were referred postnatally. The women were identified as having complex psychosocial issues, with 72.4 % having three or more Level 2 risk factors and 54 % having at least one Level 3 risk factor. The 11 women service-users interviewed were similar in age, with a similar spread of Level 2 and Level 3 risk factors to the women in the 244 medical records reviewed. Further details of the characteristics of the women referred to the PIMH service are reported elsewhere [23, 24].

### The role of the PIMH service

Clinicians stated that the PIMH service and their role was focused on the relationship between the mother and the infant, and approaches that strengthened that relationship, as one clinician stated,

> My role is to help support [women] in such a way that their mental health can be … in such a place … that they have the best relationship that they can possibly have with their infant. (P5)

Due to the specialist nature of their role, the clinicians see themselves as senior professionals who have specific training and skills in attachment-based therapies.

## Themes

The first theme - *'We don't sit in silos … but they do'* describes clinicians' positive perceptions of collaborative practice, compared with the lack of collaboration identified in the medical records and perceived by key stakeholders. The second theme - *'We need to enhance communication'* represents the mechanisms that facilitate communication and how they are used by the clinicians and key stakeholders. The third theme - *'Collaboration is hard work'* illustrates the barriers to collaboration. Figure 2 provides a summary of themes, sub-themes and data sets.

Both PIMH clinicians and key stakeholders reported that collaboration was valuable and beneficial for women and their infants. When describing collaborative care, PIMH clinicians focused on what they were doing to make collaboration happen whereas the key stakeholders focused mainly on what was not happening and identified gaps. The terms 'integration' and 'collaboration' were used interchangeably by the professionals during the interviews.

Most of the women service-users reported that referral to other services was discussed, however this mainly related to attendance at group programs about parenting and baby care. Some women were given telephone numbers to other services to make contact themselves. Other women did not want the involvement of multiple services as Sarah stated: "I just said no. I didn't want anyone else." None of the women identified that they were already linked to other services, for example maternity.

Theme 1: *We don't sit in silos … but they do*

Most of the clinicians believed that they work collaboratively with other services. Clinicians described collaboration as liaising with other professionals and services

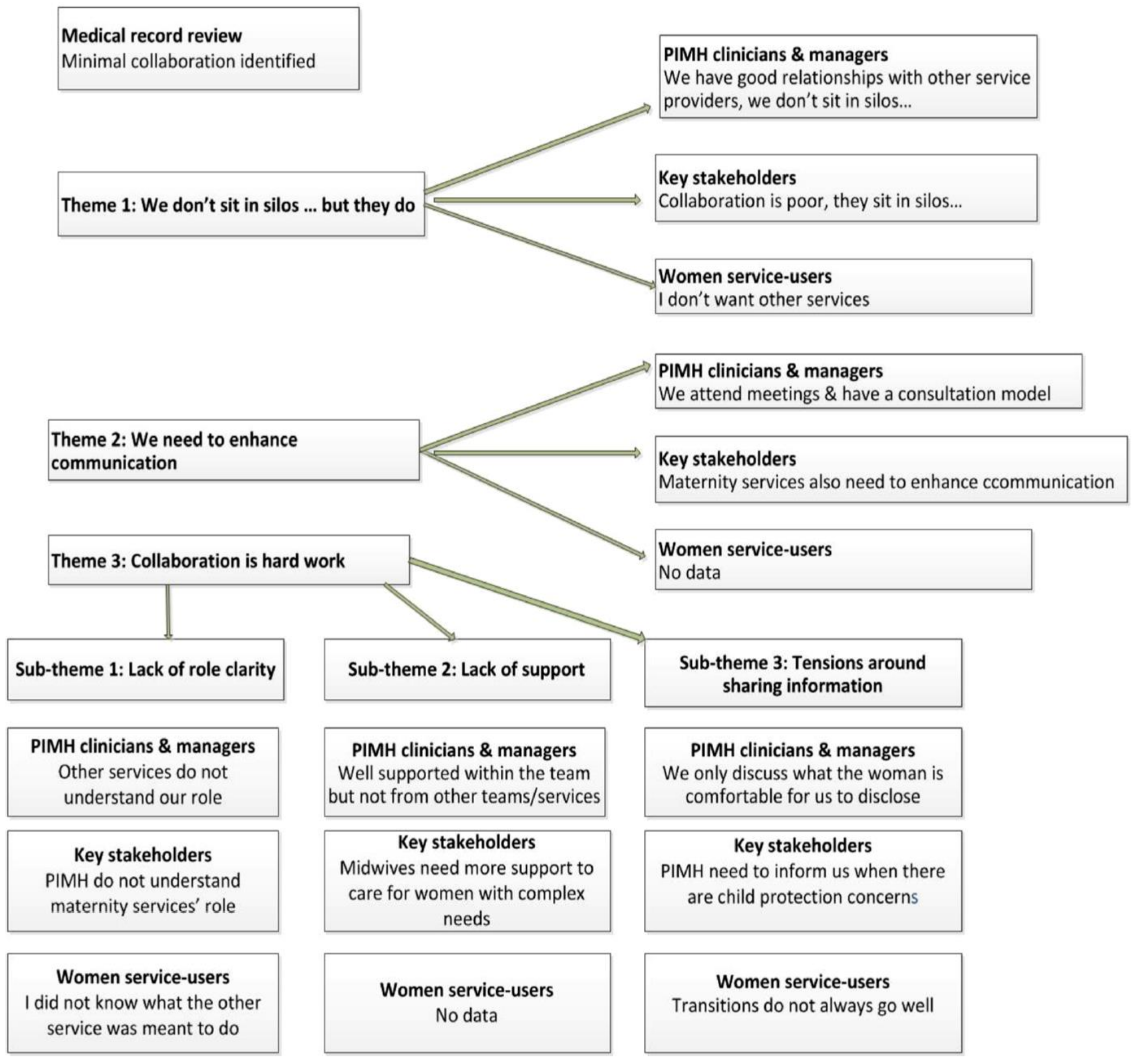

**Fig. 2** Summary of themes, sub-themes and data sets

about the women in their care, "we don't sit alone in little silos … there's a collaborative approach to the woman's [care in] .... the perinatal period" (P5). One clinician, however, indicated that collaboration was still in its "infancy" (P7) due to recent service changes which had negatively impacted on the time and resources required to attend and network at meetings. Another clinician did not believe that the service was collaborative, stating "we sit in silos, but there is … confidence and communication to have faith that everyone is doing their bit" (P6). This clinician suggested that women would often be the ones to identify if there was a gap to follow up: "There has to be confidence that other people are doing what they are required to do, and only if stuff came up did it feel that it was actually integrated" (P6), indicating that only when an issue for the woman arose did active collaboration occur.

Despite the clinicians' positive comments about working collaboratively, the medical record review identified that the clinicians had minimal contact with other services involved in the woman's care. Table 1 provides an overview of the medical record review data in relation to the services that PIMH clinicians had contact with over a two-year timeframe. Of the 244 women who had been referred to the PIMH service, over half of the

**Table 1** Frequency & type of contact between PIMH clinicians & other service providers

| *Type of contact* | *PIMH clinician to other service provider - verbal* | | | *Other service provider to PIMH - verbal* | | | *PIMH clinician to other service provider –written*[f] | | | *Other service provider to PIMH - written*[f] | | | *Face to face meeting* | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | C[e] | n | % | C[e] | n | % | C[e] | n | % | C[e] | n | % | C[e] | n | % |
| *Maternity services*[a] | 0 | 150 | 61.5 | 0 | 187 | 76.6 | 0 | 115 | 47.1 | 0 | 236 | 96.7 | 0 | 239 | 98.0 |
| | 1–2 | 79 | 32.4 | 1–2 | 52 | 21.3 | 1–2 | 115 | 47.1 | 1–2 | 8 | 3.3 | 1–2 | 5 | 2.0 |
| *N = 244* | 3–5 | 13 | 5.3 | 3–5 | 4 | 1.6 | 3–4 | 13 | 5.3 | | | | | | |
| | 7 | 1 | 0.4 | 6 | 1 | 0.4 | 6 | 1 | 0.4 | | | | | | |
| | 13 | 1 | 0.4 | | | | | | | | | | | | |
| *Child & family health nursing services*[a] | 0 | 201 | 82.4 | 0 | 210 | 86.1 | 0 | 197 | 80.7 | 0 | 240 | 98.4 | 0 | 238 | 97.5 |
| | 1–2 | 34 | 13.9 | 1–2 | 29 | 11.9 | 1–2 | 44 | 18.0 | 1–2 | 3 | 1.2 | 1–2 | 6 | 2.5 |
| *N = 244* | 3–4 | 8 | 3.3 | 3–5 | 4 | 1.6 | 3 | 3 | 1.2 | 3 | 1 | 0.4 | | | |
| | 6 | 1 | 0.4 | | | | | | | | | | | | |
| *General practitioner*[a] | 0 | 226 | 92.6 | 0 | 238 | 97.5 | 0 | 195 | 79.9 | 0 | 242 | 99.2 | 0 | 244 | 100 |
| | 1–2 | 17 | 7.0 | 1 | 6 | 2.5 | 1–2 | 47 | 19.3 | 1 | 2 | 0.8 | | | |
| *N = 244* | 3 | 1 | 0.4 | | | | 3 | 2 | 0.8 | | | | | | |
| *Maternity social worker*[b] | 0 | 210 | 86.1 | 0 | 226 | 92.6 | 0 | 235 | 96.3 | 0 | 235 | 96.3 | 0 | 236 | 96.7 |
| | 1–2 | 26 | 10.6 | 1–2 | 17 | 7.0 | 1–2 | 7 | 2.9 | 1–2 | 8 | 3.3 | 1–2 | 7 | 2.9 |
| *N = 244* | 3–5 | 7 | 2.9 | 3–5 | 1 | 0.4 | 3–5 | 2 | 0.8 | 3–5 | 1 | 0.4 | 3–5 | 1 | 0.4 |
| | 7 | 1 | 0.4 | | | | | | | | | | | | |
| *Adult mental health (Community)*[b] | 0 | 226 | 92.6 | 0 | 230 | 94.3 | 0 | 240 | 98.4 | 0 | 239 | 98.0 | 0 | 243 | 99.6 |
| | 1–2 | 11 | 4.5 | 1–2 | 10 | 4.1 | 1 | 2 | 0.8 | 1 | 4 | 1.6 | 1 | 1 | 0.4 |
| | 3–5 | 5 | 2.0 | 3–5 | 4 | 1.6 | 3–4 | 2 | 0.8 | 4 | 1 | 0.4 | | | |
| *N = 244* | 9 | 2 | 0.8 | | | | | | | | | | | | |
| *Child protection services*[c] | 0 | 223 | 91.4 | 0 | 230 | 94.3 | 0 | 237 | 97.1 | 0 | 240 | 98.4 | 0 | 241 | 98.8 |
| | 1–2 | 13 | 5.3 | 1–2 | 11 | 4.5 | 1–2 | 6 | 2.5 | 1 | 3 | 1.2 | 1 | 2 | 0.8 |
| | 3–5 | 5 | 2.0 | 3 | 2 | 0.8 | 4 | 1 | 0.4 | 3 | 1 | 0.4 | 3 | 1 | 0.4 |
| *N = 244* | 7 | 2 | 0.8 | 8 | 1 | 0.4 | | | | | | | | | |
| | 10 | 1 | 0.4 | | | | | | | | | | | | |
| *Non-government organisations*[d] | 0 | 206 | 84.5 | 0 | 218 | 89.4 | 0 | 233 | 95.5 | 0 | 233 | 95.5 | 0 | 233 | 95.5 |
| | 1–2 | 21 | 8.6 | 1–2 | 16 | 6.6 | 1–2 | 9 | 3.7 | 1–2 | 10 | 4.1 | 1–2 | 12 | 4.9 |
| | 3–5 | 7 | 2.9 | 3–5 | 4 | 1.6 | 3–5 | 2 | 0.8 | 3–5 | 1 | 0.4 | 11 | 1 | 0.4 |
| *N = 244* | 6–8 | 5 | 2.0 | 6–8 | 5 | 2.0 | | | | | | | | | |
| | 9–11 | 4 | 1.6 | 10 | 1 | 0.4 | | | | | | | | | |
| | 19 | 1 | 0.4 | | | | | | | | | | | | |

[a] Universal services, [b] Secondary services, [c] Tertiary services, [d] Provide care at all levels depending upon the service, [e] Frequency of contact, [f] Including email contact

woman had some aspect of their care discussed by a PIMH clinician with another service provider either verbally, in writing or face to face. Most of this contact, however occurred only once for any individual woman.

Email contact to maternity services was the main form of contact by a PIMH clinician to another service, reflecting the distribution of the perinatal care plan (PCP) described below. Contact with universal child and family health (CFH) nursing services is limited. When clinicians do communicate with CFH nursing services it is to inform the CFH nurse that a woman was being discharged from the PIMH service rather than informing the CFH nurse of PIMH involvement with the woman and their intended care, as documented in the medical record below,

> [Phone call] to Child & Family nurse … She looked at file & noted that baby has not been seen by them. They were not aware of antenatal risk factors or PIMHS involvement. Told that [mother] was seen regularly by PIMHS in pregnancy – postnatally only seen once … then have not been able to contact. Nurse will document in the file. Plan: File to be closed. File closed. (MR109)

Documentation in the medical records relating to shared clients and joint home visits predominantly referred to non-governments organisations (NGOs) such as family support services rather than the universal health services provided by maternity or CFH nursing services. Likewise, contact with the woman's general practitioner was limited. Clinicians made contact with multiple NGOs, however contact with any one NGO about an individual woman was minimal. Specifically, contact was made between a PIMH clinician and an NGO for 41 (16.8 %) women, with contact being made to more than one NGO for 16 (6.6 %) women. Clinicians were in contact with multiple other services, for example housing agencies, however this reflected the clinicians' role as case managers and advocates [23] rather than indicating a collaborative role for the woman's care.

Clinicians made contact with child protection services for 34 (13.9 %) women, and 14 (5.7 %) child protection reports were made, despite the risk factors identified during the assessments. Clinicians reported that child protection representatives attended the case review meetings at both sites and were therefore aware of the women's risk factors. Clinicians also made contact with NGOs, whose role was to work with families with child protection concerns for 15 (6.1 %) women. Only 42 (17.2 %) medical records documented that the woman was informed of the clinician's mandatory reporting role.

Key stakeholders also reported a lack of communication with the PIMH service as one key stakeholder commented, "it's like silos" (S5). They reported they were not informed about women who were clients of the PIMH team and did not feel like equal partners in women's care during the antenatal period.

Theme 2: *We need to enhance communication*

One of the key aspects that facilitates collaborative care is having clear mechanisms for communication, either face to face or through communication tools. The multidisciplinary case review meetings appear to be the main method of collaboration. Clinicians described interagency meetings as being beneficial,

> Those interagency meetings … make a difference … [they] build our relationships with each other … [and] it's helped [to] have a more integrated model. (P1)

Attending meetings and providing education allow the clinicians to build their profile with other services, as one clinician commented, "I'm a face – so they will help us and we'll help them" (P1). Case conferences, organised by PIMH clinicians or other services, also assist collaborative care planning, as reported in the medical record below,

> Attended case conference [with Child Protection Services] … PIMHS to assess mum's [mental health] status … Outcome of this will determine plan. (MR003)

Collaborating with some adult mental health services has been achieved by attending their clinical handover meetings for "mutual clients" (P5). Inviting other teams to the PIMH intake or review meetings helped broaden the PIMH profile and clarify their role. Some clinicians have also facilitated peer support groups for other services and provided education sessions about their service and the importance of the perinatal period. A "consultation model" (P8) promotes collaboration as other professionals can discuss a client with a PIMH clinician. One PIMH manager referred to the history of the organisation, stating "we have long-standing relationships, we've always worked together really well" (P8).

Access to computers was seen as essential, as email is the preferred method of communication because it is "quicker … [and] you can … [contact] several services at once" (P1). Emails can also be placed in the medical record as "official documentation" (P1). Communication tools and the provision of feedback, especially to maternity services via the PCP, are keys to collaboration. Perinatal care plans are used as communication tools to other services, as one clinician described:

> It's primarily for the maternity … and child and family health [services], … it needs to be a fairly, … comprehensive management plan, so that …

> [other services] know what we're going to be doing and who's going to be doing it, … who's involved with the woman's care … [It also provides information about] the vulnerabilities … [for example] depression, anxiety, … dissociative episodes, … identification of what her triggers are, what it would look like if she's being triggered, and then … how the staff can help her manage that. (P5)

One maternity unit developed an alert system to prevent women who were clients of the PIMH service from getting "missed" (S1) as they transition from antenatal care to the birthing unit and onto postnatal care. This involves placing a card in the front of the inpatient medical record.

Joint home visits with other professionals also facilitate a higher level of communication between professionals and services for "multi-service clients" (P1). Working together promotes a shared understanding of the woman's needs as well as the woman's understanding of the roles of different services. Co-location is seen as another way of improving collaboration with other services, as described by both clinicians and managers:

> I think moving to where the other services are or being in close proximity to the other services, … provides … a much smoother type [of] service for communication (P4) [and has] helped PIMHS to be more integrated across mental health. (P3)

Theme 3: *Collaboration is hard work*

The interviews with clinicians and key stakeholders conveyed a sense that it is difficult and at times a struggle to collaborate with other services. Three sub-themes - *lack of role clarity*, *lack of support* and *tensions around sharing information* describe barriers to collaboration.

Sub-theme 1: *Lack of role clarity*

Despite the joint meetings and education sessions, barriers exist which prevent some services, especially adult mental health, from understanding the role of the PIMH team, as one clinician lamented:

> They [adult mental health] don't fully understand what it is we do … And that's not through lack of trying (laugh). I've been out there doing lots of in-service and lots of education and … it's going to continue, we'll just continue to roll out education, education, education … [to help them understand that] we're not just babysitters, we're not someone just holding these women's hand through the pregnancy period and … going for cups of tea … so … it's getting [them] to see … the integrity of the service that we actually offer. [Otherwise they keep] trying to refer clients to other services … during the perinatal period." (P5)

On the other hand, some key stakeholders believe that PIMH clinicians do not understand how maternity services operate. These participants indicated that, despite the distribution of the PCP, there were gaps in service delivery,

> A lot of [the women's] issues may well be around the birth, and the perinatal and infant mental health worker doesn't even know for six days if the woman's had a baby … I think "how is this possible? How do the midwives not know this woman's with that worker, or the worker's not there?" … and then the woman is coming to that most anxious time, and the support structures, it's then like, "I didn't know she'd had a baby" … If you don't understand the volume and … activity in that maternity ward, you'll never understand why a beautifully-written perinatal care plan doesn't even get sighted, unless a social worker somewhere gets involved. (S4)

There also appeared to be confusion about the PIMH clinicians' role in case management. Case management "varies with clinicians" (P1) and clinicians had different perceptions as to what case management involved. Not all clinicians see it as a main part of their role, as one clinician commented:

> I don't do … [case management] with everybody … I would prefer not to because I don't really see that as much as our role … we're kind of specialised to mental health service. There's a lot of people who probably do it better than I do. (P2)

The perception of others doing case management "better" was not shared by one key stakeholder who reflected,

> We've had situations where some PIMHS clinicians will go to the ward's social worker and ask for assistance around … housing or transport, and we don't particularly like that because, if you've worked with a client antenatally and you're going to keep seeing them postnatally … we think it's appropriate that they would … follow that up themselves, they're the primary clinician, … we support the worker in saying "why don't you try this?" We don't just say "go away" (laughs) … but we won't do it. (S2)

When women service-users are not involved in the collaborative process of referrals they often find the role of other professionals confusing,

> [PIMH clinician] referred us to [name of service] … to have something but I guess I don't really understand … I wasn't really sure what the [service] person was supposed to be doing so it was a bit confusing (laughs). (Tanya)

Sub-theme 2: *Lack of support*

Attending multidisciplinary meetings is seen as facilitating collaborative care, however this can only be achieved if the meeting is valued by all parties. One key stakeholder expressed frustration with a specific multidisciplinary meeting due to a perceived lack of support and commitment by PIMH, which had a negative impact on the effectiveness of the meeting,

> [PIMH] send people who aren't able to make the decisions … So we meet, make … a decision and then it's not until the next meeting three months later that they say, "oh no we didn't actually … like that". (S4)

Likewise, the multidisciplinary case reviews were seen as a good way of collaborating with other agencies however only one of the teams had services outside of the health sector attend and one key stakeholder commented, "We often get apologies … So that can be really frustrating" (S3). Key stakeholders also acknowledged a lack of support within their own maternity services as some managers do not appreciate the importance of the case review meetings,

> We've been trying to encourage them [the postnatal ward and birthing unit managers] to come [to the case review meetings] but they don't think it's necessary … [but] we'd like them to come because we think it is important that they know [the women] and so the care plans don't get missed. (S1)

Key stakeholders expressed concern that minimal feedback is provided to the midwives in the antenatal clinic after the case review meetings, especially in regard to the women's risk factors and referral pathways. Key stakeholders also believed that the midwives are not supported to care for women with complex needs and that more education about perinatal mental health is needed,

> It's the midwife who's left to support that woman through the pregnancy, either because they've *not* [stress on tape] consented to service, or they've disengaged from service, they've changed their mind, or there is no service … So how do we get all of that knowledge to midwives? (S3)

Another key stakeholder commented "a lot of [midwives] wouldn't have a clue who they are … they don't even know what PIMH means" (S3). It was, however, recognised that collaboration is two sided and that all parties have a role to play. For example, one key stakeholder commented that she did not know the new PIMH staff but then reflected, "I haven't gone over there, either … that's the other side of it as well" (S4). She continued that they had not sent different midwives to the case review meetings "for a while" (S4) which could also improve the collaborative process.

All PIMH clinicians felt well supported within the PIMH team, as one clinician stated, "I think the team is supportive enough that if I needed something more, I would be able to ask for it and I will approach my manager about that." (P3). No clinician, however mentioned feeling supported by other service providers.

Sub-theme 3: *Tensions around sharing information*

A lack of information sharing, particularly about child protection concerns, impairs collaboration. One key stakeholder described difficulties that she had experienced regarding a potential assumption of care, when an infant is removed from the mother and placed in foster care by child protection services:

> Social work is the lead clinician involved in child protection when there's assumptions of care on the ward … this happened quite recently, where a woman … was being case managed by PIMHS, and then suddenly Community Services turned up and … no one was available from PIMHS, so social work just had to jump in … It didn't actually end up being an assumption [of care], but we had to do this assessment, be there for a woman who we'd never met … So I guess that there's those issues around … trying to work well together and identifying mental health, troubleshoot, you know … where do the links happen? (S2)

As this key stakeholder explained, Social Work is the "lead agency" (S2) with regard to child protection issues and therefore need to know about any child protection concerns that other clinicians have.

Equally, tensions exist between child protection services and PIMH. Perinatal and infant mental health clinicians focus on "parenting capacity" (P2) and the nuances of the mother-infant relationship such as reflective capacity: "You're really excited because they mentioned the other day that their daughter might be upset about something" (P2). Whereas child protection services want the mother to demonstrate more tangible evidence of parenting capacity: "Their measures are so different and their case plan, for example, is a tick box of things someone needs to do" (P2). With different perceptions of parenting capacity sharing information is difficult.

Barriers to collaborative care are also experienced when clinicians believe that collaboration interferes with client confidentiality. One clinician explained that her role is to give the woman the skills to share what is needed, "rather than me necessarily getting involved" (P6). Another clinician concurred,

> You're only disclosing what the clients are comfortable for you to disclose as well … and some people expect more than what the client's comfortable [with] … that's not okay. (P7)

Some clinicians reported that they worked holistically and that referral to multiple services is not needed or "helpful for … [women] to see three services" (P2).

When collaboration did not work effectively women become "lost" to the service. This predominantly occurred after the birth, as one clinician stated:

> They'll come for maybe one or two sessions and then they don't come anymore. This is with the postnatal stuff. This is where the gap is. So we don't see them. Unless we're vigilant, unless we're looking every day to see if this lady's delivered, we don't get notified that they've delivered. So that's often the reason why there's been a big gap in between … They go home and they disappear". (P4)

Likewise, when collaboration is not effective at discharge and referrals do not proceed well, women service-users experience negative consequences,

> They tried to transition [me] into another service, and that has not been successful … not because of me, but because the other service just … keeps forgetting (chuckles) … It's very disappointing to me … I know I could ring the social worker, but …, you … get to a point now when they haven't called you … three times when they said they would, … I don't want to put myself out and call. I'm not comfortable with that now. (Patricia)

## Discussion

This paper reports the collaborative practices of two PIMH services from the perspective of PIMH clinicians and managers, key stakeholders, women service-users and documentation in medical records. The study findings contribute to the literature as few studies have reported professionals' experiences of collaboration with PIMH services. There is also a dearth of literature reporting women's experiences of PIMH services [22].

The participating PIMH clinicians reported that they collaborate with other service providers, value collaboration and believe that collaboration is important for women's care. Despite these positive viewpoints, most clinicians had difficulty expressing what collaboration was, except that it involves communication with other services. A lack of clarity about collaborative practice was also reflected in the medical record data and interviews with key stakeholders. The medical record data identifies that there is minimal contact between PIMH clinicians and other service providers about specific women in their care. When clinicians discussed collaboration they referred to various multidisciplinary meetings. Meetings are not generally documented in medical records; therefore the quantitising of this data was not possible. It does however highlight that collaboration regarding women's care is more general in nature, as discussed in regular case review meetings that are part of NSW Department of Health policy [32], rather than with a specific service provider about a specific woman.

However, the focus on meetings, by both the PIMH clinicians and key stakeholders, identifies the value of placing someone in the context of their work. Face to face meetings enhance communication, knowledge exchange and competence sharing and decrease the possibility of misunderstandings [33, 34]. Knowing the other service providers and developing a trusting relationship with them has been described as the "glue" that holds collaboration together [35]. If clinicians do not know each other trust is difficult to achieve [21].

The co-location of services has also been reported to improve collaboration as it increases informal communication opportunities, enhancing working relationships [36]. Others [11], do not believe that services need to be situated "under the same roof" for collaboration to occur. Professionals, however, do need to be networked with others. Networking does not happen in isolation but requires the support of management and the investment of time and resources [37].

The participating clinicians believed that collaboration had an element of "hard work" as it is time consuming and there are tensions around sharing information. Collaborating with some adult mental health services proves difficult at times due to a lack of understanding of the PIMH role. Clinicians who work in adult services often have difficulty understanding the nature of working with the mother-infant dyad and experience anxiety when working with infants [38, 19]. Also, clinicians in adult services may not have close working relationships with child protection services, which are needed in the perinatal setting [39]. For collaboration to be effective, professionals need to respect and understand each other's role and their skills [1]. This study has also identified the difficulty professionals have in collaborating within their own service, as described by midwives at both sites.

Joint training and professional development is one strategy that may assist collaboration and enhance understanding between services [13, 34]. An element of joint professional development was achieved by attendance at case review meetings and case conferences. The midwives in this study identified that they wanted additional support and training to assist them when working with families with complex needs. Other studies [40] have also reported that non-mental health professionals, especially midwives, want more education about mental ill-health.

Importantly, while the *Supporting Families Early Policy* [10] documents integrated and collaborative care it does not define or guide how this is to be achieved. Other authors [3] note that professional standards discuss concepts such as continuity of care, but do not elaborate how to achieve this. Clear guidelines also need to be documented and agreed upon by professionals who enact collaborative care, as well as the broader services to ensure all partners understand their roles and responsibilities [19]. Policies and guidelines help the collaborative process [41]: however, it is the application and "enactment" of collaboration which results in benefits to clients [36].

Lown and colleagues [4] argue that joint training is also needed to enhance person-centred care and shared decision-making between the client and professional/s. Professionals, therefore, need interpersonal and communication skills to not only collaborate with other professionals but also to involve clients and their carers in decisions that promote health and manage illness [4]. Indeed, clinicians in this study identified that women are best situated to inform other services about their needs and that the clinicians were available to support the women in this process.

Drawing on D'Amour and colleague's [20] "typology of collaboration" both PIMH services in this study can be classified as "developing collaboration". Documentation and formal communication tools mainly involve the PCP. Relationships are not stable as they are influenced by location and service changes. Trust is more theoretical than actual. Clinicians reported they value collaboration and believe they enact it; however the analyses identified that there is minimal collaboration between PIMH clinicians and managers and key stakeholders. The professionals, however, identified that collaboration could be improved to better meet the needs of women at risk of mental ill-health.

Interagency cooperation and collaboration and maintaining a family focus are not easy to achieve [42]. Comprehensive mental health care is complex in that it requires active collaboration between multiple players, different tiers of government, and a combination of professional and non-professional services [43]. Services that are more successful in applying collaboration and communication between services and families encourage the development of relationships and foster professionals who are empowered to support families and make decisions [42]. Clinicians also need to share information [44] and to refrain from acting as gatekeepers to other services.

The clinicians reported that their global role was to enhance the mother-infant relationship. This was achieved by working therapeutically with women [23], developing PCPs, and collaborating with other services, such as maternity and child protection. Paschetta and colleagues [45] identified six key areas of the PIMH role. These include empowering women, preventing relapse, developing care plans, child protection, referring to other services and liaising with maternity and other services. One striking difference identified between the results of this study and that of Paschetta and colleagues [45] is that the latter do not mention the mother-infant relationship which was emphasised by all of the PIMH clinicians in this study [23, 24].

The women service-users in this study had little to say about care received from other services. They appeared to only know their PIMH clinician [22] and were not aware of their 'case' being linked to other services. Data identified that the women had minimal contact with other services. When other services were involved, it appeared that the women had minimal involvement in the decision-making process, leading to confusion and disappointment.

While collaboration with other services is purported to be the gold standard in patient care, other authors [46] report that women in the perinatal period with severe mental illness prefer working with professionals from a small known team. Likewise, Twomey and colleagues [47] caution that collaboration with other services does not necessarily result in positive client outcomes, particularly for families who have multiple challenges. The involvement of numerous services can lead to duplication and conflicting information with minimal awareness of the complex needs of the family members. This can place additional stress on vulnerable individuals and families who may feel they have minimal control over their lives and a perceived need to satisfy service providers [47]. Service-users, however, have reported positive aspects of collaboration due to perceived dependability of staff, flexibility when their needs change and increased communication with other services [36]. Collaboration promotes continuity and seamless care, supporting women as they transition from one service to another. It also protects women from having to retell their story to multiple professionals. Many women report that they want continuity of care [40] as they are reluctant to retell their personal stories, especially women who have experienced past trauma [22].

## Strengths and limitations

There are few studies in the literature which report the collaborative practices of PIMH services. Specifically, this study has identified that professionals value collaboration, however the level of enactment is incongruous between data sets. This study has also identified that women service-users had minimal involvement in the collaborative process, resulting in negative experiences. Despite these strengths, the study has limitations in that a small number of professionals and women service-users were interviewed. Only key stakeholders who were involved in the woman's antenatal care were interviewed. Women service-users were interviewed up to six months post discharge from the PIMH service which may have had a negative impact on recall.

### Implications for clinical practice

Integration and collaboration is increasingly being written into health policies. Without clear guidelines, limited understanding as to what collaboration means or how it should be enacted persists. Professionals believe that collaboration is essential for women with complex needs. Perinatal and infant mental health clinicians are skilled at building relationships with women, however further support is needed to build trusting relationships with other professionals and services. Additional resources would also assist services to move along the continuum from potential or developing collaboration to active collaboration [20]. Importantly, collaboration needs to include women and families to enhance person-centred care and shared decision-making so that women with complex needs can become equal partners in their care.

## Conclusion

The aim of this paper was to report the collaborative practices between PIMH clinicians and other service providers from the perspective of PIMH clinicians and managers, key stakeholders, women service-users and documentation in medical records. Although the PIMH clinicians perceived that they collaborated well with other service providers, this was not substantiated by the key stakeholders or documentation in the medical records. All participants identified the importance of and mechanisms for collaborative practice, however challenges persist which prevent active collaboration being enacted. Electronic forms of communication were time efficient, however face to face meetings were valued by all participants to build relationships with colleagues and enhance collaboration. Enhanced collaboration would also help prevent confusion and disappointment for women when transitioning to other service providers.

### Competing interests

The authors declare that they have no competing interests.

### Authors' contributions

All authors were involved in the study design. KM collected and analysed all data, and drafted the manuscript. VS, MJ and MC were involved in manuscript revisions and supervision. All authors read and approved the final manuscript.

### Acknowledgements

The authors acknowledge and thank the women and the professionals who generously gave their time to participate in this study as well as the support provided to KM by an Australian postgraduate award.

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Received: 14 May 2014 Accepted: 24 July 2015

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## 6.2 Conclusion

In Chapter Six, I have presented the findings of this mixed methods study as a published paper, "*A mixed methods study of collaboration between perinatal and infant mental health clinicians and other service providers: Do they sit in silos?"* The collaborative practices of the PIMH clinicians have been described from the perspectives of the PIMH clinicians and the key stakeholders. Chapter Seven includes the final published paper, "*'My special time': Australian women's experiences of accessing a perinatal and infant mental health service*".

# CHAPTER 7: **'MY SPECIAL TIME': AUSTRALIAN WOMEN'S EXPERIENCES OF ACCESSING A SPECIALIST PERINATAL AND MENTAL HEALTH SERVICE**

Myors, K.A., Schmied. V., Johnson, M. & Cleary, M. (2014). 'My special time': Australian women's experiences of accessing a specialist perinatal and infant mental health service. *Health and Social Care in the Community*, *22* (3), 268-277. DOI:10.1111/hsc.12079

## 7.1 Publication: Relevance to thesis

Chapter Seven includes the published paper, "*'My special time': Australian women's experiences of accessing a specialist perinatal and infant mental health service*". This paper describes the experiences of the 11 women interviewed who engaged with one of the specialist PIMH services.

Health and Social Care in the community

Health and Social Care in the Community (2014) **22**(3), 268–277 doi: 10.1111/hsc.12079

# 'My special time': Australian women's experiences of accessing a specialist perinatal and infant mental health service

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Accepted for publication 12 September 2013

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### What is known about this topic

- The mental health of women during the perinatal period is associated with the health and development of their infants.
- An infant's attachment to his or her primary carer (usually the mother) plays a significant part in child social and emotional development.
- Little has been documented about women's experiences of specialist PIMH services.

### What this paper adds

- The importance of a trusting relationship between a woman and a PIMH clinician is an essential base from which to deliver therapeutic interventions and services.
- Discontinuing a service when women still need support can be potentially devastating and long-lasting.
- Clinicians modelling a secure attachment base for mothers to take and emulate to their infants is new and needs further research.

## Abstract

Women who have few social supports, poor health and a history of stressful life events are at risk of poor mental health during the perinatal period. Infants of parents whose parenting capacity is compromised are also at risk of adverse outcomes. Specifically, poor perinatal mental health can impact maternal–infant attachment. To identify women at risk of poor perinatal mental health, psychosocial assessment and depression screening in the antenatal and early postnatal periods are recommended. This qualitative study is part of a larger mixed methods study, which explored two specialist perinatal and infant mental health (PIMH) services in New South Wales (Australia). Eleven women who had accessed and been discharged from a PIMH service participated in either face-to-face or telephone interviews. Data were transcribed verbatim and analysed thematically. One overarching theme, 'my special time' and three sub-themes, 'there is someone out there for me', 'it wasn't just a job' and 'swimming or stranded: feelings about leaving the service', were identified. The themes describe the women's experiences of being a client of a PIMH service. Overall, women reported a positive experience of the service, their relationship with the clinician being a key component. Findings from this study highlight the importance of the relational aspect of care and support; however, women need self-determination in all therapeutic processes, including discharge, if recovery and self-efficacy as a mother are to be gained. Importantly, further research is needed about how clinicians model a secure base and how mothers emulate this for their infants.

**Keywords:** attachment, perinatal and infant mental health, psychosocial, qualitative research, relationship/s, secure base, women

## Introduction

The importance of supporting the physical, psychosocial and emotional health of the mother and infant during the perinatal period, defined here as the period from pregnancy to 12 months after birth (Austin *et al.* 2008), has gained increased recognition in the past decade. Being a new mother can be challenging for many women (Hollins 2007), let alone those women who are mothering with additional physical or psychosocial needs (Montgomery *et al.* 2012). Perinatal anxiety and depression, stressful life events and poor social health are associated with adverse outcomes for women (Yelland *et al.* 2010), their children (Huntsman 2008) and their families (Edge *et al.* 2004).

In response to this growing evidence, routine mental healthcare in the form of psychosocial assessment and depression screening has been integrated into mainstream maternity and child health services in New South Wales (NSW) Australia over the past decade to identify women experiencing or at risk of poor perinatal mental health outcomes (Austin *et al.* 2012). Effective referral pathways are essential (Austin *et al.* 2007) and as a result, specialist perinatal and infant mental health (PIMH) services have been introduced in some areas (New South Wales Department of Health 2009). To date, no studies have reported the effectiveness of these services or the experience of women. The aim of this paper is to report on women's experiences of accessing the support of specialist PIMH services.

## Background

Extensive literature documents the pleasurable, yet overwhelming, nature of the transition to motherhood (e.g. Kearns *et al.* 1997, Nystrom & Ohrling 2004, Lutz *et al.* 2009). High numbers of women report distress and anxiety either in pregnancy or after the birth of their baby and between 10% and 20% of women report depressive symptoms in the first 12 months following birth (Buist & Bilszta 2005, Dennis & Chung-Lee 2006). For women who have experienced or are experiencing mental health problems and/or significant life stresses, such as the death of a close relative, a previous pregnancy loss or are pregnant with an unplanned or unwanted child (Raatikainen *et al.* 2007, Bilszta *et al.* 2008, Goldberg 2008), the transition can be more difficult with risk of self-harm, poor physical health, breakdown of relationships, social withdrawal, unhappiness in the maternal role and for some, less capacity to nurture their infant (Buist & Bilszta 2005, Milgrom *et al.* 2006, Sayil *et al.* 2006). Social support has also been found to impact maternal–foetal attachment with the absence of support attributed to a lack of attachment behaviours during pregnancy (Alhusen *et al.* 2012).

It is well known that children who live in families where parental functioning is compromised are at a greater risk of adverse outcomes during infancy and later in life (Buist & Bilszta 2005, Macomber 2006), as parenting capacity and the parent–child relationship have a direct impact on infant well-being (Waylen & Stewart-Brown 2009). An infant's attachment relationship with his or her primary carer, usually the mother, plays a significant part in the development of the child's behaviour (Fearon *et al.* 2010). Infant attachment refers to an infant's response to his/her primary carers. Secure attachment occurs when an infant is able to explore his/her surroundings but is also able to return to the carer when support and reassurance are needed (Ainsworth *et al.* 1978). An insecure attachment develops when an infant is unsure of his/her primary carer's response after previous attempts for proximity have been rejected, discouraged or responded to inconsistently (Fearon *et al.* 2010).

Poor health and psychosocial stress, however, can impact how women view themselves as mothers and how they relate to their infants. Studies of women who are mothers with a mental health problem (Montgomery *et al.* 2006, Davies & Allen 2007), with eating disorders (Tuval-Mashiachi *et al.* 2013) and infected with HIV (Wilson 2007) report challenges with regard to the societal contradictions of being a 'good mother' and the stigma of their illness. Despite these challenges, a review of qualitative research of women who had their mothering experience disrupted by illness reported that women viewed themselves first as a mother and second as a patient and were committed to present themselves as 'good mothers' (Vallido *et al.* 2010). As parenting is a 'positive role' within society, mothers of dependent children need support to balance the dichotomy of having an illness and motherhood (Mowbray *et al.* 2001).

Prevention and early intervention programmes that support women to develop secure attachments with their infants are warranted for long-term child development (Fearon *et al.* 2010). Building upon *The National Action Plan for Perinatal Mental Health* (*beyondblue* 2008), NSW Department of Health (DOH) developed a framework of promotion, prevention, early intervention and treatment for mothers, infants and their families by integrating psychosocial assessment and depression screening with routine physical care during the perinatal period. Women who are identified with multiple psychosocial stressors, for example, living in unstable housing or with an unemployed partner, experiencing intimate partner violence or maternal mental health problems or maternal substance misuse, are referred to multidisciplinary meetings where pathways to care are discussed (New South Wales Department of Health 2009). One of these pathways is referral to a specialist PIMH service. Specialist PIMH services in NSW provide care co-ordination and therapeutic interventions. In most instances, they are staffed by nurses, psychologists, social workers and psychiatrists. Many of these clinicians have also undertaken specialist training in infant mental health and/or attachment-based programmes such as the Circle of Security (Marvin *et al.* 2002).

A number of studies, however, report that women are often reluctant to seek mental health services for a range of reasons such as perceived stigma of mental health problems (Livingston & Boyd 2010), reticence to disclose experiences such as abuse (Walsh 2008), lack of trust of health professionals (Goldberg 2008) and perceived low quality and usefulness of service (Chisholm *et al.* 2004). Studies of service use by women experiencing perinatal mental ill-health or psychosocial concerns have focused on women who are using substances (Sword *et al.* 2009, Lefebvre *et al.* 2010), women receiving support from home-visiting programmes (Paton *et al.* 2013) and young parents (Mills *et al.* 2012a). While these studies report positive experiences, none of these, however, specifically addresses women using a PIMH services and their impact on the mothering role.

## Methods

The qualitative data generated for this paper are part of a larger mixed methods study (Creswell & Plano Clark 2011) exploring specialist PIMH services in NSW Australia. Data were collected during 2011 and 2012 by reviewing 244 medical records of women who had been referred to two PIMH services, interviewing 13 health professionals and interviewing 11 women service users. The research question addressed in this paper is: how do women interpret and experience specialist PIMH services? Other companion papers for this mixed methods study are currently in preparation.

### Participants and recruitment

Ethical approval was obtained from the human research ethics committees of the university and the relevant area health services. To avoid potentially compromising any therapeutic interventions, only women who had been discharged or were close to being discharged from the PIMH services were approached to participate in the study. Initial recruitment was by the service managers sending a letter to women who had been discharged within the past 6 months. Forty-five letters were sent with one response. An ethics amendment was completed for a revised recruitment strategy where the PIMH clinicians informed women about the study prior to discharge. Interested women completed a consent to contact form.

### Data collection

All participants completed a consent form and were informed verbally and in writing that they could withdraw from the study at any time. The interviews were facilitated by an interview guide (see Box 1), digitally recorded and transcribed verbatim. Eight interviews were conducted at the women's family home and three over the telephone and none lasted more than 40 minutes. At completion of the interviews, the women were either given or posted a gift voucher of AU $20.00 to thank them for their time.

### Data analysis

Data were analysed thematically using a four-step process of data immersion, data coding, creation of categories and identification of themes (Green *et al.* 2007). Thematic analysis is an iterative process of moving back and forth through the steps to test the fit of ideas and ask new questions of the data (Green *et al.* 2007). Data immersion involved listening to the digital recordings and making corrections to the transcripts, then reading and re-reading the transcripts. Codes such as 'desperation', 'hesitation' and 'relief' were identified, which led to the development of categories such as 'needing help'. Themes such as 'there is someone out there for me' were finally generated. The generation of a theme is an active process and the inclusion of a theme depends upon its relationship with the overall research question (Braun & Clarke 2006). Through the process of inductive analysis (Braun & Clarke 2006), the themes fell into the

**Box 1** Interview guide

Describe your initial feeling/reaction when you were asked about being referred to a specialist PIMH service
What happened after your initial referral to the PIMH service, e.g. how long did you have to wait to be contacted? What was this like for you?
Tell me about your experience with the service – what were the best and the less positive things for you?
Did you have contact with the same person from the service? If not, would you have preferred to have had contact with mainly one person? How many people from the service were in contact with you?
Where did you usually meet, e.g. at home, at a health centre, in a public area, main contact over the phone? What was your preferred venue?
What did the clinician provide for you – any particular treatment or services, e.g. review with psychiatrist, medication management, videotaping, education about child development?
Were you involved with other services at the same time? If so, what was helpful or less helpful about these other services?
Looking back, what was your overall experience?
Is there anything else you would like to add?

sequence of the women recognising that they needed help, the women's experience of the service and then their discharge.

To promote rigour and trustworthiness, the initial analysis of the data was undertaken by KM. This was reviewed by VS and then discussed and confirmed by all authors. Reflexivity also promotes rigour, particularly when populations that have complex needs are involved (de Laine 1997). Constant reviewing and reflection (Emerson 2001) with a critical lens (Finlay & Gough 2003) promote the researcher's awareness of his/her own thoughts and feelings and how this may impact the analysis (Maijala *et al.* 2005). As such, it is important to acknowledge that KM previously worked as a PIMH clinician; however; through ongoing reflection and discussion with the co-authors, the analyses have remained faithful to the experiences of the participants.

## Findings

### Profile of the women

Eleven women participated in interviews. Seven of the women were referred to the PIMH service by the midwives in the antenatal clinic, two women self-referred antenatally, one woman was referred by the practice nurse in the general practice clinic antenatally and one woman was referred by the mental health crisis team postnatally. The women were aged between 20 and 39 years and were identified as having multiple mental health and psychosocial issues. All the women were partnered at the time of referral. One woman experienced a relationship breakdown during her time with the PIMH service. Nine women were from an English-speaking background. The women were with the service from 27 to 121 weeks, with three of the women being previous PIMH clients (see Table 1). All of the women in this study were supported by a female clinician.

### Themes

One overarching theme, 'my special time' and three sub-themes, 'there is someone out there for me', 'it wasn't just a job' and 'swimming or stranded: feelings about leaving the service', were drawn from the data. The overarching theme describes the women's experience of being a client of a PIMH service. The sub-themes describe the women's journey and how they perceived the support they received from the clinicians and the service. The following section reports on the themes with illustrative quotes taken from the participants. In some instances, additional wording has been made in square brackets to aid interpretation. Pseudonyms have been used to protect the identity of the participants.

#### *Overarching theme: 'my special time'*

The women spoke openly about their experience and were overwhelmingly positive about the support they received from 'their' clinician during the time they were a client of the PIMH service. They described the service as a 'life line', questioning how they would have 'coped' without it.

Women reported that the clinician's interest and the time they gave meant that they could rely upon the clinician for support. This was important, as many of the women were socially isolated and had experienced traumatic past events. Women also reported gaining 'confidence' in themselves, as mothers and in particular, in the ability to 'ask for help' in future.

Others spoke about a quicker recovery from the birth and a sense of being 'fixed' after a telephone conversation with the clinician. This fix was described as, 'taking Panadol for pain relief', what you take when you need all encompassing support as a parent. This did not mean that the service was a quick fix, but that it helped to address the problems that the women were experiencing at the time. As the relationship developed, women described the clinicians being 'all for me' and viewed these sessions as 'my special time'.

The following sub-themes reflect the women's journey with the PIMH service, from referral to discharge.

#### *Subtheme: 'there is someone out there for me'*

Before being referred to the PIMH service, women felt isolated and alone with their feelings, that no one would be able to support them with their 'problems'. Some women were 'feeling quite desperate' to get 'help' as Nancy describes before her self-referral:

> …I did that questionnaire, where you grade how you're feeling …, and was given the package and the perinatal mental health pamphlet was in there. And I hung onto it because this was my third pregnancy and I did suffer from postnatal depression with my first child … things were getting on top of me, … I was feeling quite … overwhelmed by everything that was happening around me and it was going on for a couple of months …, I felt that I was losing control of my emotions when I was about 5 months pregnant …, I had a lot of anger and not able to deal with my eldest son's behaviour … I went back to when I had the postnatal depression after I had him …, I had a lot of images in my head of like, … just throwing someone against the room or something like that, … I've never, ever done that, but just having those thoughts in my head are quite scary …, they were coming back …, regarding

**Table 1** Characteristics of the women

| Pseudonym | Age | English or non-English speaking background | No. of children | Risk factors identified by referrer | Previous PIMH client | Time with PIMH (weeks) for last referral |
|---|---|---|---|---|---|---|
| Mary | 39 | NESB | 4 | Current: depression, postnatal depression (PND)<br>Past: PND | No | 47 |
| Nancy | 33 | ESB | 3 | Current: maternal disability/chronic illness<br>Past: PND, anxiety, childhood abuse/neglect | No | 121 |
| Cathie | 33 | ESB | 1 | Current: anxiety, relationship issues, poor support network<br>Past: depression, thoughts of deliberate self-harm (DSH) | No | 40 |
| Melissa | 27 | ESB | 3 | Current: PND, anxiety, child with a disability/chronic illness<br>Past: PND | Yes | 78 |
| Sharon | 33 | ESB | 2 | Current: high antenatal Edinburgh Depression Scale (EDS), depression, anxiety<br>Past: high antenatal EDS, PND, depression, anxiety | Yes | 37 |
| Tabitha | 32 | ESB | 2 | Current: depression, anxiety<br>Past: PND, depression, anxiety | No | 94 |
| Andrea | 33 | NESB | 4 | Current: high antenatal EDS, anxiety, poor support network<br>Past: PND | No | 66 |
| Carol | 20 | ESB | 3 | Current: anxiety, relationship issues, mental health problem<br>Past: high antenatal EDS, PND, depression, anxiety, relationship issues, adult sexual assault, childhood abuse/neglect, DSH, maternal substance use, intimate partner violence, child protection issues | Yes | 73 |
| Patricia | 24 | ESB | 4 | Current: high antenatal EDS, anxiety, mental health problem, relationship issues, poor support network, financial stress<br>Past: PND, depression, anxiety, mental health problem, neonatal death, DSH, suicide ideation | No | 56 |
| Tanya | 35 | ESB | 2 | Current: high antenatal EDS, depression, anxiety, financial stress<br>Past: PND, mental health problem, childhood abuse/neglect | No | 94 |
| Sarah | 23 | ESB | 2 | Current: high antenatal EDS, depression, relationship issues, diagnosed mental health problems<br>Past: depression, childhood abuse/neglect | No | 27 |

PIMH, perinatal and infant mental health; NESB, English-speaking background; ESB, English-speaking background.

> around him and …, I didn't want to open up to anyone and tell, … family or friends about that because, … [of] the whole judgement and criticism and 1 day, and I'll never forget it, it would've been about ten to five …, the service was closing and I just rang up and was like 'I really need some help', and they called me straight back the next day … (M)y clinical nurse … immediately started seeing me within a week because they … could see how desperate I was for some help…. (Nancy)

Despite the negative images and feelings of desperateness, Nancy hesitated contacting the PIMH service as she left the phone call until late in the afternoon. These ambivalent feelings were also expressed by other women; however, the feeling of 'relief' was greater and this prompted the women to accept the service and receive support. The fact that the PIMH service is voluntary was a comfort for some women and helped them to feel that they were still in control.

Three women reported previous negative experiences either with a counselling service or with another health service and were quite 'stressed' at the thought of a referral. One woman had been referred to one of the PIMH services during a previous pregnancy, but the service never contacted her so she was not confident that the more recent referral would have a positive outcome. For Sarah, however, the actual referral process was quite confronting and she felt completely out of control during the process:

> I didn't want to be there in the room at that certain point in time. So I wasn't expecting it [the referral] … because the lady just came into the room … and then just goes 'ok, because of your results, I'm here to talk to you' … so I felt kind of bombarded … It was certainly in the antenatal clinic and they get you to do that test. So I did that and then all of a sudden, this lady was in there and I was just like 'who the hell are you?' (laughs) … I can't remember exactly how it happened. But then all of a sudden, there

> were two in the room and just me sitting in the corner (laughs). It was very intimidating … Then all of a sudden she goes 'oh, we'll get a few people to ring you to see if you want help', blah-blah-blah … I didn't think much of it, I just wanted to get out of the room and then I left. (Sarah)

Sarah's experience demonstrates the need for clinicians to be sensitive during screening processes, to be open and provide support, so as not to deter women from help seeking in future.

### *Subtheme: 'it wasn't just a job'*

As the relationship between the women and the clinicians developed, the women reflected that 'it wasn't just a job' for the clinicians as they 'did everything' the women needed. Some women stated that they just 'clicked' or 'gelled' with their clinician due to the clinician's 'personality' as Cathie describes:

> …she was a very gentle person. It was a kind of softness, it wasn't harsh … she listened and she asked … the right questions … there was something in her approach that made me feel that I could open up to her … and feel comfortable doing it…. (Cathie)

For others, the development of 'rapport' and 'trust' had to be 'earned'. This was a process based upon consistency, flexibility, reliability, confidentiality and a sense of maintaining control. Once the women felt secure and trust had been gained, having a 'one-on-one relationship' meant that the women felt 'comfortable' and 'safe', 'to talk to her about things, it was safe, it just felt really safe and comfortable to open up…. (Melissa)'

This feeling of safety was promoted by continuity of care. It was important that the clinician

> …knew my background and my history … I didn't want to have to relay or bring up anything from the past that I shouldn't have had to as things went on further. (Sharon)

All of the women were adamant that without continuity of clinician, they would not have continued with the service as they did not want to repeat their stories.

The women acknowledged that the clinicians were not just like a 'friend', but had specific skills such as the ability to 'really listen', were understanding, non-judgemental and had specific knowledge. Advocacy was also important as women felt that they could not always speak up for themselves, especially when talking to other professionals:

> She made sure that the pregnancy went smoothly, everything that I wanted happened. She talked to the doctors, if they wouldn't give me an answer, she found it. Then after the pregnancy, she was there because I wasn't coping very well. (Sarah)

### *Subtheme: 'swimming or stranded: feelings about leaving the service'*

While all of the women talked positively about 'their' clinician and their time with the PIMH service, discharge was a difficult process for some women. For the women who initiated the process, they felt 'confident' that they 'wouldn't fall apart' as Cathie describes:

> …being the one to be able to cope … being able to say, 'alright, I can swim' … makes it easier to make that … departure from the service, if it's on your terms, when you're ready … jump in the deep water. (Cathie)

The women who 'weren't ready' to be discharged felt 'gutted', 'extremely anxious' and 'stressed'. These women were aware that it 'was a timed decision' that is, the service was developed to support women from the antenatal period until the infant's first birthday. Some women reported that the clinician 'pushed' to keep the service going, however, questioned the process. Patricia was not ready to be discharged from the service, but because her infant was 12 months old and due to the capacity of the team, the discharge had to proceed:

> …what do you do with someone who still needs your help? … for some people who don't need help, their baby's born and they're coping ok and that's good … but for people that turn out to be a more long-term issue, there's nothing. You either get put deep into the mental health system … – which I don't find is the best system – or … you get left feeling a bit stranded and not sure where to turn, and even the workers themselves, they weren't sure what the next step could be … they had to work hard to find an appropriate service to attach me to and even then it hasn't come through … it's a bit of a shame that there's not a better system around that at the end. (Patricia)

Patricia had had a previous negative experience with a mental health service and therefore was hesitant at being referred to another service. The service that she was referred to did not follow up the referral so she felt quite 'stranded' and disappointed at the end, placing a scar on the 'special time' she had experienced.

## Discussion

This qualitative study has explored women's experiences of the support provided by a specialist PIMH service. The study's findings contribute to the existing literature as few studies have reported on women's experiences of mental health services during the perinatal period (Myors *et al.* 2013). The women in this study were mainly positive about the support they received, specifically the close relationship they developed with 'their' clinician, which enabled personal growth as individuals and as mothers. While only a few of the women reported negative experiences with the service, the impact of these was potentially devastating and long-lasting as they pertained to the discontinuation of the service when the women were still needing support.

Many of the women in this study spoke about feeling desperate and alone, unsure if help was available, before their referral to the PIMH service. Despite these feelings, they were also hesitant about seeking or accepting help. For three of the women, this was directly related to past negative experiences, which highlight the impact that health professionals can have in promoting or disenfranchising women from help-seeking behaviours (Dennis & Chung-Lee 2006). Other studies (e.g. Sword *et al.* 2008, Bilszta *et al.* 2010) also report that women experiencing perinatal distress recognise the need for help but are ambivalent about seeking help due to the stigma of mental health problems and being labelled as an 'unfit mother'.

Despite potential risks perceived by women, many are willing to engage in specialist perinatal programmes (Jack *et al.* 2005). While some of the women in this study reported to 'click' easily with the clinician, others spoke about a longer process. Relational models of care are promoted, especially for women with complex support needs, as they focus on the woman and her experience, rather than a prescribed issue, which promotes trust (Fels Smyth *et al.* 2006, Mills *et al.* 2012b). Services and professionals who promote the attainment of trust are more likely to engage with parents and families (Katz & Hetherington 2006, Lazear *et al.* 2008). Trust also promotes a woman's propensity to seek help from health and other professionals and subsequently engage in services (Dennis & Chung-Lee 2006). Likewise, women who feel comfortable and secure with consistent, non-judgemental professionals and have flexibility with frequency and length of appointments are more likely to return for follow-up (Hall & van Teijlingen 2006, Lefebvre *et al.* 2010). Therefore, clinicians who provide relational support to women experiencing perinatal disorders can assist them to recover and gain self-efficacy as a mother (Montgomery *et al.* 2012). Jack *et al.* (2005) describe a theory of maternal engagement where women overcome fear, build trust and seek connection to negotiate a home-visiting programme. These themes echo the findings in this study where the women overcame their hesitancy to accept help and developed a strong connection with their clinician.

In addition to the relational qualities of the clinicians, the women spoke about specific skills that the clinicians had, which were different from being 'friends'. These skills included the ability to listen, be understanding and non-judgemental and having specific knowledge (Davis *et al.* 2002). The authors note, however, that it is not just the skills but how they are used that can increase the chance of behaviour change (Henderson 2009–10, Eronen *et al.* 2010), especially in relation to parenting capacity (Eronen *et al.* 2010, Rossiter *et al.* 2011). One of the skills that a number of the women spoke about was the ability of the clinician to advocate for them. Advocacy is needed as women at risk of perinatal mental health problems often have poor support networks, which increase their vulnerability (Lagan *et al.* 2009). Nurses and other health professionals have a role to play in advocating for women's rights, challenging existing policies and advocating for change (Benbow *et al.* 2011). Advocacy and support also promote empowerment as women's self-efficacy and self-confidence increase to enable them to make decisions for themselves (Aziz *et al.* 2011).

Many of the women in this study had experienced traumatic life events. Despite this, women reported that over time they felt 'safe' to disclose their personal stories with 'their' clinician. As many of the clinicians were trained in attachment-based programmes, the 'safe' feeling the women expressed could be their experience of a 'haven of safety' (Bowlby 1958, p. 369). As described in attachment theory (Ainsworth *et al.* 1978), this 'haven' or 'secure base' may have allowed the women to explore and work through personal issues, which enabled them to gain 'confidence' in themselves and also in their parenting.

While this study did not focus on the screening process, the experience of one of the women in this study demonstrates the need for professionals to be sensitive during screening processes. A recent study that examined health professionals' and women's experience of psychosocial assessment and depression screening reported that midwives demonstrated a high level of skill; however, at times, midwives were not supportive, but directive and focused on the task (Rollans *et al.* 2013). For women who had experienced trauma or stressful life events, disclosing and talking about their mental health at their first visit in pregnancy were distressing (Rollans *et al.* 2013).

The findings highlight the positive experiences that women gain from accepting support from specialist PIMH services. However, for benefits to be achieved, these specialist services need the resources and commitment from management and clinicians alike to be able to provide long-term continuity of care (Katz & Hetherington 2006), as women are reluctant to engage in services where they have to continually retell their personal stories. Likewise, the duration of services needs to be flexible (Johns *et al.* 2009), be able to provide stability and a 'secure base'. The current study also identified that when services cease prematurely, before a woman is ready to disengage, women feel 'stranded', which may contribute to their further isolation and marginalisation. Professionals need to work collaboratively with other services and professionals to prevent disenfranchisement from health and other support services (Dawson *et al.* 2013, Myors *et al.* 2013) and thereby undo the positive gains that have been achieved.

Generalising these findings to other settings warrants caution due to the small convenience sample from only two sites in NSW. Also, the women who participated may have had more positive experiences and therefore not be representative of all women who have accessed the support of a PIMH service. Recall of the women may have also differed between those who were more recently discharged and those discharged for longer periods. Also, as KM had worked as a PIMH clinician, this may have influenced in both positive and negative ways the data that were collected. However, this study is an important addition to the literature as it has been able to engage women who have complex needs and report on their experiences of a specific health service.

## Conclusion

Nurses and other health professionals have a pivotal role in supporting women at risk of poor perinatal mental health. The findings from this study indicate that women who have complex support needs are not only hesitant but also willing to engage with services. It also points to the need for professionals who work with women with complex needs to not only have relational and other professional skills but also the ability to provide a 'secure base'. The importance of developing a therapeutic relationship is well documented; however, less is known about clinicians providing a secure attachment base that is not part of a prescribed programme. Many of the clinicians from the two PIMH services were trained in attachment-based interventions; however, the direct impact of this on women needs further investigation.

## Acknowledgements

The authors acknowledge and thank the women who generously participated in this study, as well as the services and staff who assisted with recruitment. The authors also thank the reviewers for their constructive feedback, which assisted in shaping the final draft of this paper.

## Conflicts of interest

None.

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## 7.2 Conclusion

In Chapter Seven, I have presented the last published paper in this thesis, "*'My special time': Australian women's experiences of accessing a specialist perinatal and infant mental health service*". In this paper I described the experiences of women who were identified as being at risk of poor perinatal mental health outcomes, and who engaged with a specialist PIMH service. This is an important paper as it adds to the scant literature that reports women's experiences of mental health services. In Chapter Eight, I will present the final findings chapter and report the PIMH clinicians' experiences of working in a specialist PIMH service.

# CHAPTER 8: **"TO BE HELD": CLINICIANS' EXPERIENCES OF WORKING IN A PERINATAL AND INFANT MENTAL HEALTH SERVICE**

## Introduction

During the interviews the clinicians reflected on what it meant to them to work in a specialist PIMH service. In this chapter, I report the findings of the thematic analysis of the PIMH clinicians' interview data related to their experiences of working in a specialist PIMH service.

One main theme, "To be held" and four sub-themes, "Emotionally challenging work", "Holding myself", "Support from colleagues and management", and "I love my work" have been identified. The main theme, "To be held" describes the support that the clinicians report that they need, framed within Attachment Theory. The first sub-theme reports how the clinicians perceive their work and why they need support. The second and third sub-themes describe the types of support that the clinicians identified that they need. The fourth sub-theme describes how clinicians experience their work when they feel supported.

The clinicians described the women they worked with as being “vulnerable”, because they are “pregnant" and are at risk of mental ill-health. The clinicians' therefore see the PIMH service as a specialist "early intervention, prevention ... [service to] ... give the baby the best outcome [possible]" (P2). As described in Chapter Five, the clinicians have identified that their main role is to promote a positive mother-infant relationship and specifically a “secure attachment” (P2) between the infant and the mother. As one clinician described,

> [Supporting the women] in such a way that their mental health can be ... in such a place, … that they have the best relationship that they can possibly have with their infant. (P5)

The clinicians acknowledged that it is often difficult for women with risk factors to “engage with you, [as it] is a huge leap of faith for them ..." (P6). This is particularly so for many women who have had previous negative experiences with health services, as described by one clinician:

> [Many women are] service-jaded and suspicious ... they're so used to ... having something very quick, and brief, and then being sort of spat out and sent on their way. (P7)

### *To Be Held*

The clinicians spoke openly about their role, and were overwhelmingly positive about working in the PIMH service, as one clinician stated, "I love it! I love the work, I really love what I do with the women, and I really love seeing the results" (P5). However, to support the women and families, the clinicians recognised they need support emotionally from colleagues, from management, in clinical supervision, and with resources. As one clinician described,

> You have to attend to your own emotional experience before you can ... work with other people properly and effectively ... [Because we] deal with some really complex families … you need to be held yourself. (P3)

#### *Emotionally challenging work*

Clinicians described their work as being emotionally challenging and therefore they need "to be held" emotionally themselves. The emotional challenges were described in the context of mothers being unable to make the changes needed to develop a positive relationship with their infant, as one clinician reported,

> Some parents just can’t do it, and that’s heartbreaking, they can’t get to be good enough ... So that’s always hard, because you know that they want to ... (P7)

Clinicians also find it emotionally challenging when they have to juggle the competing needs of both the mother and the infant, as one clinician described, "[managing the] two agendas ... [of the] mother's perspective and the baby's [which are at times] in conflict with each other" (P2). Clinicians also reported the emotional challenges of listening to mothers describe their infants in negative terms and the harsh discipline the mothers sometimes use,

> It can be very painful hearing the awful side of humanity, terrible things that people go through and terrible things that they're also capable of doing, and that's never fun (P2).

One clinician described an incident and the impact on her:

> Hearing a mother in the last couple of weeks, who's very frustrated with her daughter's inability to go to sleep on her own, so she's using fairly harsh punishment around her daughter ... at one stage she was putting her outside, ... because she keeps getting up, she's three, ... she was being punished for that. It was incredibly difficult to have to hear and to think about how you can help her to see things differently because as annoying as that little girl might be being to her mum, she's got a need that she's trying to express for whatever reason, it's very unsafe or scary for her to go to sleep at the moment. (P2)

At times, clinicians feel helpless because some infants and children are living in unsafe home environments despite the support that they try to give to mothers. Perinatal and infant mental health clinicians are mandated to report child protection concerns to statutory child protection services, however a child protection report does not always lead to any action, as one clinician explained:

> You can see that they're not getting there, and there’s no action from the family and [child protection services] … it's that helplessness … that’s probably familiar to lots of people … to have to walk out of a home, and leave children in something that’s not safe, because nobody else is doing anything about it ... and it’s not our job to do something about it, apart from tell people. (P7)

The clinicians also reported positive emotions from their work as they witnessed beneficial changes. One clinician became teary as she reflected, "seeing the relationships develop ... and the families change [is incredibly rewarding]" (P7).

### *Holding myself*

The clinicians acknowledged that they have responsibility in being able to emotionally "hold" or provide support for themselves. The clinicians reflected that they must have appropriate education and be willing to undertake specific training, "[especially to gain] an understanding of Attachment Theory [and the mother-infant] relationship" (P5). Knowledge and skills in other areas such as infant and child development, communication skills, assessment skills, mental health and midwifery were also seen as being beneficial.

Having time for clinical supervision relies upon management support and, as one clinician explained, each clinician has to personally value clinical supervision. She described clinical supervision as bridging the gap between practice and theory:

> Having ... adequate supervision ... [helps] make sense of how you're working and what you're doing ... because you're working in isolation with really vulnerable families in their homes ... you can do your certificate or your diploma, and have learnt in a book, but have not integrated it clinically ... For me the only space to do that is in supervision, ... the foundation has to be the supervision and then however you got your experience ... is fair ... (P6)

Irrespective of any training or clinical supervision, clinicians believed that they need to have "passion [to work in PIMH, as families] can feel very quickly of where you sit, in terms of mental health and ... parenting" (P6) and families can tell whether clinicians are supportive or judgemental of them. Clinicians also described being strength-focused, to leave families with a positive experience, especially as the service is voluntary and women can discharge themselves at any time, as one clinician reported,

> Whenever I see someone, potentially that’s the last time I’ll meet with them, so what am I leaving them with? And my hope would be to not be fearful of a service. So even if that’s the last time I’ve seen them that it’s been an interaction and a conversation that hasn’t made them felt wary or defended. (P6)

One clinician also talked about the need to have "hope" (P1) that families are capable of change, because without any hope it is easy for clinicians to "burn out" (P1). Clinicians also need to have hope and be able to instil hope for the women and families that change is possible:

> I think that all parents ... want to do the best job for their babies so that no matter where they've come from, what they've done in the past that this is a glimmer of hope ... that they can make changes in their life and I think it's lovely to be a part of that and to help them kind of come out with maybe the best parts of themselves, to then be able to do the best thing for their baby. (P2)

*Support from colleagues and management*

To work therapeutically in emotionally challenging situations the clinicians recognised that they need a supportive environment and to refrain from working in isolation, as one clinician stated, "To provide a really quality service [is] ... not going to happen when people are on their own" (P3). All of the clinicians described the benefits of being in a team, as opposed to working as a sole PIMH clinician, which is the model in some health areas. The team milieu provides opportunities to debrief and to review clients with their colleagues. Clinicians are able to give each other emotional support as they have "a shared understanding" (P6) of the work. As one clinician described the collegial support:

> One clinician doesn't hold the clients ... we're all together ... in managing [the women] which I think is so crucial in being able to survive ... [and being] very mindful of each other [that] this is a hard job at times and that we check in a lot. (P2)

Management support is needed to ensure the clinicians have access to and time to attend clinical supervision, which they believe is critical to help them "get through" (P2) the emotionally challenging parts of their work. Some clinicians, however, reported difficulty in finding someone suitable to provide clinical supervision "within the system who has the skill set ... [to provide] mother-infant supervision" (P7), prompting some clinicians to access private supervision which they self-fund.

Support from colleagues and management is also needed when working with some of the other services, as they do not always work together with a shared goal and understanding of the woman and infant. The PIMH clinicians reported that at times they feel they are competing with other professionals and services and experience a "lack of understanding, lack of compassion ... from the broader services, … [which is] frustrating ... and disappointing ..." (P6). As highlighted in Chapter Six, clinicians talked about professionals in other services who prefer to work independently rather than collaborate. One clinician specifically referred to child protection services and difficulties that she had experienced:

> [Child protection services] can have this whole plan about your client that you just have no awareness of ... and that can be particularly difficult if we’re ... trying to increase maternal-reflective functioning, so that she’s ... in a better place to be able ... [to] connect with her infant, and they're planning to take the infant away ... And we don’t know. So that can be particularly difficult, and it feels like we’re ... perpetrators of the abuse [as well]. (P7)

For clinicians, "to be held" also meant having adequate human and physical resources. One clinician was adamant that there is a "lack of resources ... even though we’ve got more than everyone else, it’s still not enough" (P5), which at times has a negative impact on women engaging with the service. One of the resource deficiencies is the availability of cars to attend home visits. Without access to cars, clinicians rely upon women attending the centres for appointments; however many of the available rooms are not family friendly and lack toys for other children who have to attend. Cars are also needed to attend combined team meetings (as the clinicians work across sites), as well as meetings with other services.

In recent times one of the teams had to access consultation rooms in the acute mental health unit and use the waiting room with the adult mental health clients. One clinician stated she stopped using the facility, as women with infants had been alarmed by what they had witnessed,

> [Women have been] frightened by the kind of clients that come here - and there's [been] a number of violent incidents ... in the waiting area [as well] ... and I don't think it's appropriate for mums and babies. (P3)

Adequate human resources are needed to meet the number of referrals to the PIMH service. When referrals exceed resources and clinicians have to decline the referral, the clinicians often feel a "level of conflict, angst, defensiveness with other teams ... to justify ... decisions" (P1), especially if a woman with similar risk factors had been accepted into the PIMH service previously. Increased human resources are also needed to increase the length of engagement beyond 12 months post birth:

> For some women they don’t need to stay with the service, but ... [for] some women ... we’ve come from this point to get to this point where things are really improving ... Mum's developing some great insight, mum's developing some really beautiful ways of relating with this baby, and then we have to discharge them ... (P5)

*I love my work*

Clinicians reported that they feel privileged and very satisfied at being able to support women during the perinatal period, as women are "open to making changes ... to be the best parents they can be ..." (P7). Witnessing the women gain "confidence in themselves, ... their faith and their strengths and who they are, ... their capacity as a parent, and then when the relationship with the child took off" (P6) is especially rewarding. Clinicians also find their work rewarding when women are discharged because they "don’t need you anymore ... (laughs) … when they feel that they can do it without a service to support [them]" (P7). One clinician reflected on a woman she had recently discharged:

> She had a very significant mental health diagnosis ... and when I first met her she was very standoff-ish about "I don’t want to be with mental health," ... in her evaluation of the service she actually said things like, "I thought it was rubbish ... I didn’t know what she wanted to do, why she wanted to see me, I was very suspicious of her," and she wrote in the end that had she not been involved in this service, she wouldn’t have had the delight of being able to experience her little girl as she did ... So that’s the sort of stuff that makes my job worthwhile – ohh, makes me all teary ... (P5)

## Conclusion

In this chapter, I have presented the findings of a thematic analysis of the data from the interviews with PIMH clinicians in relation to their experience of working in a specialist PIMH service. One main theme, "To be held", and four sub-themes, "Emotionally challenging work", "Holding myself", "Support from colleagues and management", and "I love my work" were identified. The themes reflect the support that the clinicians need in order to work therapeutically with women and families who have complex needs, as well as the satisfaction and rewards that they gain from working in a specialist PIMH service.

In the next chapter, Chapter Nine, I discuss the findings or inferences of this mixed methods study, including the meta-inferences of the findings. The **Discussion** is the final chapter of this thesis.

# CHAPTER 9: **DISCUSSION**

## 9.1 Introduction

In this chapter, I discuss the findings of this mixed methods study of specialist PIMH services. I commence by providing an overview of the study findings and I discuss the value of a mixed methods approach. I also take the opportunity to highlight how the data from different datasets have been integrated to address the research questions. The main focus of the discussion are the meta-inferences of the findings. In mixed methods research, meta-inference refers to the integration of findings or inferences from all data from the study, not just the individual components, and reflects the synthesis of qualitative and quantitative research processes (Creswell & Plano Clark 2011; Onwuegbuzie & Coombs 2010; Tashakkori & Teddlie 2010). The meta-inferences are therefore made at the conclusion of the study, and provide a coherent conceptual framework that addresses the research questions (Woolley 2009). The findings from this study demonstrate the central place of Attachment Theory in the specialist PIMH service model. The meta-inferences that I present in this discussion chapter progress from being informed by Attachment Theory to the application of a Theory of Attachment Based Exploratory Interest Sharing (TABEIS) (Heard, Lake & McCluskey 2012). In this chapter, I also address issues related to knowledge translation, implications for practice, further research, the study strengths and limitations and the final reflection on my research journey.

The aim of this study is to explore specialist PIMH services. When the study commenced, two sites in NSW were chosen (one metropolitan, the other regional) where the PIMH services had been established for approximately 10 years. To achieve these aims, a convergent, embedded, mixed method design was used. Data collection involved reviewing 244 medical records of women who had been referred to a PIMH service between January 2010 and December 2011, interviewing six PIMH clinicians, two PIMH managers, five key stakeholders (four midwives and one social worker) and 11 women who had engaged with one of the PIMH teams.

## 9.2 Study findings: An overview

### 9.2.1 The value of a mixed methods research design

Mixed methods research designs use the strengths of both qualitative and quantitative data collection techniques and analyses to enhance understanding of the research problem (Creswell 2009; Hesse-Biber 2010; Ridenour & Newman 2009; Woolley 2009). Mixed methods studies combine or integrate different types of data at a predetermined stage within the research process (Halcomb *et al.* 2009; Creswell, Fetters & Ivankova 2004). The integration of the qualitative and quantitative data enhances the research findings or inferences (Bryman 2006) as new findings emerge which would not have been observable if only one type of data had been collected (Andrew *et al.* 2008). Pragmatism embraces all research methods to find truth (Feilzer 2010), and was therefore chosen as the theoretical framework to guide this study design.

The mixed methods design for this study has provided data about the demographic characteristics and risk factors of women who are referred to the PIMH services, as well as the perceptions and experiences of the PIMH clinicians and managers, key stakeholders and women service-users. Mixed methods research also provides the opportunity to confirm and to complement data from different sources, as well as to identify contrasts or conflicts within the data (Bryman 2006).

The initial directed content analyses (Hsieh & Shannon 2005) of the qualitative data from the interviews with the PIMH clinicians confirmed the interventions identified by the descriptive analyses of the quantitative medical record review data. A further thematic analysis (Braun & Clarke 2006; Green *et al.* 2007) of the clinicians' data, however, identified contrasting views about the interventions initially described. The thematic analysis of the clinicians' interview data identified that the clinicians focus on the mother-infant relationship and that their main intervention is to model a secure-base. This concept was not evident in the medical record documentation. This provides a more complete picture of the interventions that the clinicians use in their work, highlighting that attachment work is somewhat invisible and difficult to articulate and document.

Contrasting data was also identified in regard to collaborative practice. The participating clinicians perceived that they collaborate well with other service providers. However, this contrasts with what was recorded in the medical records and the interview data with the key stakeholders who described minimal collaboration with the PIMH service.

The qualitative data from the interviews with the clinicians and the women service-users also provide additional information about the experiences of clinicians working in a specialist PIMH service and of the women who engaged with a PIMH service. These data provide a more holistic view of the PIMH service.

### 9.2.2 Overview of findings

This study has identified that women who are referred to a specialist PIMH service have multiple and complex needs, with many women having a past history of complex trauma and maladaptive coping strategies, for example deliberate self-harm. This is an important finding, because women who experience childhood trauma, particularly child sexual assault, are more likely to have insecure attachment models, which often result in insecure adult attachment relationships (Hsu, Chen & Lung 2013) and the development of poor parenting skills and impaired mother-infant relationships (Gardner, Loya & Hyman 2014).

Engagement with a service and in the therapeutic process can provide the necessary environment for change and recovery (Warnick *et al.* 2014). In this study, engagement has been conceptualised as a continuum from initial contact through treatment until mutual discharge, with active participation by both the clinician and the client (Kim, Munson & McKay 2012). There has been much research about barriers to engagement with mental health services (for example, Bates & Stickley 2013, Vogel *et al.* 2013). The main reasons for non-engagement in this study are the time lag between the midwives' screening process and contact from a PIMH clinician, as well as the stigma of mental illness and mental health services. Despite these barriers, the medical record review has identified that most women who were referred (71.3%) engaged with the PIMH service.

To facilitate engagement and decrease stigma, the PIMH clinicians use a variety of strategies. These include focusing on the infant and the mother-infant relationship. Being woman-led and being an advocate for the women in their care enhances engagement, particularly the focus on meeting the individual needs of the women (Jack, DiCenso & Lohfeld 2005). Discharge processes that are not woman-led, however, leave women feeling abandoned and unsupported. Of note, is that women who are not partnered are less likely to engage with a PIMH service. This warrants attention as these women may have less social supports and are potentially more at risk of adverse outcomes (Austin & Priest 2005; Lancaster *et al.* 2010).

The clinicians use a variety of interventions dependent upon their professional background and additional training and professional development. All of the clinicians have undertaken training in attachment-based interventions and/or approaches to working with women with trauma histories. Analyses of all of the data identified the complexities of the therapeutic interventions that the clinicians use. The quantitative and directed content analyses identified the individual interventions that are used, for example, family of origin work, non-directive counselling and mindfulness. The thematic analysis of the clinicians' interview data identified that the main intervention is modelling a secure-base. The aim of this modelling is for the women to be able to replicate being a secure-base for their infant, as well as being able to use the model with other adult relationships. Therefore, Attachment Theory underpins or supports all of the interventions (refer to Figure 9.1). All of the interventions are either provided within a purely therapeutic model of care, a case management model of care or a combination of both.

**Figure 9.1: PIMH model of therapeutic interventions.** In the centre are the interventions that the PIMH clinicians use, which are framed within a therapeutic or a case management model of care. All of the interventions are supported by Attachment Theory, and characterised by the clinicians modelling a secure-base.

Collaboration and integrative care aim to promote a seamless transition through the health care system (Psaila *et al.* 2014a), and are increasingly being written into policy documents. In this study, I have used D'Amour and colleagues' (2008) typology of collaboration to understand the collaborative practices between the PIMH clinicians and other service providers. The clinicians perceived that they collaborate well with other service providers; however collaborative practice is more about attending multidisciplinary service meetings rather than communicating with a specific service/professional about a specific woman. Conversely, the key stakeholders reported that they have minimal contact with the PIMH clinicians. Drawing upon the typology of collaboration, the PIMH clinicians can be classified within the "developing collaboration" (D'Amour *et al*. 2008: 11) typology, that is, they are in the early stages of collaboration with the other antenatal service providers.

Interviews with the women service-users revealed that the women highly valued their time with the PIMH service. The women referred to their PIMH clinician in positive terms, and described the development of a trusting relationship that helped them feel comfortable and safe to talk about private concerns. Despite these positive reflections, when they were discharged prematurely from the service, before being ready to "swim", they felt stranded and let down. When discharge practices were woman-led the women felt "confident" that they would be able to cope alone.

The PIMH clinicians reported both positive and challenging aspects of working in a PIMH service. Positive emotions were reflective of the developing mother-infant relationships. Challenging aspects of the clinicians' work were described when they witnessed mothers who were unable to make effective changes to strengthen the relationship with their infants. To continue to work in emotionally charged environments, clinicians need support from their colleagues, managers and other service providers, to have shared goals and to have an understanding of the complexities of working with women at risk of mental ill-health during the perinatal period.

## 9.3 Meta-inferences of study findings

### 9.3.1 Reflections on meta-inferences

During the data analyses and the writing of the papers and other chapters, Attachment Theory stood out as the central concept to be examined in this Discussion Chapter. In Figure 9.2 I illustrate the relationship between the central concept of Attachment Theory and the other core elements of the PIMH service model. In the centre of the model are the PIMH clinicians, with Attachment Theory as the framework underpinning the model of care, and the women service-users. These three components are central to the service. Radiating from the centre are the three other important aspects of the service that capture the role of the PIMH clinicians: engagement with women service-users and other professionals and services, the therapeutic interventions used, and collaboration with other professionals and services. Each of these components makes up the complete model of the PIMH service. The gap between the centre and the three outer components demonstrates the perceived and existing gaps that are present in this complex model of care; if all these components are not interlinked then it is likely that the best outcomes will not be achieved for the majority of families.

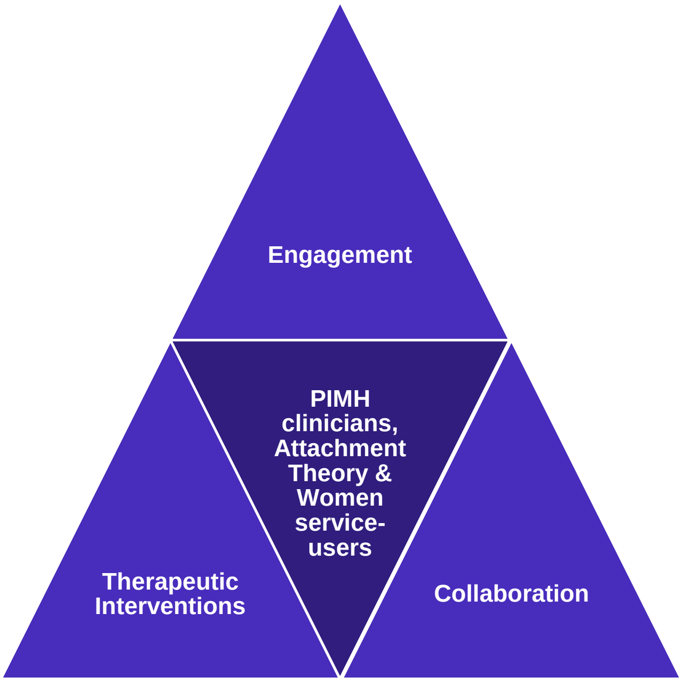

**Figure 9.2: Initial illustration of the PIMH service model of care.**

Central to Attachment Theory is the premise that the mother provides a secure-base for her infant (Bowlby 1958, 1978). That is, the mother provides support for her infant to explore his/her environment and is welcoming when her infant needs to return for comfort (Powell *et al.* 2014). Infants who consistently experience their mother as a secure-base develop secure infant-mother attachments. Conversely, infants who experience their mother as an inconsistent secure-base develop insecure infant-mother attachments (Araneda *et al.* 2010; Powell *et al.* 2014). Infants who develop an insecure infant-mother attachment are also more likely to develop insecure attachments in their later relationships (Karakurt & Silver 2014; Rutten *et al.* 2013).

Women with histories of complex trauma can be challenged by relationships with their own infants/children and other adults that are reminiscent of times they felt devalued or unsafe (Gardner *et al.* 2014). Other authors (for example, Karakurt & Silver 2014; Letourneau *et al.* 2014; Maas *et al*. 2014) have drawn on Attachment Theory as a framework for the therapeutic relationship between the clinician and the woman. What is absent from this literature is an infant. In other words, these authors are referring to working therapeutically with women across the lifespan, not just the perinatal period or early childhood years. Reflecting on this literature and despite trying to develop a number of models to embed Attachment Theory within the meta-inferences (for example, Figure 9.2), I found that Attachment Theory did not fully encapsulate how I now understand the specialist PIMH service. It was not sufficiently broad to encompass relationships with other service providers; it did not fit beyond the interventions stage of the PIMH role, that is, with the engagement and collaboration focus of this study. I then found the work of Heard, Lake and McCluskey (2012), which has allowed me to conceptualise and explain the study findings.

### 9.3.2 From Attachment Theory to a Theory of Attachment Based Exploratory Interest Sharing

As described in the Introduction to this thesis, the original concepts of Attachment Theory, developed by Bowlby (1958, 1969) and later Ainsworth (1969), promote specific attachment behaviours: careseeking (by the infant) and caregiving (by the mother) and thereby survival of the infant. The mother's response to her infant's cues promotes the development of internal working models in the infant (Bowlby, 1973), which an infant takes to other relationships in the future (Karakurt & Silver 2014; Rutten *et al.* 2013). Internal working models and therefore attachment behaviours are plastic, that is, they can change over time depending upon experience (Powell *et al.* 2014; Siegel 2001).

Over the decades that have transpired since Bowlby and Ainsworth's ground breaking work, Attachment Theory continues to be used and developed as a theory for working with clients within a therapeutic relationship. Heard, Lake and McCluskey (2012) have added further dimensions to Bowlby's original theory of attachment and have called it a Theory of Attachment Based Exploratory Interest Sharing (TABEIS). These authors describe five parts of an individual as selves or systems, which they call the "dynamic self", and a further two separate systems - the external supportive/unsupportive and the internal supportive/unsupportive systems. The aim of the dynamic self is to restore wellbeing after a threat has been sensed. See Box 9.1 for a summary of TABEIS adapted from: *Attachment therapy with adolescents and adults. Theory and Practice Post Bowlby (*Heard *et al.* 2012).

The defensive self - is present or activated when a threat, either real or perceived, is sensed. The threat activates the individual's fear system (fight or flight) and the attachment system or careseeking self (proximity to a secure-base). An adult may experience a secure-base or a secure state either internally or externally, which is dependent upon their internal working model and whether their previous experiences have led to secure or insecure attachments with others.

The defensive self in Heard and colleagues' model is not the same as the dichotomised self of good or bad, positive or negative sense of self as described by other authors (for example, Showers, 1992; Shower & Zeigler-Hill 2007). The dichotomised self is often viewed within affective and cognitive processes (Showers 1992), that is, extreme mood states or extreme self-views of being either positive or negative. The defensive self within TABEIS is within a system that aims to promote an individual's wellbeing.

The careseeking self - is based upon Attachment Theory and the notion that the attachment system is active throughout life. Heard and colleagues expand the theory of the secure-base to not only include a caregiver who is "older and wiser" (p. 70), but to also include those individuals who share similar interests and therefore promote positive emotions. Attachment figures are divided into four categories: 1. "Primal attachment" (p. 74) figures being mother and/or other primary carers; 2. "Early attachment figures" (p. 74) such as grandparents who have regular have contact with the infant; 3. "Mentor-like" (p. 74) attachment figures such as teachers, family friends, older employees; and 4. Romantic attachment figures.

The caregiving self - also based upon Attachment Theory, is seen when an individual responds to careseeking behaviours by protecting, comforting and soothing the other. In TABEIS the caregiving role "as the educative interest sharing aspect of caregiving" (p. 75) is also included. This aspect of caregiving involves being both sympathetic (an unconscious response) and empathic (a conscious response) - a response which can be diminished if the fear system is activated. Caregivers who move between the two types of caregiving, supplying comfort when fear is experienced and then moving to interest sharing, help an individual to develop positive internal working models. Individuals can then draw upon these positive models in the future without needing the support of others, except during times of crisis.

The interest sharing/exploring self - is defined as sharing or interacting about a topic with mutual interest. This sharing enhances a sense of relationship or belonging with another individual.

The sexual self – is seen within three behaviours: 1. Affectional sexuality, which exists within a relationship of mutual and supportive care, 2. Defensive sexuality, which exists within unequal relationships (either as children or within IPV), 3. The reproductive function of sexuality, which exists with both the affectional and defensive sexuality behaviours.

These dynamic parts of the self operate either within a supportive or unsupportive system.

The external supportive/unsupportive system - the external supportive system is seen when an individual, through the experience of positive role models, has built up an external network of supports, for example family, friends, work colleagues, who can be relied upon for support when a threat has been perceived. The external unsupportive system is present when the external supports are insufficient to support the individual to regain their sense of wellbeing and therefore the environment is not restorative.

The internal supportive/unsupportive system - is built upon the internal working models that the individual has created from past experiences. The supportive system can only be actualised/activated if an individual has received empathic care by a caregiver who has been in synchrony with their emotions and needs. If the individual has not received empathic caregiving they may not have developed supportive internal working models to draw upon in times of need. They therefore continue to seek support from outside the self, or practice maladaptive coping strategies, for example deliberate self-harm.

**Box 9.1: Summary of TABEIS**

The way an individual responds to friends and others is partially dependent upon whether they are secure or insecure in themselves (Heard *et al.* 2012). Heard, Lake and McCluskey (2012) describe the secure self as a state of being when an individual is confident that if a threat is sensed (the defensive self is activated) and support is needed (careseeking), others are available who can be turned to for comfort and security (caregiving) that is ongoing and consistent. Alternatively, the insecure self has learnt through experience that others are often inconsistent and contradictory in the support they give, which can result in the caregivers failing the careseeker.

Heard and colleagues (2012) developed TABEIS to assist clinicians to work therapeutically with adolescents and adults, individually or within group programs. The ultimate aim of the theory is to understand an individual's needs during therapy, which part of the individual's self has been activated by therapy, and to promote exploration. To activate the interest sharing/exploratory self, an individual needs to have a positive sense of wellbeing. When an individual feels supported they can: 1. find new meanings in activities or interests; 2. be creative; and 3. think laterally or solve problems in unique ways. Activation of the fear or attachment systems inhibits the exploratory system.

This theory more comprehensively captures the nature of the PIMH service demonstrated in the findings of this study. In the following sections, I describe the elements of the findings and draw upon TABEIS to explain what is happening.

### 9.3.3 Risk factors of women referred

Women referred to the PIMH service have been identified as having multiple and complex risk factors for poor perinatal mental health. Specifically, women have experienced childhood trauma, adult sexual assault and IPV. Women who experience childhood trauma and IPV are predisposed to postpartum depression and decreased parenting capacity (Malta *et al.* 2012), with a concomitant impaired mother-infant relationship (Gardner *et al.* 2014). Acknowledging women's previous negative sexual experiences, clinicians need to work with women in relation to their sexual self. Clinicians can assist women to understand their sexual selves as either predominantly seeking affectional sexual relationships based upon equality, comfort and support or defensive sexual relationships, based upon inequality and abuse (Heard *et al.* 2012). Due to the multiple and complex risk factors of the women referred to the PIMH service, women may not have partners or significant others who can support them (Macomber 2006; Wilkinson & Marmot 2003). This study identified that women who were not partnered were less likely to engage with a PIMH service.

### 9.3.4 Engaging women with complex needs

***Engagement barriers and facilitators***

Upon first contact by a PIMH clinician, a woman's fear system may be activated. The woman may be particularly fearful if the psychosocial assessment and depression screening process was not positive or supportive, if the woman was not aware of the referral or if she had previous negative experiences with mental health or other services. Psychosocial assessment and depression screening is conducted by midwives in the antenatal clinic. Midwives have demonstrated varying levels of skill when conducting psychosocial assessments. Some midwives have a high level of skill, whereas others are directive and focus on the task rather than on the woman and her experience (Rollans *et al.* 2013). Perinatal and infant mental health clinicians therefore need to draw upon their caregiving selves at the outset to deactivate or at least ameliorate the fear system in the woman and provide a sense of security or safety to promote engagement. Consistent and timely referrals also promote care seeking behaviours from women who are at risk of perinatal mental ill-health (*beyondblue* 2011; Myors *et al.* 2013). The majority of the women (84.8%) were referred to the PIMH service in the antenatal period. Recruiting women antenatally as opposed to postnatally is more effective in promoting engagement, especially for home visiting programs (McDonald *et al.* 2012).

Stigma is a well-documented barrier to engagement in mental health services (Bates & Stickley 2013; Vogel *et al.* 2013), as well as shame for women with traumatic backgrounds (Talbot & Gamble 2008). The fear of being stigmatised or feeling shame will potentially activate the defensive self, prompting women, especially if they are insecure, to withdrawal from the perceived threat and therefore the service. Clinicians are mindful of the engagement process especially around language, and the stigma of mental ill-health and mental health services. Fear and lack of knowledge of health services has also been reported as barriers to help seeking (Ghafoori, Barragan & Palinkas 2014).

Clinicians draw upon a variety of strategies to facilitate engagement with the women. The clinicians are client-led or woman-centred in their interactions, meaning that when a woman identifies an area or an aspect where she needs support (careseeking) the clinician responds positively and consistently (caregiving). In their caregiving capacity during engagement, clinicians work with women either within a purely therapeutic model or within a case management model, being flexible in their approach. Flexible models of care (Gibbons *et al.* 2010), choice (Laugharne & Priebe 2006) and focusing on women's relational strengths promote engagement and empowerment, and enhances the therapeutic relationship (Wisdom *et al.* 2009). Providing a choice of setting (home or centre) also promotes engagement as vulnerable families need additional support to use services (McDonald *et al.* 2012). The clinicians stated they are also woman-led in regard to the inclusion of a woman's significant others, and reported working with women's partners and mothers.

Discharge practices prove disturbing at times and result in negative consequences for some women, especially when they are reactive and ad hoc. Some clinicians reported that women disengage prematurely or abruptly if they do not feel appropriately supported to explore specific areas of their life. Within TABEIS, this would be recognised as a defensive response to a perceived threat. The woman may not activate her careseeking self if her internal working model has identified that a caregiver will not be able to provide appropriate support. It could also resonate with a mismatch or misattunement between a woman and a clinician who lacks sufficient empathy for the woman and has not provided a secure-base from which the woman can gain support.

Drawing upon TABEIS and other engagement strategies, such as Talbot and Gamble's (2008) engagement analysis or Grote and colleagues' (2007) engagement interview, PIMH clinicians may be able to enhance engagement along the continuum, preventing premature disengagement and those women who become "lost to care". Likewise, not having formal service time limits may promote higher retention rates (Crawford *et al*. 2009).

Engagement is not only relevant for the women service-users, but also to the other professionals and services that work with women during the perinatal period. Using TABEIS, PIMH clinicians can also promote engagement between themselves and other professionals. This will be discussed further in the section below which details collaboration with other service providers.

### 9.3.5 Therapeutic interventions used by PIMH clinicians

The clinicians use a range of therapeutic interventions when working with women who have engaged with the PIMH service. In a literature review of service delivery processes and strategies, Moore and colleagues (2012) identify that it is the process, or "how" a specific intervention is delivered, that has greater impact than "what" the intervention is. These authors describe seven key elements needed to underpin service delivery if the best outcomes for families are to be achieved. These include:

relationship-based, partnership-based, providing choice, providing advocacy and practical support, are non-stigmatising, are culturally aware and sensitive, and maintain continuity of care. Clinicians also need to be able to provide a diverse range of evidenced-based interventions and practical assistance, or advocacy, to assist families with their challenges (Moore *et al*. 2012). The process features are the foundation of service delivery, whereas the evidenced-based strategies provide a flexible approach to meet families' changing needs (Moore *et al*. 2012). Process also relates to being able to challenge parents in ways that promote growth (Moore 2006).

The clinicians in this study demonstrate Moore and colleagues' (2012) seven key elements of service delivery, have a large repertoire of interventions and are advocates for the women in their care, which was also reflected in the interviews with the women service-users. Advocacy is an important component of therapy as it promotes empowerment and skill development, especially when working with trauma survivors (Elliott *et al.* 2005).

The PIMH model of therapeutic interventions (Figure 9.1) that I have developed reflects the "how" and "what" of service delivery as described by Moore and colleagues (2012). The "what" or individual interventions are at the centre of my model, and have been provided within a case management and/or a therapy based model of care. The "how" of service delivery is the modelling of a secure-base by the clinicians, for the women.

Within a framework of Attachment Theory, the PIMH clinicians talked about being "dependable, available and consistent", and modelling a secure-base in order to enhance a woman's emotional regulation, reflective capacity and empathy. In this way the clinicians employ the concept of parallel process, where the relationship between the clinician and the woman parallels the relationship between the woman and her infant (Moore 2006). The clinicians also use non-directive counselling, and are "client-led", which promotes empathic attunement to a woman's emotional state and the development of a safe and secure therapeutic alliance. This sense of security and safety provides the opportunity for an individual to disclose deep and emotionally distressing histories (Heard *et al.* 2012). Heard, Lake and McCluskey (2012: 66) state:

> Careseeking can only happen when a client can be "held" in therapy by the consistently empathic behaviour of the therapist for long enough for the client to discover that the behaviour of seeking care can be undertaken safely.

Bowlby first articulated the notion of clinicians providing a secure-base for clients in 1988 (Ainsworth & Bowlby 1991). The idea that the therapeutic relationship is a form of attachment relationship has gained momentum over the years (Guedeney *et al.* 2014; Lilliengren *et al*. 2014). Lilliengren and colleagues (2014) suggest that a client's attachment to their clinician is reflected in how the client uses the therapeutic relationship and relates emotionally (both consciously and unconsciously) to the clinician. If women feel misunderstood, they may either abruptly disengage, fail to return to future appointments, or the relationship may no longer be trusting and therefore decrease a woman's ability for recovery (Heard *et al.* 2012). The ability to empathically follow the changing emotions of a woman (Heard *et al.* 2012) promotes: attachment with another, the exploration of frightening and distressing memories and experiences, and a sense of support and comfort by the attachment figure (Karakurt & Silver 2014; Lilliengren *et al*. 2014).

Within the clinician-client relationship, the PIMH clinicians work therapeutically as caregivers to provide a secure-base and safe haven for the women, to "support them in what they're going through". Providing woman-led care places the woman at the centre of the process and provides psychological support for the transition to motherhood (Hopkins, Clarke & Cross 2014). Being woman-led, however, involves asking what is important to the individual and their family rather than making assumptions (Cleary *et al*. 2013).

During therapeutic engagement, the woman may move between the different dynamic selves. The defensive self may be activated if the therapy touches on emotionally painful memories and past experiences. The defensive self may in turn activate the careseeking self, as the woman seeks comfort and support from the clinician, or she may disengage. Within the therapeutic relationship the clinician assists the mother to understand how her internal working models affect her interactions and, therefore, her relationship with her infant (Guedeney *et al.* 2014). During therapeutic engagement, the clinicians also draw upon Winnicott's "holding" environment (Winnicott 1960: 591). Infants cannot survive alone: "[when] we look at an infant we see an infant in care" (Winnicott 1962: 238). Mother's hold or care for their infants both physically and emotionally in order to promote growth and development. The PIMH clinicians do not physically hold the women, but they provide emotional support for the women so that they can explore and overcome the challenges in their lives. As Winnicott (1960: 591) stressed,

> Mother's who have it in them to provide good enough care can be enabled to do better by being cared for themselves in a way that acknowledges the essential nature of their task. Mother’s who do not have it in them to provide good enough care cannot be made good enough by mere instruction.

As therapy draws to an end, the clinicians aim for the woman to be able to activate her caregiving self in response to her infant's cues in consistent and emotionally attuned ways. By nurturing and providing the secure-base for her infant, it is hoped that the infant will develop a secure attachment to his/her mother, promoting the development of positive internal working models which, over time, can be drawn upon as a way of relating to others.

As the woman recovers from her past experiences, the clinician may activate the woman's interest sharing/exploring self, whereby the woman can learn new ways of reacting to past memories within the supportive therapeutic relationship. The aim is to not only enhance a secure infant-mother attachment but also to decrease any maladaptive coping mechanisms of the mother, such as deliberate self-harm. Deliberate self-harm is associated with a past history of childhood trauma (Mangnall & Yurkovich 2008), which negatively impacts an individual's attachment models (Hsu *et al*. 2013). Shepherd and colleagues (2008: 2) assert that trauma can only be resolved:

> If the person can discover – or rediscover – their sense of personal control (‘agency’) and gain a belief in the future (hope). Without hope they cannot begin to build their lives.

Hope is a powerful concept. Health care providers can learn strategies that inspire and encourage hope in others (Moore 2005) and promote recovery.

### ***Recovery-oriented programs***

The clinicians did not talk specifically about recovery; however the aim of any intervention is for the patient/client to recover either emotionally or physically. Recovery-informed mental health care has gained international recognition and has been adopted as the underlying principle for mental health services in Australia, New Zealand, the USA, Scotland and Ireland (Shepherd, Boardman & Slade 2008). Recovery does not mean cure, but promotes an individual's journey to autonomy and independence (Shepherd *et al.* 2008). The aim is to instil hope that life can be fulfilling and to recognise that every individual has a unique journey. Therefore, the quality of an individual's life is judged by the individual and not by mental health clinicians or other service providers (Shepherd *et al.* 2008).

To work within a recovery-oriented framework involves clinicians changing from working as the expert and authority figure to working in partnership, which is a more equally balanced relationship. Research has identified that clinicians, and in particular nurses, often struggle to work in more supportive ways with clients and families due to lack of support, education and busy workloads (Cleary *et al*. 2012; Myors, Schmied & White 2014). The knowledge and expertise of clients need to be recognised as valuable and constructive, rather than as a threat to professionals if the client-clinician partnership is to be enhanced (Bennetts, Cross & Bloomer 2011).

Perinatal and infant mental health clinicians are well placed to be able to work within the concept of recovery with women who have complex needs. The PIMH clinicians reported that part of their role is to instil in families the hope that change is possible (refer to Chapter 8). Likewise, by recognising and responding appropriately to the needs of the women, and understanding that recovery is not possible while trauma persists, the PIMH clinicians have adopted trauma-informed care and practice in their work and attended trauma-informed training. Trauma-informed care and practice is currently being developed as a national mental health service model in Australia (Mental Health Coordinating Council (MHCC) 2013). Trauma-informed services address the impact of complex trauma and aim to avoid retraumatising the individual when providing care within the mental health system (Hummer *et al.* 2010). Education and cultural change in services, however, are often needed before trauma-informed care can be implemented (Hummer *et al*. 2010).

### 9.3.6 Collaboration between PIMH clinicians and other service providers

Professionals and clinicians enter the workforce with their own past histories and experiences. Some may have experienced secure relationships and developed positive internal working models whereas others may have experienced insecure early relationships and therefore developed less positive internal working models. Perinatal and infant mental clinicians can draw on TABEIS to support other professionals and enhance collaborative care for women. For example, if clinicians feel unsupported in their work they may have difficulty interacting with others positively (Myors *et al.* 2014). Perinatal and infant mental health clinicians have expertise in Attachment Theory and, with the expansion of TABEIS, they can promote a sense of safety for other professionals to work more collaboratively with them. Increased collaboration would place the PIMH service within the "active collaboration" typology (D'Amour *et al*. 2008: 11), whereby a sustainable partnership has developed between health care providers.

This study has identified that when professionals do not work collaboratively, women experience negative outcomes. Negative outcomes have been identified in the early postnatal period when PIMH clinicians are unaware that the woman has given birth and has subsequently become "lost to care", and at discharge when referrals have not been acted upon. A lack of understanding of professionals' roles also impacts women negatively when information is not shared about child protection concerns, and PIMH clinicians do not share their knowledge with midwives, who are left to support the woman if she declines or is denied acceptance into the PIMH service. Collaboration needs to involve interdisciplinary and community partnerships to promote identification and appropriate interventions for health care users (Cleary *et al.* 2012).

### 9.3.7 Women’s experiences of engaging with a PIMH service

The 11 women interviewed for this study were extremely positive about their experience with the PIMH service, despite initial feelings of hesitancy and previous negative experiences with mental health services and/or the referral process. The women specifically talked about the relationship that they developed with the PIMH clinician as being "like a friend but not a friend". This could be an example of the women having had their fear and attachments systems activated, which in turn activates the defensive and careseeking selves. Women therefore found, in the PIMH clinician, a caregiver who was supportive and able to provide a secure-base, which could, in turn, promote the development of positive internal working models. Over time, the women were able to activate the interest sharing/exploratory self with the PIMH clinician as they explored together new ways of perceiving, experiencing or reacting to other individuals, situations or memories.

When discharge practices were clinician-led, as opposed to woman-led, the women did not feel supported. One woman in particular had a negative experience when a referral was not acted upon by the new service. After a positive experience with the PIMH clinician she felt abandoned at the end, which has possibly affected her ability to initiate careseeking in the future. Health professionals need to develop effective ways to recognise those women who require more support and then provide specific, woman-centred approaches to care (Fenwick *et al*. 2013).

### 9.3.8 Clinicians’ experiences of working in a specialist perinatal and infant mental health service

The PIMH clinicians in this study have various professional qualifications; however they all stated that Attachment Theory informs their work. The clinicians reported that they need to "hold" women and provide a secure-base to support the women to work through the many challenges in their lives, and become more emotionally available for their infants. In this way the clinicians acknowledged and initiated their caregiving self in their professional role. The clinicians recognised that the women who are referred to their service are vulnerable because they are pregnant and are at risk of mental ill-health. The perinatal period was seen as a "window of opportunity" to work with women and promote changes that would have a positive impact on their developing infant.

That the clinicians also found their work emotionally challenging was evident when they talked about feeling helpless when women are unable to change and the mother-infant relationship does not develop; likewise, when the needs of the mother are incongruous with those of her infant. However, positive emotions were also evident in the interviews when two clinicians became teary while talking about the unique experiences of working with women and infants.

Analyses have also revealed that the clinicians also need to be "held" (Winnicott 1960) so that they can continue to work with women with complex needs, to provide appropriate care and to avoid burning out. The clinicians reported that they are emotionally supported by each other and have opportunities to discuss their clients at regular review meetings, as well as attend regular group clinical supervision. Some clinicians reported that they also attend individual private supervision when they need additional support. In this sense the clinicians become the careseeker as they initiate receiving support from others.

The support that the clinicians receive helps them maintain the hope that change is possible for families and prevent burn out. Green and colleagues (2014) define clinical burn out as occurring when an individual's ability to work optimally is inhibited, leading to decreased service quality. Health care and other public service professionals are often exposed to stressful events on a daily basis, many of which pertain to human suffering (Matuska 2014). Managers and services which promote supportive work place environments (that is, streamline activities to reduce workloads, and are collaborative and strength-based in their approach to clinicians and other staff) promote a sense of competency and job satisfaction (Green *et al*. 2014), which also promotes resilience in clinicians (Matuska 2014). Improved clinician functioning concomitantly supports individuals and their families who are at risk of mental ill-health (Green *et al*. 2014).

By providing supportive working environments and opportunities for the PIMH clinicians to be emotionally "held" in clinical supervision, the PIMH managers and clinical supervisors have become the caregivers to the PIMH clinicians (the careseekers). By receiving the emotional care needed, the clinicians are able to prevent the defensive self, due to feelings of burn out or being overwhelmed, from dominating their interactions with women. They can then continue to be seen as their caregiving self when interacting with the women and their infants. Clinical supervision is an important support mechanism for clinicians who work with trauma survivors. It is through supervision and the parallel process that clinicians learn about clinical practice through reinforcement of process and practice models (Shulman 2006). As one clinician commented, "clinical supervision bridges the gap between theory and practice".

Heard, Lake and McCluskey's (2012) expansion of Attachment Theory has provided a framework to not only conceptualise the attachment behaviours of careseeking and caregiving but also to work with women and infants, and other professionals, and for clinicians to understand their own support needs. Additional testing of the TABEIS model has not been documented in the literature. There is potential for this model to be explored further in the future.

## 9.4 Making the invisible visible

Health care records are a basic and fundamental source of healthcare information for clinicians, managers, patients, educators, researchers, and for legal use (Dehghan *et al.* 2013). From a legal perspective, accurate documentation protects health care professionals by providing evidence of thought processes, practices and joint client decisions should clinical practice need to be reviewed (Dahlen 2012). Health care record documentation also needs to reflect local policies and procedures, the standard against which accuracy will be tested (Teng 2013). They also provide clinical coders with the opportunity to identify the complexities of an individual's care and, therefore, the mechanism for appropriate reimbursement (Alonso & Love 2013), as well as measuring outcomes, providing quality measurement systems and benchmarking (Baker, Shanfield & Schnee 2000; Craddock, Young & Sullivan 2001). Thus, documentation in health care records aims to promote patient/client safety, continuity of care and transfer of information, and is a reflection of all care given, decisions leading to care planning and discussions with other professionals (NSW Ministry of Health 2012). Accurate documentation is particularly important if a client's condition deteriorates and a transfer of the patient/client between clinical settings is needed (NSW Ministry of Health 2012).

An important finding of this study is that the health care records of the women who engage with the PIMH services do not accurately reflect the work of the PIMH clinicians. The "what" of therapeutic interventions that the clinicians used (for example genograms, non-directive counselling and CBT) have been documented such that the information could be extracted from the medical record review. However, the interviews with the PIMH clinicians identified that the clinicians' main therapeutic intervention is modelling a secure-base to the mother so that she could internalise this and then emulate it for her infant: the "how" of service delivery. Documentation about the infant or the mother-infant relationship or any parent-infant focus, for example the Circle of Security Program (Powell *et al.* 2014), is minimal (70 of the 244 medical records reviewed). The documentation in the medical records does not clearly reflect the attachment work that the clinicians undertake. More research is needed to explore how best to document this type of work. Concern regarding health care record documentation, specifically the lack of documentation, however is not new (Craddock *et al.* 2001; Psaila *et al.* 2014b).

There is a limited amount of literature pertaining to clinicians providing a secure-base, especially for women with traumatic histories (Karakurt & Silver 2014), and a form of attachment relationship for the client (Lilliengren 2014). Moore and colleagues (2012) argue that the "how" of service delivery is more important than the "what" of service delivery; however they do not describe how the process can be documented in meaningful ways that can be utilised and understood by other professionals or women service-users who may review their medical record.

With regard to the lack of documentation in health care records, Craddock and colleagues (2001) caution against using only one source of data when undertaking a quality review, and promote the use of interviews, both client and staff, to provide a holistic picture of care. There is a dearth of published literature that reports best practice for health care record documentation in community mental health settings. As with this current study, recent literature referring to health care record documentation reports on outcomes of reviews or audits to ascertain specific information, for example the use of a specific tool to identify physical health problems in clients who have a serious mental illness (Shuel *et al.* 2010), the identification of substance use disorder and the mental health treatment of Veteran Affairs clients (Harris *et al.* 2010), and the retention of HIV positive clients in psychotherapy (Bottonari & Stepleman 2009). No literature was found that provides best practice or models for documenting psychological therapeutic interventions.

## 9.5 Knowledge translation

With all health service research there are implications for clinical practice that must be acted upon in order for health benefits to be achieved (MacDermid & Graham 2009), otherwise gaps persist and continue to widen (Bjørk *et al.* 2013). Knowledge transfer is a complicated process as clinicians work in complex environments, where change has become the norm rather than the exception (MacDermid & Graham 2009). Knowledge transfer is also time consuming, therefore busy working environments may not provide sufficient opportunities for clinicians to develop the necessary technical skills needed to search databases and make sense of the literature presented (Bjørk *et al.* 2013), which prevents the implementation of new clinical evidence (MacDermid & Graham 2009). Clinicians may require additional support such as clinical educators to facilitate knowledge translation (Bjørk *et al*. 2013).

Researchers who involve clinicians in a collaborative process and provide education in the clinical environment promote knowledge transfer (Bjørk *et al.* 2013). Barwick and colleagues (2012) conducted a broad systematic review (1952 - 2009, dependent upon the database) to evaluate the effectiveness of knowledge translation, that is behaviour change as opposed to attitudinal and knowledge change, in child and youth mental health services. Despite the poor quality of some of the studies, which warrant caution in regard to the conclusions of the study, the authors identify three key components related to education that produce the most effective outcomes. These are: 1. education programs that take place over a longer period of time, as opposed to short, quick programs; 2. education programs that focus on sustainability; and 3. programs that are delivered in interactive ways, such as role plays, videos and discussions. Other studies (for example, Goldner, Jenkins & Fischer 2014; Myors *et al.* 2014) have also identified that practice change is more likely to be implemented if it is practical, beneficial to the clinicians, any related education is provided by outside professionals, feedback and comparison with other services is provided, and the clinicians are supported by change agents or champions.

This study did not involve clinicians in the development phase, however all clinicians at the two sites were informed of the study and invited to participate. A feedback session was given to the PIMH services at each site after all data had been fully analysed. Both feedback sessions lasted approximately one hour and provided the opportunity for clinicians and managers to ask questions and discuss new information. This was also an important process for the validity of this study as it helped to ascertain whether or not the findings resonated with the clinicians. Both feedback sessions were extremely productive as the clinicians had an opportunity to contribute to the discussion of the findings and consider how these would be applied in practice. Clinicians specifically commented about the interventions model of care (Figure 9.1), noting that it helped them conceptualise their work. One clinician stated that although she had been working in the service for approximately five years, she had difficulty articulating to other professionals how her work differed from other mental health services. This model has given her a mental picture to use: "You have drawn what is in my head". Reflecting on the model, the same clinician commented that the secure-base they provide for the women supports them in translating the therapy to other parts of their life; just as a mother cannot teach her infant everything he/she needs to know, the mother's role is to provide the secure-base for the infant to explore and learn from their environment.

Another clinician commented that the sub-themes of modelling a secure-base, that is: enhancing reflective capacity, enhancing emotional regulation and enhancing empathy, have provided her with short reminders of what she needs to consider when documenting in a woman's medical record. Medical record documentation produced a large amount of discussion at one of the sites. Clinicians expressed difficulty in documenting what they actually do, that is the attachment focus of their work. One clinician also stated that caution was needed to ensure that what was documented made sense to others, including the women who may read the medical records in the future. After the completion of this thesis a written report of the quantitative data for each site will be presented to the PIMH managers, as requested, to assist with service development.

On a broader perspective, I have presented at conferences and published in peer reviewed journals to assist the dissemination of the knowledge produced from this study to the wider health service arena. However, it is acknowledged that these processes alone do not change practice (MacDermid & Graham 2009).

## 9.6 Implications for clinical practice

**Education and training for PIMH clinicians:** Working in a PIMH service requires a broad knowledge base that extends across the antenatal and postnatal periods for the woman and her infant. The women in this study were also identified as having multiple and complex needs, with many women having a past history of trauma. All of the clinicians in this study have undertaken various professional development courses. Clinicians need extensive knowledge of Attachment Theory and how to work with women with trauma histories. Knowledge of TABEIS would also assist PIMH clinicians in their work.

**Collaboration:** This study has identified that a lack of collaboration isolates services from other services and professionals from other professionals, promoting uncertainty and, at times, confusion about the role of the PIMH clinician. Clinicians in this study expressed frustration at the dismissive way other mental health professionals talk about their role. Opportunities for clinicians to work in other services, for example for adult mental health clinicians to work alongside the PIMH clinicians, may increase understanding and thereby collaboration between the services. A lack of collaboration can also have a negative impact on service-users, particularly at discharge, as seen in this study. The transfer of an individual's care to another service requires communication and coordination to ensure the transition is smooth and seamless (Psaila *et al*. 2014a).

To work in more collaborative ways requires extra time, resources (Psaila *et al.* 2014a), a change in professionals' attitudes (Callaly *et al.* 2010; Schmied *et al.* 2010) and a change in the culture of an organisation (Myors *et al.* 2013). While service and policy documents continue to stress the importance of collaboration, some of the opportunities for informal collaboration are diminishing. For example, in the LHD where I work, nearly all of the mandatory training is undertaken on-line, compared to a group environment, which occurred in the past. More and more ongoing professional development is also occurring online rather than face to face. While there are practicalities associated with this, it does limit the opportunities to meet and get to know other colleagues and service providers. The lack of face to face meetings and educational opportunities changes the working milieu, which is an important component of working relationships.

The midwife key stakeholders reported the lack of contact and support they receive from the PIMH clinicians. Management support for the PIMH clinicians to provide ongoing professional development and clinical supervision may support midwives to work with women who have complex needs, particularly if the woman declines or is not accepted into the PIMH service. It will also increase collaborative practice for women during the women's maternity care (Rollans *et al*. 2013).

**Support for clinicians:** Clinicians in this study reported that they enjoy working in the PIMH service, however they also acknowledged that their work is emotionally challenging at times. For clinicians to continue to work effectively with women at risk of perinatal mental ill-health they need support to gain appropriate skills, especially in relation to Attachment Theory and TABEIS, and to have access to clinical supervision.

**Documentation**: Clear guidelines about documenting psychological therapies need to be formulated. Not only is it necessary to document what interventions have been delivered but also how they have been delivered, for example modelling a secure-base. Documentation also needs to include the women's responses to the intervention delivered.

**The risk of isolated services and lack of outcomes data:** Earlier this year I received an email, sent to all of the mental health services in the LHD, from one of the PIMH study sites. It stated that the NSW Ministry of Health had ceased funding one of the PIMH clinician positions. The impact of this funding withdrawal was a significant reduction in the capacity of the service to provide care for vulnerable women during the perinatal period. Not only was an expert clinician lost to the PIMH service, but the women in her care had to be discharged, possibly resulting in negative experiences for the women, as reported in this study.

Large outcome studies are beyond the scope of any individual service; however health care services can provide opportunities for service-users to give feedback. This could occur in the form of short questionnaires or small qualitative studies that may assist in the recognition of the value of a service. Health services can also partner with researchers and/or universities to provide the necessary research expertise.

## 9.7 Strengths and limitations of this study

### 9.7.1 Strengths of this study

There are few studies in the literature that report the characteristics and risk factors of women who are referred to and who engage with specialist PIMH services, and the role and practices of PIMH clinicians. As such, this is an important study that adds to the growing literature about these specialist services. A mixed methods design has provided unique data that would not have been available if a quantitative or qualitative study design alone had been used. The medical record review covered a two-year time-frame, and all available records were reviewed. The small number of women service-users (11) who consented to be interviewed may be considered a limitation of this study; however as few studies report women's experiences of services, especially in mental health, the contribution of these women's experiences is an important aspect of this study. The meta-inferences from this study also go beyond Attachment Theory (Bowlby 1958, 1978) and present a Theory of Attachment Based Exploratory Interest Sharing (Heard *et al.* 2012) as a model for PIMH clinicians to use in their work.

### 9.7.2 Limitations of this study

The medical records reviewed in this study represent a small group of women who received services at two specific sites in NSW, and are not necessarily representative of the population requiring this service. The study was limited by the data that was available in the medical records. A number of variables were deleted from the review tool after the pilot test, for example the women's living arrangements. Although every attempt was made to capture the meaning of the textual data relating to the PIMH clinicians, the use of abbreviations and truncated phrases may have led to some minor misinterpretation. Where there was a lack of clarity, this was reviewed by a supervisor to confirm meaning. Only six PIMH clinicians were interviewed; the clinicians who did not participate in the study may have used different engagement strategies, therapeutic interventions and collaborative practices, and had different experiences from those who were interviewed. A small number of key stakeholders (five) who were involved in women's antenatal care were interviewed. Due to time and resource constraints, the views of key stakeholders who work with women in the early postnatal period were not sought.

Another limitation was the difficulty experienced recruiting women service-users. Two recruitment strategies were needed to recruit the 11 women. Difficulty recruiting women in the perinatal period who are at risk for mental ill-health is not uncommon, especially if it involves contact by an unknown professional (Carter *et al*. 2005). It could be that the women who consented to participate had more positive experiences with the PIMH service than those who chose not to participate. Furthermore, this study did not examine the outcomes for women or infants after being discharged from the PIMH service, which is where future research is needed. Nor did this study canvas the experiences of women who left the service prematurely and who may have been dissatisfied with the service. Nor does it address cultural diversity or differing ages of the women.

The findings of this study, therefore, may not be generalisable to other PIMH services. However, as there are few specialist PIMH services in Australia, these findings will provide potential health services and managers with aspects to be considered when new PIMH services are commissioned.

## 9.8 Recommendations for further research

Despite the positive experiences that the women reported from their engagement with the PIMH service, the short and/or long term outcomes for these women and their infants remain unknown. Large-scale longitudinal research is needed to determine the outcomes of woman, and their infants, who engage with a PIMH service. In the absence of outcome data and evidence, ongoing resources in a continually resource scarce environment will continue to be used with unknown long-term benefits. However, for this to be achieved, appropriate funds and resources are imperative.

Authors (for example, Grote *et al.* 2007; Talbot & Gamble 2008) have recommended specific strategies to enhance engagement into mental health services. Specific engagement strategies need to be implemented and evaluated to help prevent women disengaging prematurely from PIMH services (refer to Chapter 4).

Ongoing research is needed to build upon the current literature base to better understand the specific interventions that provide the best outcomes for women and their infants. Likewise, research about the specific training and skills that clinicians require in order to work in a PIMH service is needed. Without this knowledge, clinicians will continue to use a diverse range of interventions, dependent upon personal preference (refer to Chapter 5).

This study has identified that the PIMH clinicians were at an early stage of collaboration with other professionals and services. Research is needed to identify specific resources needed to enhance collaborative practice (refer to Chapters 6 & 7).

Research is needed to ascertain how best to document the therapeutic work of the PIMH clinicians, especially in relation to Attachment Theory and modelling a secure-base. Any documentation must be clear and must be able to be understood by other professionals and women who may review their medical record.

Finally, further research is needed in regard to TABEIS (Heard *et al.* 2012), especially in the PIMH setting: if and how it resonates with PIMH clinicians, and if it contributes to improved outcomes for women, their infants and their families.

## 9.9 Final research thoughts

As this research journey draws to an end, I reflect on the work of the PIMH clinicians whom this study is predominantly about. The work they do with such passion continues to inspire me. I also think about the women who have additional challenges as they prepare for becoming new mothers. My hope is that services such as PIMH will continue to be developed for the health and wellbeing of mothers and infants, our community and the future generation.

Lastly, I reflect on my current professional position and the choices that I have ahead. To be able to conduct research in an area in which I am committed, mothers and infants, and to continue to work in clinical practice has been a privilege. I look forward to what the future will bring.

## 9.10 Conclusion

The aim of this study has been to explore and describe two specialist PIMH services in NSW, Australia. A convergent, embedded, mixed methods research design was used to understand: the risk factors of women referred to a PIMH service, engagement strategies used by PIMH clinicians, therapeutic interventions and the collaborative practices of PIMH clinicians, the experiences of women who engaged with a PIMH service, and clinicians' experiences of working in a PIMH service.

The inferences for each of the research questions identified that:

- Women referred to the PIMH services have multiple and complex needs; and as such the clinicians focus on the infant, the mother-infant relationship, and are woman-led to enhance engagement throughout the engagement continuum;
- The PIMH clinicians use a diverse range of therapeutic interventions which are underpinned by modelling a secure-base;
- There is a dichotomy between the PIMH clinicians' and key stakeholders' perspectives pertaining to collaboration, and PIMH clinicians require support to work in more collaborative ways;

- Woman service-users value their time with the PIMH service, however discharge practices leave some women feeling abandoned;
- The PIMH clinicians enjoy working with women referred to the PIMH service, however they require support to negotiate an emotionally challenging environment and remain effective clinicians.

In the meta-inferences of this study I have drawn upon the Theory of Attachment Based Exploratory Interest Sharing (TABEIS) and suggest it as a model of care for PIMH clinicians. Being cognisant of the dynamic selves and the external/internal supportive/unsupportive systems may provide opportunities for PIMH clinicians to work in new ways with women. Using TABEIS may assist women to identify and understand the activation of their own individual selves or states, and move to the interest sharing/exploratory self in relation to their infant and his/her needs, as well as the other relationships that the women have. It may also assist clinicians to understand their own selves in the therapeutic relationship, and assist them to work more collaboratively with other service providers.

The importance of the perinatal period for the health and wellbeing of future generations has growing international recognition. The inferences and meta-inferences of this study add to the extant literature to promote the further development of policy, education and clinical practice for professionals who work with women and their infants at risk of poor perinatal mental health outcomes.

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# Appendix 1: **Abstract - *International Journal of Mental Health Nursing***

Myors, K.A., Schmied, V., Johnson, M. & Cleary, M. (2013). Collaboration in perinatal and infant mental health - by whose definition? Abstracts of the Australian College of Mental Health Nursing 39th International Mental Health Nursing Conference – *Collaboration and Partnership in Mental Health Nursing. International Journal of Mental Health Nursing*, *22* (Supplement 1): 25. DOI: 10.1111/inm.12047

## Collaboration in perinatal and infant mental health – by whose definition?

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**INTRODUCTION & BACKGROUND** Over the past decade routine mental health care in the form of psychosocial assessment and depression screening, has been integrated into mainstream maternity and child health services in NSW, Australia. The aim is to identify women at risk of poor perinatal mental health outcomes and refer to appropriate services. Specialist perinatal and infant mental health (PIMH) teams are one such service.

These specialist PIMH services have been implemented within policy documents that refer to the integration and coordination of services for women in the perinatal period. There are however, numerous definitions of collaboration and integrative care. Without clear guidelines implementation poses challenges for clinicians which can impact on service users.

**AIM** To identify how PIMH clinicians, key stakeholders and women service-users view and experience collaboration.

**METHODS** This was a concurrent embedded mixed methods study. Data collection comprised of reviewing 244 medical records, transcriptions of textual data, interviews with 13 professionals and interviews with 11 women who had accessed and been discharged from a PIMH service. Ethical approval was granted by the University of Western Sydney and the two area health services.

**RESULTS** PIMH clinicians reported that they worked within a collaborative framework. Key stakeholders reported collaborative practices needed to improve. Collaboration impacted women negatively when referral processes weren’t followed through, especially at discharge.

**OUTCOMES/SIGNIFICANCE** There are multiple definitions for collaboration. Policy documents are often not clear about collaboration or integration. Clinicians and services view collaboration differently.

**TRANSLATION TO POLICY AND/OR PRACTICE CHANGE** Key services need to mutually agree about collaborative practices.

**LEARNING OBJECTIVES** 1. Collaboration has different meanings to different professionals. 2. Collaboration needs to be defined within services if it is to be enacted by professionals. 3. Collaboration can impact upon client outcomes.

# Appendix 2: **Abstract - *Archives of Women's Mental Health***

Myors, K.A., Schmied, V., Johnson, M. & Cleary, M. (2013). Specialist perinatal mental health services: characteristics of women & services provided. The Marce International Society International Biennial General Scientific Meeting "Acting Together Around Childbirth", *Archives of Women's Mental Health, 16* (Supplement 1): s36. DOI: 10.1007/s00737-013-0355-x

## Specialist Perinatal Mental Health Services: Characteristics of Women & Services Provided

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**Introduction**: In Australia, integrated models of care are being explored for women who need additional support during pregnancy and after birth. Many women identified as having risk factors for poor perinatal mental health are referred to specialist perinatal and infant mental health (PIMH) teams. To date however, there has been limited evaluation of these teams and the services they provide.

**Aims**: This presentation will:
1. describe the characteristics of women who are referred to specialist PIMH teams;
2. report on the services that the specialist PIMH teams provide to women; and
3. illustrate how specialist PIMH clinicians envisage their role with women and other services.

**Methods**: A mixed method study (utilising both quantitative and qualitative methods of data collection and analyses) was undertaken in two sites in New South Wales, Australia. 244 medical records were reviewed of women who had been a client of a specialist PIMH team between 2010 and 2011, representing 85 % of the caseload over this time frame. 11 women who had accessed the services of a specialist PIMH team and 13 professionals were interviewed.

**Results**: 57 % of women were multiparous, 73 % were married or living as married, over 90 % of women had greater than 2 risk factors and the majority of women received over 3 types of interventions e.g. supportive counselling, psychoeducation.
Specialist PIMH teams are multidisciplinary. Professionals use a number of strategies to engage women including home visits, text messaging and written letters. Following initial referral, the PIMH service made on average 2–3 phone calls to make contact with women and 29 % of women did not engage in the service.
Professionals work in both a case management model and a therapy model, depending upon the needs of the woman, and provide a consultative role for other services e.g. adult mental health, private obstetricians.
Women reported that they highly valued the service but did not have a strong sense of the interventions they were receiving.
Conclusions: This study has helped provide clarity about specialist PIMH teams, a little researched area, the services that are provided and the characteristics of the women who receive the care.

# Appendix 3: **Chapter Two Online Supporting Information**

**Table S1.** Studies of professionals' perceptions and experiences of collaboration and integration – extended version.

| Authors/Country/Title | Aim | Type of study | Participants | Results | Related themes |
|---|---|---|---|---|---|
| Janssens, A., Peremans, L. & Deboutte, D. (2010). Belgium. Conceptualizing collaboration between children's services and child and adolescent psychiatry: A bottom-up process based on a qualitative needs assessment among the professionals. | To explore professionals of children's services and child and adolescent psychiatry perceptions of the development of future collaborative partnerships. | Grounded theory: focus groups. | 16 children's services and 1 child and adolescent psychiatric centre. Children's services – 5 focus groups with 30 participants. Child and adolescent psychiatry centre – 3 focus groups with 26 participants. | Participants agreed upon the goal of partnership and preferred case level to organisational level collaboration, with direct face to face communication seen as a key factor. Defined boundaries and role definitions within an atmosphere of mutual trust was also seen as necessary. | Funding and resources for collaboration;<br>Pathways and guidelines;<br>Role clarity;<br>Continuity of care;<br>Shared vision, aims and goals;<br>Building relationships and trust. |
| Brown, M., Mills, N., McCalmont, C. & Lees, S. (2009). United Kingdom. Perinatal mental health services. | To explore how perinatal mental health services are provided in three local primary care trusts. | Mixed methods study: review of documentation, structured questionnaire, focus groups. | The questionnaire was completed by community midwives (n=74), final year midwifery students (n= 19), obstetricians (n=22), perinatal mental health practitioners (n=3) and health visitors (n=13).<br>Six focus groups with midwives (n=50). One | To increase perinatal mental health service provision organisations need to implement: universal pathways to care; increased liaison and communication between services and professionals; structured mental health assessments; and interdisciplinary | Funding and resources for collaboration;<br>Pathways and guidelines. |

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| | | | focus group interview with midwifery students (n=18). | education about perinatal mental health. | |
| Lees, S., Brown, M., Mills, N. & McCalmont, C. (2009). United Kingdom. Professionals' knowledge of perinatal mental health care. | To explore perinatal mental health services in one area of the UK. | Mixed methods: analysis of referral documentation, structured questionnaire, focus groups. | Referral documentation for women who were referred for perinatal mental health care 1.9.2006 - 31.8.2007; a structured questionnaire sent to perinatal mental health staff, midwives, student midwives, obstetrician and health visitors (n=74), 6 focus groups with midwives (n=50); and 1 focus group with student midwives (n=18). | Formal referral pathways and universal processes need to be developed; more specialist perinatal mental health staff are required; and healthcare staff need further training on perinatal and mental health issues. | Funding and resources for collaboration;<br>Pathways and guidelines;<br>Training and education of staff. |
| McConacie, S. & Whitford, H.<br>(2009). United Kingdom. Mental health nurses' attitudes towards severe perinatal mental health. | To explore the experiences and attitudes of mental health nurses when working with women who have severe mental illness during the perinatal period. | Qualitative: Cross-sectional exploratory study using focus groups. | Three focus groups with mental health nurses (n=16). | Participants reported that: symptoms of mental illness are the same during the perinatal period as other times; there were feelings of fear and anxiety when caring for women who had infants; the use of a screening tool had decreased communication | Pathways and guidelines;<br>Support to work in new ways;<br>Building relationships and trust. |

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| | | | | between services and clinical decision making; and increased confidence was expressed when professionals worked with colleagues who they knew and trusted. | |
| Darlington, Y. & Feeney, J.A.<br>(2008). Australia.<br>Collaboration between mental health and child protection services: Professionals' perceptions of best practice. | To explore mental health and child protection professionals' perceptions of best practice when working in cases where there is parental mental illness and child protection concerns. | Qualitative: responses to a open-ended question on a self-administered cross sectional state wide survey. | Professionals in mental health (n=128) and child protection (n=97) services.<br>7 participants worked in either both services or did not provide this information. | To improve interagency relationships and collaborative processes professionals need: improved communication at the organisational and clinical (case) level; enhanced knowledge and skills; and adequate resources and appropriate service models. | Funding and resources for collaboration;<br>Pathways and guidelines;<br>Training and education of staff;<br>Role clarity;<br>Continuity of care;<br>Shared vision, aims and goals;<br>Building relationships and trust. |
| Hauck, Y., Rock, D., Jackiewicz, T. & Jablensky, A.<br>(2008). Australia.<br>Healthy babies for mothers with serious mental illness: A case management framework for mental health clinicians. | Development of a framework for community mental health clinicians to improve the reproductive health outcome for women with serious mental illness. | Qualitative: focus groups and interviews. | Focus groups with community mental health clinicians (n=55), interviews with midwives (n=11), midwifery managers (n=4), psychiatrists (n=5), general practitioners (n=2) obstetrician (n=1) and community agencies (n= not given). | A framework for perinatal mental health services should include: a holistic approach; reproductive/consumer choice; and continuity of care. This led to 3 key elements: early detection and monitoring of pregnancy; providing | Role clarity;<br>Continuity of care;<br>Shared vision, aims and goals. |

| | | | | | |
|---|---|---|---|---|---|
| | | | | reproductive choices; and a small known team approach. | |
| Rothera, I. & Oates, M. (2008). United Kingdom. Managing perinatal mental health disorders effectively: identifying the necessary components of service provision and delivery. | To identify the core components of care and service delivery for women experiencing perinatal mental illness and identify service gaps. | Qualitative: interviews and focus groups | Interviews: health professionals (n=39) – adult and perinatal psychiatrists, obstetricians, health visitors, midwives, general practitioner, primary care mental health practitioners and health service managers.<br>Focus groups: 2 with recovered women (n=5, n=7). | Non – specialist health care professionals lacked specific knowledge and skills; need improved access to psychiatric care; the systematic development of pathways, protocols and guidelines; there are fragmented and disjointed services with minimal communication; professionals are unclear about their roles and responsibilities. | Funding and resources for collaboration;<br>Pathways and guidelines;<br>Training and education of staff;<br>Role clarity;<br>Continuity of care;<br>Shared vision, aims and goals |
| Rowan, C. & Bick, D. (2008). United Kingdom. Evaluation of the provision of perinatal mental health services in two English strategic health authorities. | To evaluate service provision and the implementation of the NICE recommendations in two UK health authorities. | Quantitative: semi-structured survey questionnaire. | 24 of 39 maternity units responded (62% response rate). The paper does not identify the professionals who completed the survey. | Most of the maternity units had guidelines for women at risk of perinatal mental illness. Less than half of the units had access to a perinatal psychiatrist or midwife. Liaison with psychiatric services needs to be strengthened. Most units were restrained | Funding and resources for collaboration;<br>Training and education of staff;<br>Building relationships and trust. |

| | | | | | |
|---|---|---|---|---|---|
| | | | | by planning and resource issues. | |
| Elliott, S.A., Bewley, S., Green, L., Hunter, M. & Hodgkiss, A. (2007). United Kingdom. Stakeholder views: necessary but not sufficient in devising mental health provision for maternity services. | To identify stakeholder views for the development of a new perinatal mental health service. | Qualitative: interviews. | Midwives (n=6), maternity services manager (n=1), consultant obstetricians (n= 5), antenatal clinic users (n=4), user group providers (n=2), members of user groups (n=3), users of the prior specialist mother and infant mental health service (n=2), adult mental health clinicians (n=8), child and family mental health clinicians (n= 2), learning disability service clinician (n=1), perinatal mental health specialists (n= 7), general practitioners (n= 2), health visitors (n=2), nurse educator in perinatal mental health(n=1), providers from a voluntary service (n=2), social workers (n=2) and members of the health authority (n=2). | Maternity staff should receive training to support their role in perinatal mental health; referral pathways are needed between maternity and mental health services; mental health services should include multidisciplinary teams which provide a range of treatments; collaboration between services need to occur at the organisational and professional level. | Funding and resources for collaboration;<br>Pathways and guidelines;<br>Training and education of staff;<br>Role clarity;<br>Continuity of care;<br>Support to work in new ways;<br>Building relationships and trust. |

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|---|---|---|---|---|---|
| Freeman, T. & Peck. E. (2006). United Kingdom. Evaluating partnerships: a case study of integrated specialist mental health services. | An evaluation of a county-wide implementation of specialist integrated community mental health services, 2002-2004. | Multi-method approach: focus groups, interviews and questionnaires. | Focus groups with users and carers (n=31) of the mental health system, semi-structured interviews with team managers (n=31), self completion questionnaire for each team member (medical, social care, nursing, psychology) of community mental health (n=not given). | Professional disagreement during crisis episodes, the 'extra' time through integration was not forthcoming. The co-location of teams increased informal communication. Users of the new system were positive. Carers were also positive about the new change however, carers and users have different frames of reference, re inpatient admissions, due to different lived experiences. Two of the teams reported positive benefits from the change. Two teams reported decreased job satisfaction and one team reported difficulty in implementing the new model due to staff shortages and turnover. | Funding and resources for collaboration;<br>Role clarity;<br>Continuity of care;<br>Building relationships and trust. |
| Darlington, Y., Feeney, J.A. & Rixon, K. (2005a). Australia. Practice challenges at the intersection of child | To examine collaboration between mental health and child protection services where there | Qualitative: in-depth interviews. | Child protection workers (n=17), adult mental health workers (n=15) and child and youth | Four domains assist collaboration: communication, knowledge, role clarity and resources (staff, | Funding and resources for collaboration;<br>Training and education of staff; |

| | | | | | |
|---|---|---|---|---|---|
| protection and mental health. | is parental mental illness and child protection concerns. | | mental health workers (n= 4). Participants were from metropolitan, rural and remote areas. | training and time). Challenges to collaboration related to the often chaotic nature of mental illness and balancing the needs of parents and children. | Role clarity;<br>Continuity of care;<br>Shared vision, aims and goals;<br>Building relationships and trust. |
| Darlington, Y, Feeney, J.A. & Rixon, K. (2005b). Australia. Interagency collaboration between child protection and mental health services: Practices, attitudes and barriers. | To examine factors that facilitate and hinder interagency collaboration between child protection and mental health services. | Quantitative: self administered, cross sectional survey. | 1105 questionnaires mailed to the medical officers of the Suspected Child Abuse and Neglect (SCAN) Team, all child protection workers and team leaders of mental health teams in the state of Queensland in July 2002. 232 responses, 21% overall response rate – 36% SCAN Team medical officers, 17% child protection workers, 24% mental health workers. | Current practices: moderate amount of interagency contact, minimal in-depth collaboration.<br>Attitude: most respondents reported a positive attitude to collaboration but felt constrained by lack of organisational supports.<br>Barriers: inadequate resources, confidentiality, gaps in interagency processes, unrealistic expectations and professional knowledge domains and boundaries. | Funding and resources for collaboration;<br>Pathways and guidelines;<br>Training and education of staff. |
| Macdonald, E., Mohay, H., Sorensen, D., Alcorn, N., McDermott, B., Lee, E. & Members of the Mater CYMHS Infant Mental Health Steering Committee. | To identify support services for infants 0 – 2 years and their families, identify access issues and make | Qualitative: focus groups and semi-structured interviews. | Focus groups and semi-structured interviews with staff of antenatal care or children's (0-2 years) services (n=18 | Of the 18 services only 4 provided a joint parent- infant focus. Services were fragmented, lacked communication and | Funding and resources for collaboration;<br>Pathways and guidelines;<br>Role clarity; |

| | | | | | |
|---|---|---|---|---|---|
| (2005). Australia.<br>Current delivery of infant mental health services: are infant mental health needs being met? | recommendations to increase access. | | services) either home, community or hospital based. | continuity as the infant/s developed over time; there was a shortage of services working jointly with the parent and infant; and services had difficulty providing support for some at-risk populations. | Continuity of care;<br>Shared vision, aims and goals;<br>Building relationships and trust. |
| Darlington, Y., Feeney, J.A. & Rixon, K.<br>(2004). Australia.<br>Complexity, conflict and uncertainty: Issues in collaboration between child protection and mental health services. | To examine collaboration between mental health and child protection services and to determine if the uncertainty of parental mental illness and of child protection concerns impacts upon professional collaboration. | Qualitative: analysis of written case studies. | Adult mental health and child protection workers (n=122) provided descriptions of 300 cases. | Professionals collaborated widely across government and community-based organisations; workers found the collaborative process rewarding. Difficulties reported related to the need for: improved communication, increased role clarity, leadership and coordination, inadequate resources and when there was uncertainty about parental mental illness or child protection concerns. | Funding and resources for collaboration;<br>Pathways and guidelines. |

# Appendix 4: **Letter of Invitation for Women**

Local Health Network Letter Head

## Perinatal Pathways Study

### LETTER OF INVITATION

Dear ,

This is a letter of invitation to participate in a study about your experience of being a client of a perinatal and infant mental health service. In NSW it is routine to ask all women before and after birth about their social and emotional wellbeing. Women who identify as having some emotional or social difficulty at these times are often referred to a specialist perinatal and infant mental health service.

The purpose of this study is to explore women's experiences of these specialised services, the treatments or services that were provided and the outcomes for women and their infants at the end of the service use. From this study we hope to be able to improve the services available for women, infants and their families.

The study is being conducted through the University of Western Sydney by Professor Virginia Schmied, Professor Maree Johnson, Associate Professor Michelle Cleary and PhD candidate Ms Karen Myors.

Participation in the study will involve:

1. A face to face interview. This will occur at a time and place convenient to you. The interview will involve a number of questions about your experience or perceptions of the perinatal and infant mental health service that you received. The interview will take approximately 30 to 60 minutes and with your permission will be audio recorded.

2. The researcher will also ask your permission to review your medical record for the time you were a client of the perinatal and infant mental health service.

The study is completely voluntary and you can withdraw at any time.

If you are interested and would like to have further information, please complete and return the attached slip in the reply paid envelope and you will be contacted by Karen Myors, or alternatively you can contact her on [redacted].

Please be assured that I will not be aware of whether you participate in this study or not, so whatever you decide to do, it will not affect the care you receive from me now or in the future.

Yours sincerely,

[insert name of PIMH manager]

Perinatal Pathways Letter of Invitation, Version 3, December 2010 Page 1 of 2

# Perinatal Pathways Study

I am interested in the study and would like to find out more about it:

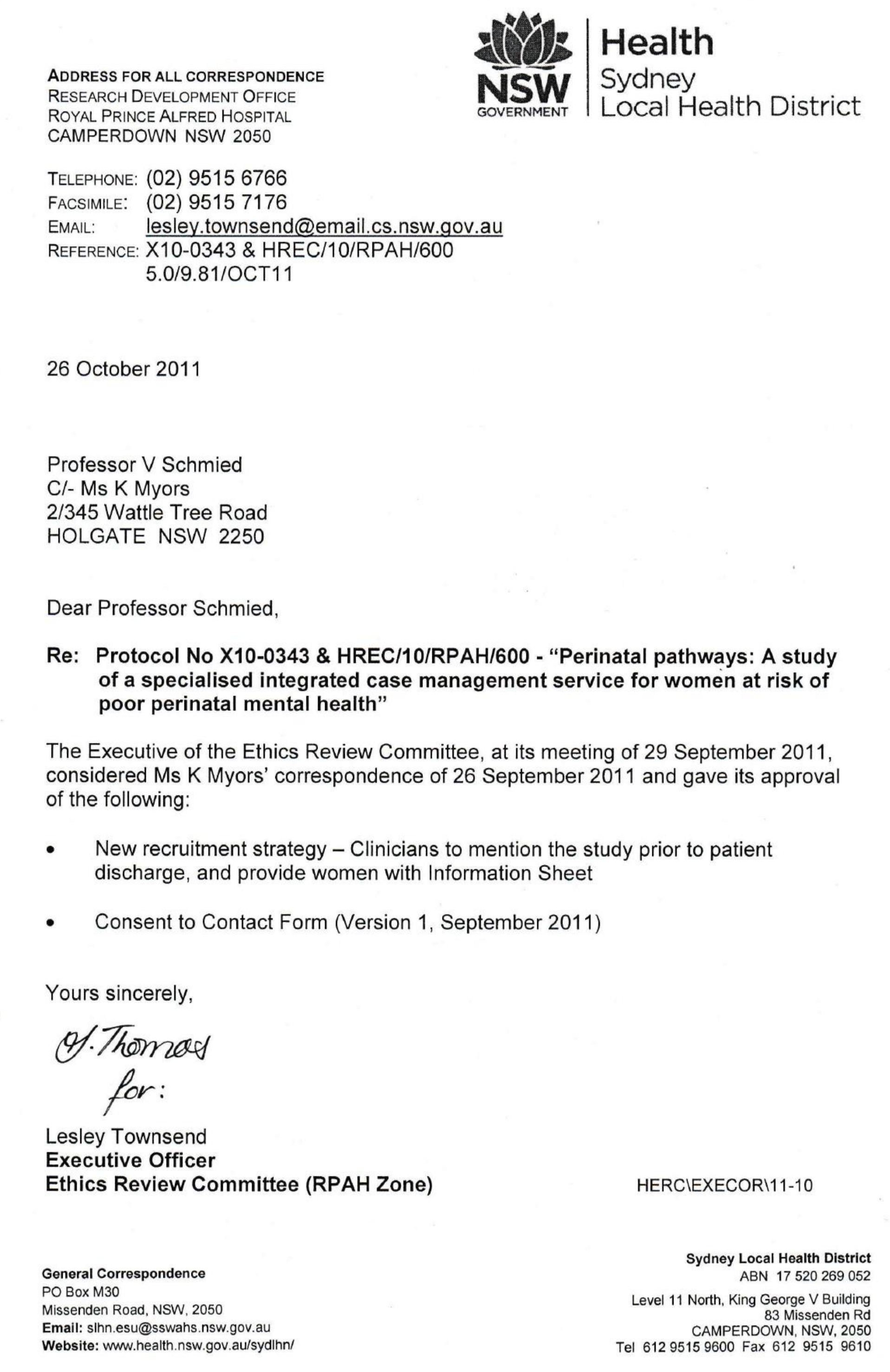
Name: ..........................................................................................................................

Telephone Number: ..........................................................................................................................

Please mail to:

Ms Karen Myors/Professor Virginia Schmied
C/- University of Western Sydney
Parramatta Campus
School of Nursing & Midwifery
College of Health & Science
Locked Bag 1797
Penrith South DC
NSW 1797

# Appendix 5: **Ethics Amendment**



Health
Sydney
Local Health District
NSW
GOVERNMENT

ADDRESS FOR ALL CORRESPONDENCE
RESEARCH DEVELOPMENT OFFICE
ROYAL PRINCE ALFRED HOSPITAL
CAMPERDOWN NSW 2050

TELEPHONE: (02) 9515 6766
FACSIMILE: (02) 9515 7176
EMAIL: lesley.townsend@email.cs.nsw.gov.au
REFERENCE: X10-0343 & HREC/10/RPAH/600
5.0/9.81/OCT11

26 October 2011

Professor V Schmied
C/- Ms K Myors
2/345 Wattle Tree Road
HOLGATE NSW 2250

Dear Professor Schmied,

**Re: Protocol No X10-0343 & HREC/10/RPAH/600 - "Perinatal pathways: A study of a specialised integrated case management service for women at risk of poor perinatal mental health"**

The Executive of the Ethics Review Committee, at its meeting of 29 September 2011, considered Ms K Myors' correspondence of 26 September 2011 and gave its approval of the following:

- New recruitment strategy – Clinicians to mention the study prior to patient discharge, and provide women with Information Sheet
- Consent to Contact Form (Version 1, September 2011)

Yours sincerely,

Y. Thomas
for:

Lesley Townsend
**Executive Officer**
**Ethics Review Committee (RPAH Zone)**

HERC\EXECOR\11-10

**General Correspondence**
PO Box M30
Missenden Road, NSW, 2050
**Email:** slhn.esu@sswahs.nsw.gov.au
**Website:** www.health.nsw.gov.au/sydlhn/

**Sydney Local Health District**
ABN 17 520 269 052
Level 11 North, King George V Building
83 Missenden Rd
CAMPERDOWN, NSW, 2050
Tel 612 9515 9600 Fax 612 9515 9610

# Appendix 6: Consent to Contact Form

Locked Bag 1797
Penrith South DC NSW 1797 Australia
Professor Virginia Schmied
School of Nursing & Midwifery
College of Health & Science
v.schmied@uws.edu.au
Ph 61-2- 9685 9505
Fax 61-2- 9685 9835

University of Western Sydney

**Study Title**: Perinatal Pathways: A study of a specialised integrated case management service for women at risk of poor perinatal mental health.

**Researchers**: Ms Karen Myors, student researcher
Professor Virginia Schmied
Professor Maree Johnson
Associate Professor Michelle Cleary

## Perinatal Pathways Study

## CONSENT TO CONTACT

I give my permission for my name and contact details to be given to the researcher, Karen Myors, and for Karen to contact me. I understand that I am not obliged to participate in this study.

My name is: ________________________________________ (please print)

Signature: ___________________________________ Date: ________________

My telephone contact numbers are: (Home) _______________________________

(Mobile) ______________________________

The best days/times to call me are: __________________________________

# Appendix 7: **Medical Record Review Tool**

## Perinatal Pathways
## Medical Record Review Tool

**Demographic data:** **1.** Review date: **2.** Code Number:

**3.** [redacted] ANC [redacted] ANC [redacted] ANC [redacted] ANC

Other referral:

**4.** Country of Birth: **5.** Date of birth: Age in years at time of (last) service:

**6.** Parity: G: P: **7.** EDC: **8.** DOB (baby):

**9.** Gestation at: Referral to PIMH: **10.** First contact by PIMHS: **11.** Assessment by PIMHS:

**12.** Previous client of PIMH service: ☐ Yes ☐ No

**13. Marital status:**

☐ 1. Married/living as married

☐ 2. Widowed

☐ 3. Divorced / separated

☐ 4. Never married

**SAFE START Risk Factors identified in the psychosocial assessment and referral to PIMHS**

**14. Level 2:**

| **Past** | **Present** | **From Ax** |
|---|---|---|
| ☐ | ☐ | ☐ 1. High EDS antenatally |
| ☐ | ☐ | ☐ 2. Depression |
| ☐ | ☐ | ☐ 3. PND |
| ☐ | ☐ | ☐ 4. Relationship issues |
| ☐ | ☐ | ☐ 5. Anxiety/anxious mood |
| ☐ | ☐ | ☐ 6. Adult sexual assault |
| ☐ | ☐ | ☐ 7. Childhood abuse/neglect |
| ☐ | ☐ | ☐ 8. Age (< 20 years) |
| ☐ | ☐ | ☐ 9. Recent grief or loss |
| ☐ | ☐ | ☐ 10. Mental health problem e.g. eating disorder |
| ☐ | ☐ | ☐ 11. Lack of/Poor support network/isolated |

| **Past** | **Present** | **From Ax** |
|---|---|---|
| ☐ | ☐ | ☐ 12. Breastfeeding issues |
| ☐ | ☐ | ☐ 13. Medical condition of baby |
| ☐ | ☐ | ☐ 14.Financial stress |
| ☐ | ☐ | ☐ 15. Unstable housing |
| ☐ | ☐ | ☐ 16. Partner unemployed |
| ☐ | ☐ | ☐ 17. Late antenatal care |
| ☐ | ☐ | ☐ 18. Refugee/recent migrant |
| ☐ | ☐ | ☐ 19. Child with a disability/chronic illness |
| ☐ | ☐ | ☐ 20. Adult with a disability/chronic illness |
| ☐ | ☐ | ☐ 21. Other |

**15. Level 3:**

| **Past** | **Present** | **From Ax** |
|---|---|---|
| ☐ | ☐ | ☐ 1. Maternal mental illness |
| ☐ | ☐ | ☐ 2. Partner mental illness |
| ☐ | ☐ | ☐ 4. Maternal substance use |

| **Past** | **Present** | **From Ax** |
|---|---|---|
| ☐ | ☐ | ☐ 3. Domestic violence |
| ☐ | ☐ | ☐ 5. Child protection issues |

**Psychiatric only**

**16. Current medications: (use generic name)**

| Current Medication | Dose | Frequency | Route |
|---|---|---|---|
| | | | |
| | | | |

**17. Management of medication in the community:** ☐ **GP** ☐**Psychiatrist** ☐ **Other:**

**18. MH-OAT Risk Assessment –**

| | **Suicide** | | | **Violence** | | |
|---|---|---|---|---|---|---|
| | **Y** | **No** | **UNK** | **Y** | **No** | **UNK** |
| 1. Significant past history of risk | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2. Recent thoughts, plans, symptoms indicating risk | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3. Recent behaviour suggesting risk | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| **MH-OAT Risk Assessment (continued)** | **Yes** | **No** | **UNK** |
|---|---|---|---|
| 1. Current problems with alcohol or substance abuse | ☐ | ☐ | ☐ |
| 2. Major mental illness or disorder | ☐ | ☐ | ☐ |
| 3. At risk mental state | ☐ | ☐ | ☐ |
| 4. Person's level of risk appears to be highly changeable | ☐ | ☐ | ☐ |
| 5. Significant uncertainty in the assessment of the level of risk | ☐ | ☐ | ☐ |
| 6. Has the Risk Assessment module been completed? | ☐ | ☐ | ☐ |

| **Overall level of risk (current/immediate)** | **High** | **Med** | **Low** |
|---|---|---|---|
| 1. Suicide | ☐ | ☐ | ☐ |
| 2. Violence | ☐ | ☐ | ☐ |
| 3. Other* (specify) | ☐ | ☐ | ☐ |
| 4. Other* (specify) | ☐ | ☐ | ☐ |
| **consider child safety, absconding, domestic violence, homelessness, neglect, abuse* | | | |

**19. Clinician's professional background:**

☐ Nurse ☐ Psychologist ☐ Social worker ☐ Psychiatrist ☐ OT ☐ Other:

**20. Diagnosis/Clinical impression as recorded in notes by a health professional:**

**(tick as many as applicable)**

- ☐ 1. Depression
- ☐ 2. Anxiety
- ☐ 3. Post Traumatic Stress Disorder/complex trauma
- ☐ 4. Situational crisis
- ☐ 5. Relationship breakdown
- ☐ 6. Past eating disorder
- ☐ 7. Developmental delay
- ☐ 8. Past alcohol and other drug use
- ☐ 9. Grief and loss
- ☐ 10. Bipolar disorder
- ☐ 11. Schizophrenia
- ☐ 12. Adjustment to parenting
- ☐ 13. Other (please specify)
- ☐ 14. Other (please specify)

**21. Treatments/Interventions implemented by clinician:**

- ☐ 1. Review by psychiatrist: ☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x ☐ 6x

- ☐ 2. Parent/infant therapy
- ☐ 3. Parent/infant therapy (with videotaping)
- ☐ 4. Cognitive behavioural therapy
- ☐ 5. Interpersonal therapy
- ☐ 6. Narrative therapy/scaling questions
- ☐ 7. Psycho-education (handouts)
- ☐8. Strategies for managing anxiety, depression
- ☐ 9. Body Awareness
- ☐ 10. Wellness plans
- ☐ 11. Relapse prevention
- ☐ 12. Solution Focused questioning
- ☐ 13. Motivational interviewing
- ☐ 14. Family of origin work, genograms
- ☐ 15. Couples work
- ☐ 16. Family intervention
- ☐ 17. Strength cards and other media
- ☐ 18. Role play (experiential)
- ☐ 19. Modelling
- ☐ 20. Perinatal Care Plan
- ☐ 21. Advocacy
- ☐ 22. Child development (play)
- ☐ 23. Groups
- ☐ 24. Transport
- ☐ 25. Risk assessments
- ☐ 26. Service coordination/referrals
- ☐ 27. Management/Care plans
- ☐ 28. Supportive counselling
- ☐ 29. Mental health (DASS, EDS, K10 etc),
- ☐ 30. Medication management
- ☐ 31. Domestic Violence
- ☐ 32. Child protection
  - ☐ informed of mandatory reporting
  - ☐ report made
- ☐ 33. Other:
- ☐ 34. Other:

**Text example of intervention:**

☐ 35. Referral to another service

| Service | Verbal referral | Written referral | Client attended | Feedback to CM |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Text example of referral:**

**22. Contact with CM (record date)**

**No of attempted contacts for first contact:** ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

01 P/C no answer/message left 02 P/C appt made/info given 03 P/C brief counselling

| Date | Data e.g. P/C, Centre, HV | Related text |
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**Total no of contacts (+ attempts):**

**Total no of contacts directly with client:**

**23. CM contact with other services (record date):**

| Service | Verbal contact initiated by CM | Verbal contact initiated by service | Written contact by CM | Written contact by service | Face to face meeting |
|---|---|---|---|---|---|
| Midwifery services | | | | | |
| C&FHN | | | | | |
| GP | | | | | |
| Mental Health C/L | | | | | |
| Adult Mental Health community | | | | | |
| CAMHS | | | | | |
| Community Services | | | | | |
| NGO specify | | | | | |
| NGO specify | | | | | |
| Other specify | | | | | |
| Other specify | | | | | |

**Text example of contact with other service:**

**24. Notes held open for ?weeks:** ☐ 0 ☐ 1-2 ☐ 2-4 ☐ 6-8 ☐ 8-10 ☐ 10-12 ☐ 12-14

**25. Discharge:**

☐ 1. Mutual/negotiated discharge by case manager

☐ 2. Referred to another service by case manager

Who:

☐ 3. Self discharged

☐ 4. Discharged as unable to be contacted

☐ 5. Other:

**Text example of discharge:**

**26.** Length of time with PIMHS: Months Weeks

**27.** Age of child at discharge:

☐ 1. antenatal

☐ 2. < 3months

☐ 3. 3-6 months

☐ 4. 6-9 months

☐ 5. 9-12 months

☐ 6. > 12 months

**28.** Engagement: ☐ Nil ☐ Low ☐ Mod ☐ High

**Text example of engagement**

**29.** Exit Outcome: ☐ Positive ☐ Negative

**Text example of outcome**

**Definitions**

Engagement:

- nil - the woman declines the service;
- low - case managers have difficulty making contact with the woman (over 3 phone calls and / or a letter sent) prior to contact and/or two or more appointments cancelled/no shows with no reason given; or the woman attends appointments does not engage with the clinician (difficult to determine form the notes)
- high - contact is negotiated between the case manager and the woman.

Note engagement does change at times as well.

Exit outcome:

- positive - the case manager and the woman negotiate and agree to discharge from the service and/or referral to another service;
- negative - the woman insists upon discharge against the case managers recommendation and/or does not accept referral to another service and/or cannot be contacted by the case manager and is therefore discharged from the service.

# Appendix 8: **Medical Record Textual Data Template**

**Perinatal Pathways**

## Medical Record Review Textual Data Template

**Code Number:**

**Text example of intervention:**

**Text example of referral:**

**Text example of contact with other service:**

**Text example of discharge:**

**Text example of engagement:**

**Text example of outcome**

# Appendix 9: **Interview Guide - PIMH Clinicians**

## Perinatal Pathways:
## A study of a specialised case management service for women at risk of poor perinatal mental health

## Interview Guide - PIMH Clinicians

In 2009 the Supporting Families Early policy (also known as SAFE START) was introduced by NSW Health. Despite this, your area was already implementing many of the strategies. This study is particularly interested in the specialist PIMH services.

What is your professional background?

<u>Service</u>:

Can you describe your service for me?

What are its aims?

What theories/concepts or frameworks informs your practice?

e.g. attachment theory.

<u>Engagement</u>:

Families with multiple challenges are often difficult to engage in services. What do you find works to connect with the woman in some sense?

e.g. What strategies do you use to engage women in the service?

How do you know that a woman is engaged in the service?

e.g. What do you look for/identify that a women has been successfully engaged with the service?

Are there any other strategies that you would like to use but can't e.g. due resources?

Stigma is cited in the literature as being a primary barrier to engagement in mental health services. Do you find stigma an issue, either about the service or the stigma of having a mental illness or a history of trauma?

e.g. How do you deal with the issue of stigma related to mental health treatments/services or mental illness or trauma itself in engaging women into your service?

Within health care developing a trusting relationship with clients is important, however it is more essential for mental health services. How do you build a trusting relationship with your clients?

e.g. What strategies/techniques do you use?

Interventions:

What services or interventions do you provide/use for the women you see?

Out of these interventions which three would you use most of the time?
Why?

Case management:

What does the term case management mean to you?

Do you work within a case management model?

Integration:

What other services do you predominantly work with in regard to your clients?

Can you describe the forms or ways that you communicate with these services?

Are some services more closely connected to you and others more distant?

What type of working relationship do you have with these other services?

Do you refer your families to other agencies/organisations?

Which ones do you mainly refer to?

The NSW Health *Supporting Families Early* policy i.e. SAFE START, talks about integrated services. Do you think the service you work in is integrated?
Why?
Why not?

Experiences:

Can you describe some of the positive experiences of working in a PIMH team?

Can you describe some of the negative experiences of working in a PIMH team?

What skills or training do you think is needed for someone to work in this type of specialty service?

Working with families who have many challenges can be draining and stressful for clinicians. Do you feel supported in the work that you do?
By your colleagues, by management?
Why?
Why not?

What is your usual caseload?

Is there anything else you would like to add?

# Appendix 10: **Interview Guide - PIMH Managers**

## Perinatal Pathways:
## A study of a specialised integrated case management service for women at risk of poor perinatal mental health

### Interview Guide - PIMH Managers

1. Can you tell me about the history of the PIMH service, was there anything in particular that made it happen, why it was established, who designed it and championed its implementation?
2. What year was the service initially set up?
3. Can you describe the current PIMH service and its model/s of care and how it operates?
4. How was the model/s developed and who designed it?
5. How long has the service been working in this model/s?
6. Is the current service model significantly different to the one that was initially implemented?

   If so, why?
7. Can you describe the demographics of the population that you service and how has this influenced the model/models of care?
8. In regard to the staff how many FTEs are employed and what is their professional background?
9. What are the factors that facilitate the services' continuing function?
10. What are the barriers or challenges in providing the service?
11. In regard to other services, who does the PIMH service work most closely with and why?
12. How would you describe the relationships with these other services and professionals?
13. What does/or would facilitate these relationships?
14. In an ideal world with no barriers such as resources, how would you like to see the service operating?

# Appendix 11: **Interview Guide - Key Stakeholders**

## Perinatal Pathways:
## A study of a specialised case management service for women at risk of poor perinatal mental health

### Interview Guide - Key Stakeholders

1. Can you tell me about the history of the PIMH service, was there anything in particular that made it happen, why it was established, who designed it and championed its implementation?

2. What year was the service initially set up?

3. Can you describe the current PIMH service and its model/s of care and how it operates?

4. How was the current model/s developed and who designed it?

5. How long has the service been working in this model/s?

6. Is the current service model significantly different to the one that was initially implemented?

7. If so, why?

8. What is the current aims or purpose of this service?

9. Has this changed since it was initially set up?

10. From your experience what may be the benefits for women and their families of engaging in this service?

11. Are there any less positive aspects of the service for women and families?

12. From your experience what has been the positive aspects of working or linking with this service?

13. Is there anything that you would have liked to have been different?

14. In an ideal world with no barriers such as resources, how would you like to see the service operating?

# Appendix 12: **Interview Guide - Women Service-users**

## Perinatal Pathways: A study of a specialised case management service for women at risk of poor perinatal mental health

### Interview Guide - Women

1. Can you describe your initial feeling/reaction when you were asked about being referred to a specialist perinatal and infant mental health service?
2. Can you remember what happened after your initial referral to the perinatal and infant mental health service, for example how long did you have to wait to be contacted?

   What was this like for you?
3. Can you tell me about your experience with the service – what were the best things and the less positive things for you?
4. Over this time, did you have contact with the same person from the service?
   Would you have preferred to have had contact with mainly one person?
   How many people from the service were in contact with you?
5. Where did you usually meet e.g. at home, at a health centre, in a public area e.g. coffee shop, main contact over the phone?
6. What was your preferred venue?
   Why?
7. Can you tell me something about what the case manager or other clinicians provided for you – any particular treatment or services?
   For example, what interventions or treatments did you receive from the service e.g. review with a psychiatrist, medication commencement/change, videotaping, education about child development?
8. Did you find that you could easily relate to the person who you had contact with?
   Why? Why not?
9. Were you involved with other services at the same time?
10. What was helpful or less helpful about these other services?
    Why? Why not?
11. Did you tell anyone, family or friends, that you were seeing a mental health specialist?

    Why? Why not?
12. Looking back, now that you are no longer with the service, what was your overall experience?
13. In the future how would you feel if you were referred to another perinatal and infant mental health service?
14. Is there anything else you would like to add?

# Appendix 13: Mixed Methods Matrix of Therapeutic Interventions

| Intervention - grouped from medical record review | Quantitative data - frequency of use from medical record review (N=244) | Intervention - examples from medical record review (N=244)† | Qualitative data -textual examples from medical record review (N=244) | Qualitative data - interviews with PIMH professionals (N=8) and key stakeholders (N=5) | Qualitative data - interviews with past clients (N=11)‡ |
|---|---|---|---|---|---|
| Mental Health assessment / Care Coordination | 845 | Family of origin (FOO) - genogram (n=161) | Discussed FOO intrusive attempts to “support” (client) in looking after the baby, not realising their “undermining” of (clients) mothering. Assertiveness encouraged. (MR053) | The genogram's really important. So getting a family tree, an understanding of where all that fits. (P2) | I didn’t realise myself but that a lot of my issues are from ... past experiences and childhood and all that sort of stuff. (Nancy) |
| | | Referrals (n=127) | (Client) requested counseling from a Vietnamese speaking worker and she has been referred to transcultural mental health for follow up. She has also been given the contact details of (name) community centre who provide a Vietnamese family worker. (MR054) | Referring them to other services for more practical type support, or social, to reduce their social isolation. (P7) | She helped me into a few ... programs to help me feel more confident with my parenting. (Carol) |
| | | Mental health assessment (n=82) | [During home visit] MSE: Presents as very teary & depressed. Appetite decreased over last week, not eating much, once day. Feels depressed, more than ever has before. Finding it hard to cope w baby at times. Regular | So usually in the assessment I've got a bit of an idea of some of their early experiences. (P2) | |

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| | | | thoughts of self harm. About 2-3/52 ago took an o/d of 7-8 Panadeine Forte tablets after fight w husband. He knew about it, didn't go to hospital. About 1/52 had thought of killing herself & baby – felt very scared about it. No immediate plan at present<br>Discussed options –<br>1. Hospitalisation, procedure for this<br>2. Review by our psychiatrist next week.<br>(Client) said she will be safe from self harm until an app next week. Discussed what she could do if the thought came – she named few friends she could call. (MR043) | | |
| | | Medication management (n=79) | (Partner) convinced that she should go back on medication. (Client) feeling 'torn' b/c she recognises the benefit of CBT & realises that medication is not a solution. (MR001) | Involvement with medication...they're asking about side effects...so you have to know resources...and those places to get information. (P1) | They wanted to put me on a medication and I felt that that medication was perfect, it helped balance me out and everything. (Melissa) |
| | | Advocacy (n=67) | [Letter] I am writing to support the request for (Client) requesting financial assistance to support childcare arrangement for her second and third daughters. (Client) | I often write Housing advocacy letters and get my clients on the Housing list. (P7) | She took it upon herself and she went through the hospital system and did a complaint for me... no one responded to her or myself, but the fact |

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| | | | has been a patient of our service since (date) and I have been treating her for depressive symptoms. To date, she continues to experience ongoing psychological distress exhibiting thoughts of wanting to harm herself and I believe that her children should be placed in childcare as an opportunity to allow her psychological wellbeing to improve. It is pertinent that her children be placed in childcare given that she is exhibiting a fragile psychological state. I feel that this would allow her emotional wellbeing to improve significantly. (MR028) | | that she was proactive and really tried to help seek justice in the situation...that helped me emotionally. (Nancy) |
| | | Perinatal care plan (n=64) | We discussed the perinatal care plan and considered: recommending a single room so (partner) and family members can potentially stay with (client) day & night for support. (MR029) | A perinatal support plan ... tells ... who should be contacted at delivery ... what to observe for ... on the ward, some sort of guidance. (S1) | |
| | | Psychiatric review (n=62) | (Client) was depressed and reviewed by (psychiatrist) and commenced on Sertraline. (MR072) | We have psychiatrist on our team, we work as a team so part of my job would be to keep an eye on the biological stuff and if it ever changes then we can | I did see the (psychiatrist) every now and again ... if I needed like a review on the medication or something like that. (Melissa) |

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| | | | | always get you then to see the psychiatrist in our team. (P2) | |
| | | Service coordination (n=57) | P/C to (Name), (service). Explained above. We will continue to liaise w each other & will inform when discharging. (Name) will continue to offer support. (MR043) | You have to coordinate and liaise with all the other services, and swap information. You have case conferences for planning. (P1) | (Clinician) referred me to a ... mother and baby massage [course]. (Tabitha) |
| | | Other care plans (n=56) | Discussed Baby Care Plan – in event of hospitalisation being needed, will f/up at next appt. (MR221) | It's also going to take into consideration a baby ... plan ... S o if mum has to ... be admitted to a mental health unit, what's going to happen to the baby, who's going to look after the baby, what's going to happen with breastfeeding, so it's going to be fairly explicit ... care planning ... (P5) | |
| | | Risk assessment (n=42) | (Client) was assessed on (date). There were no risk issues. (MR054) | ... protective factors, and then looking at risk assessment, would be primary. (P6) | |
| | | Biopsychosocial model (n=24) | Explained biopsychosocial model of anxiety/depression & treatment. (MR043) | The biopsychosocial model we draw three circles that overlap...the letter B ... stands for biology ... The next circle is psychological or your personality and that talks about your early | |

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| | | | | experience ... the last circle is the social circle and that really touches on what is happening for you now. (PP2) | |
| | | Other e.g. transport (n=24) | (Client) transported to and from (service centre) for medication review. (MR221) | Sometimes I've had to drive people down to Housing. (P7) | |
| Mental health therapeutic intervention | 535 | Anxiety & depression management (n=213) | Gave (client) the relaxation CD to try ... Also gave (client) the anxiety monitoring sheet. (MR005) | Breathing ...or progressive muscle relaxation, those really practical things, if their anxiety ... is out of control. (P3) | … working on techniques to cope and manage ... day to day and with anxiety and stress. (Patricia) |
| | | E.g. - Scaling questions (n=39) | (Client) reports a current mood of between 71/2 & 8 out of 10 (1=low). (MR225) | I use Likert scales, I use naught to 10 ... for the depression, naught is ... really low ... and 10 is quite good ... and anxiety is a similar range. (P5) | |
| | | - Challenging negative thoughts (n=15) | Encouraged to acknowledge differences and recognize strengths. Challenge perceptions of “not being able to cope”. (MR240) | | |
| | | - Normalising (n=14) | P/C to (client). Sounds reactive over phone. Reports that last night was ok but is feeling very tired today. Reflected that this was understandable having had baby for the week. Her husband will be home on the | | While I see it as stress now ... and that a lot of women feel that way... making me see how it’s okay to be a little upset or stressed, but then to recognise it and then be |

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| | | | weekend & I encouraged to get him to help with the baby so perhaps she can rest. (MR015) | | able to move on from it. (Cathie) |
| | | - Mindfulness (n=13) | Talked through series of mindfulness exercises. Will practice mindful breathing over the next week. (MR240) | Mindfulness is ... being purposefully aware of what's happening in your body, at any one time. (P5) | |
| | | - CBT (n=10) | We discussed CBT & other strategies including: cognitive thinking, has diary card, relaxation, scheduling/planning her day which includes some time out/ exercise. (Client) wrote these down. (MR111) | A bit of CBT as well ... around the anxiety. (P6) | |
| | | Supportive counselling (n=156) | (Client) feels like there is no one around her. We discussed how she ‘wishes’ things were different. (MR053) | Supportive counselling ... it'll be driven by the client and what's happening for them at the time. (P1) | It was just, basically, talking about the things that I wanted to talk about. (Mary) |
| | | Psycho-education (n=50) | Commenced today's session with explaining how "wooly", confused she felt after last session. We spent half of the session discussing the therapeutic process. (Client) felt more contained & 'certain' of direction of therapy. (MR014) | Psycho-education, providing them with information about what to expect ... (P7) | She also had a lot of information as well, so a lot of good feedback ... I had a lot of funny questions ... she had a lot of good answers for questions that I had. (Melissa) |
| | | Self care (n=22) | We discussed taking time for herself. (Client) identified this | | |

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| | | | as an ongoing struggle and we have previously discussed. Has 2x days to herself per week but finds she spends it doing housework. We discussed creating time to do her scrapbooking... (MR128) | | |
| | | Other e.g. Grief & loss (n=94) | (Client) was tearful over the phone but acknowledged this in keeping with ongoing grief at husband's death. (MR024) | Quite often it is about ... wanting people to understand their trauma or their previous loss or their current anxiety. (P6) | It was also talking through sometimes some of the grief about the fact that I wish I'd done things different with my eldest. (Tabitha) |
| Child protection | 138 | Domestic violence (n=48) | At our last visit (client) indicated that her husband can be verbally aggressive toward her and on occasion pushes and shoves her. He is also quite controlling. I referred (client) to Khmer DV worker at (suburb) Community Centre. (MR072) | … in particular things like domestic violence ... so... it's where you draw the line. (S2) | |
| | | Informed of mandatory reporting (n=42) | Aware of assessment process, including confidentiality and subsequent limits if necessary. (MR021) | … the only times we're not confidential, we have to tell them about that – that we're mandated reporters. (P1) | |
| | | Discussion with child protection services (n=34) | Explained to (client) that I spoke with (name) from (Child Protection services @ suburb) & that they are gathering | | |

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| | | | information & ensuring there are supports in place. (MR035) | | |
| | | Child protection report (n=14) | Relationship stress continues – (see MRG) [Mandatory reporting guide]. (MR221) | if it was detrimental to the child's wellbeing and safety you'd have to do a report. (P6) | |
| Parent - infant focus | 98 | Parent - infant therapy (n=60) | Week 1 COS-P<br>(Client's) level of insight good with relation to her understanding of the basis of the 'circle'. Pleased to hear about 'good enough parenting'. (MR225) | Lately a lot of Circle of Security ... that's very good in getting them to understand their children's needs. (P3) | She bought videos and things around on ... Circle of Security That was really good. (Tanya) |
| | | - with videotaping (n=7) | We will try & see each other more often and will do some video work to build their r/s. Took video tape of (client) & (baby). (MR065) | I've had DVDs of parents themselves. Like we've done filming and then I've brought that in the next session. (P3) | |
| | | Sleep & settling (n=14) | Seems possible that (client) does not know what to do with her baby but not want to appear 'incompetent'. Asked to try some settling techniques for baby & to write down what she is doing with her. (MR004) | ... whether it's the baby having to go to sleep on its own. (P2) | |
| | | Infant development (n=4) | (Baby) is not yet walking at 17 months, needs paediatric review. Not saying words. Discussed with (client) who | ... giving them that information about what the child needs to develop healthy relationships. (P7) | |

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| | | | agreed for referral to speech pathology … (MR136) | | |
| | | Other e.g. infant feeding (n=13) | Still fully breastfeeding and reports a marked decrease in anxiety. (MR039) | | |
| Family intervention | 73 | Coupes work (n=28) | Seen at home … Discussed main issue as r/s w (partner) ... Given lots of space to express her feelings, not able to talk to anyone about it. Encouraged to take her issues & concerns to counselling and see their commitment to attend it as a sign of hope. (MR125) | Circle of Security ... that's attachment really ...you can use that with everything. So I use that with couples. (P2) | |
| | | Child development (n=22) | We ended the session by me reminding her that when (daughter, 5 years) is asking or giving (client) a hug, that she is wanting a special connection between them. Suggested to (client) that she focus on the positive connections that she experiences with children. (MR014) | It's not unusual for the women ... to have older children ... and ... for those older children to have significant developmental, behavioural or relationship issues ... to get support in place for them ... it's usually a part of what we do. (P7) | ... and gave me great advice on things to go with the children as well. (Carol) |
| | | Child behaviour (n=11) | Describing challenging behaviour from three daughters. Discussed utilising behaviour charts/reward systems & empowering the girls to choose a shared bedtime activity. (MR049) | | |

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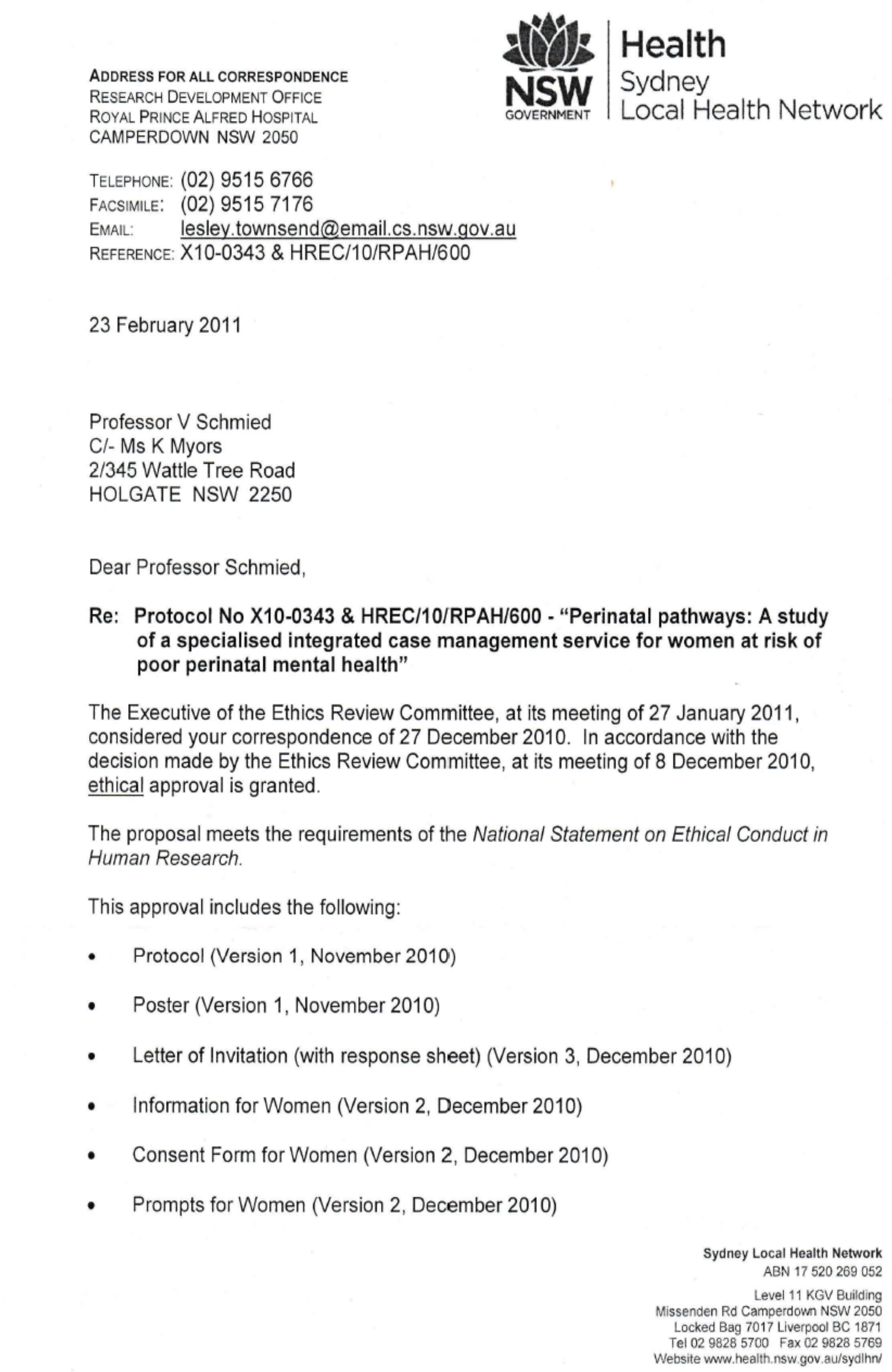
| | | Family intervention (n=6) | D/W (client) my concerns regarding her son (15 years) that he needs an assessment to review his psychological wellbeing … Also explained that he needs to be linked in with COPMI [Children of Parents with a Mental Illness]. (MR142) | | |
| | | Other e.g. Childcare discussion (n=6) | (Client) inquiring about In-Home Childcare – have previously mentioned this service. Will post info to her for her to look at. (MR135) | … or they needed childcare ... then I would probably refer through to Brighter Futures because I know that they can fund 13 weeks of childcare. (P7) | They referred me to a baby massage course with the baby ... and ... my older two were babysat. (Patricia) |
| Education - other | 21 | Contraception (n=17) | Discussed contraception. (Client) not using any active method. Recommended that she go to Family Planning at (suburb). (Client) agreed. (MR005) | | |
| | | Other e.g. Signs of labour (n=4) | Discussed “nesting behaviour”. (MR065) | | |

† clients received multiple interventions and individual interventions were used multiple times.

‡ pseudonyms used.

# Appendix 14: Ethics Approval



NSW GOVERNMENT | Health
Sydney
Local Health Network

**ADDRESS FOR ALL CORRESPONDENCE**
RESEARCH DEVELOPMENT OFFICE
ROYAL PRINCE ALFRED HOSPITAL
CAMPERDOWN NSW 2050

TELEPHONE: (02) 9515 6766
FACSIMILE: (02) 9515 7176
EMAIL: lesley.townsend@email.cs.nsw.gov.au
REFERENCE: X10-0343 & HREC/10/RPAH/600

23 February 2011

Professor V Schmied
C/- Ms K Myors
2/345 Wattle Tree Road
HOLGATE NSW 2250

Dear Professor Schmied,

**Re: Protocol No X10-0343 & HREC/10/RPAH/600 - "Perinatal pathways: A study of a specialised integrated case management service for women at risk of poor perinatal mental health"**

The Executive of the Ethics Review Committee, at its meeting of 27 January 2011, considered your correspondence of 27 December 2010. In accordance with the decision made by the Ethics Review Committee, at its meeting of 8 December 2010, ethical approval is granted.

The proposal meets the requirements of the *National Statement on Ethical Conduct in Human Research.*

This approval includes the following:

- Protocol (Version 1, November 2010)
- Poster (Version 1, November 2010)
- Letter of Invitation (with response sheet) (Version 3, December 2010)
- Information for Women (Version 2, December 2010)
- Consent Form for Women (Version 2, December 2010)
- Prompts for Women (Version 2, December 2010)

**Sydney Local Health Network**
ABN 17 520 269 052
Level 11 KGV Building
Missenden Rd Camperdown NSW 2050
Locked Bag 7017 Liverpool BC 1871
Tel 02 9828 5700 Fax 02 9828 5769
Website www.health.nsw.gov.au/sydlhn/

- Information for Perinatal and Infant Mental Health Clinicians (Version 2, December 2010)
- Consent Form for Perinatal and Infant Mental Health Clinicians (Version 1, November 2010)
- Prompts for PIMH Clinicians (Version 2, December 2010)
- Information for Key Stakeholders (Version 2, December 2010)
- Consent Form for Key Stakeholders (Version 1, November 2010)
- Prompts for Key Stakeholders (Version 2, December 2010)
- Medical Record Review Tool (Version 2, December 2010)

You are asked to note the following:

- **This letter constitutes ethical approval only. You must NOT commence this research project at ANY site until you have submitted a Site Specific Assessment Form to the Research Governance Officer and received separate authorisation from the Chief Executive or delegate of that site.**
- This approval is valid for four years, and the Committee requires that you furnish it with annual reports on the study's progress beginning in February 2012.
- This human research ethics committee (HREC) has been accredited by the NSW Department of Health as a lead HREC under the model for single ethical and scientific review and is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research* and the *CPMP/ICH Note for Guidance on Good Clinical Practice*.
- You must immediately report anything which might warrant review of ethical approval of the project in the specified format, including unforeseen events that might affect continued ethical acceptability of the project.
- You must notify the HREC of proposed changes to the research protocol or conduct of the research in the specified format.
- You must notify the HREC and other participating sites, giving reasons, if the project is discontinued at a site before the expected date of completion.
- Where appropriate, the Committee recommends that you consult with your Medical Defence Union to ensure that you are adequately covered for the purposes of conducting this study.

Should you have any queries about the Committee's consideration of your project, please contact me. The Committee's Terms of Reference, Standard Operating

Procedures, membership and standard forms are available from the Sydney South West Area Health Service website.

A copy of this letter must be forwarded to all site investigators for submission to the relevant Research Governance Officer.

The Ethics Review Committee wishes you every success in your research.

Yours sincerely,

Lesley Townsend

Lesley Townsend
**Executive Officer**
**Ethics Review Committee (RPAH Zone)**

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# Appendix 15: **Participant Information Sheet - PIMH Clinicians / Managers**

Locked Bag 1797
Penrith South DC NSW 1797
Australia

Professor Virginia Schmied
School of Nursing & Midwifery
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Ph 61-2- 9685 9505
Fax 61-2- 9685 9835

University of Western Sydney

## Perinatal Pathways:
## A study of a specialised integrated case management service for women at risk of poor perinatal mental health.

## INFORMATION FOR PIMH CLINICIANS / MANAGERS

### Introduction

You are invited to take part in a research study about the process and impact of being a case manager with a perinatal and infant mental health service. In NSW it is routine to ask all women before and after birth about their social and emotional wellbeing. Women who identify as having some emotional or social difficulty at these times are often referred to a specialist perinatal and infant mental health service.

The purpose of this study is to explore case managers' experiences of working in these specialised services, the interventions or treatments that are used, the outcomes for women and their infants at the end of the service use and how you work with other services.

The study is being conducted within this institution by Associate Professor Virginia Schmied (University of Western Sydney), Professor Maree Johnson (University of Western Sydney), Associate Professor Michelle Cleary (University of Western Sydney) and PhD candidate Ms Karen Myors (University of Western Sydney).

### Study Procedures

If you agree to participate in this study, you will be asked to sign the Participant Consent Form. You will then be invited to participate in a face to face interview with the researcher. This will occur at a time and place convenient to you. The interview will involve a number of questions about your experience or perceptions of working in a perinatal and infant mental health service. The interview will take approximately 30 to 60 minutes and with your permission will be audiotaped.

### Risks

Your participation in this study involves an interview with the researcher and it is not expected that this should cause you any discomfort. If you are uncomfortable being interviewed, remember that participation in this study is completely voluntary and you can withdraw at any time without any consequences.

### Benefits

While we intend that this research study will help improve perinatal and infant mental health services and ultimately improve women's experience of care during the perinatal period from conception to post delivery in the future, it may not be of direct benefit to you.

### Costs

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

### Voluntary Participation

Participation in this study is entirely voluntary. You do not have to take part in it. If you do take part, you can withdraw at any time without having to give a reason.

### Confidentiality

All the information collected from you for the study will be treated confidentially, and only the researchers named will have access to it. The study results may be presented at a conference or in a scientific publication, but individual participants will not be identifiable in such a presentation

### Further Information

When you have read this information, Karen Myors will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact her on [redacted].

This information sheet is for you to keep.

### Ethics Approval and Complaints

This study has been approved by the Ethics Review Committee (RPAH Zone) of the Sydney South West Area Health Service. Any person with concerns or complaints about the conduct of this study should contact the Executive Officer on 02 9515 6766 and quote protocol number X10-0343.

**Thank you for considering this invitation**

# Appendix 16: **Consent Form - PIMH Clinicians / Managers**

Locked Bag 1797
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University of Western Sydney

## Perinatal Pathways:
## A study of a specialised integrated case management service for women at risk of poor perinatal mental health.

## CONSENT FORM FOR PIMH CLINICIANS / MANAGERS

I, ........................................................................................................ *[name]*
of
.........................................................................................................…*[address]*

have read and understood the Information for Participants on the above named research study and have discussed the study with Ms Karen Myors.

I have been made aware of the procedures involved in the study, including any known or expected inconvenience, risk, discomfort or potential side effect and of their implications as far as they are currently known by the researchers.

I understand that the interview will be audiotaped, and I agree to this.

I freely choose to participate in this study and understand that I can withdraw at any time.

I also understand that the research study is strictly confidential.

I hereby agree to participate in this research study.

**NAME:**
**..........................................................................................................................**

**SIGNATURE:**
**.........................................................................................................................**

**DATE:**
**..........................................................................................................................**

**NAME OF WITNESS:**
**.........................................................................................................................**

**SIGNATURE OF WITNESS:**
**.........................................................................................................................**

# Appendix 17: **Participant Information Sheet - Key Stakeholders**

Locked Bag 1797
Penrith South DC NSW 1797 Australia

Professor Virginia Schmied
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University of Western Sydney

## Perinatal Pathways:
## A study of a specialised integrated case management service for women at risk of poor perinatal mental health.

## INFORMATION FOR KEY STAKEHOLDERS

### Introduction

You are invited to take part in a research study about the process and impact of integrated perinatal and infant mental health services. In NSW it is routine to ask all women before and after birth about their social and emotional wellbeing. Women who identify as having some emotional or social difficulty at these times are often referred to a specialist perinatal and infant mental health service.

The purpose of this study is to explore the experiences and perceptions of key stakeholders (who work with women in the antenatal period) working with these specialised integrated services.

The study is being conducted within this institution by Associate Professor Virginia Schmied (University of Western Sydney), Professor Maree Johnson (University of Western Sydney), Associate Professor Michelle Cleary (University of Western Sydney) and PhD candidate Ms Karen Myors (University of Western Sydney).

### Study Procedures

If you agree to participate in this study, you will be asked to sign the Participant Consent Form. You will then be invited to participate in an interview with the researcher. This will occur at a time and place convenient to you. The interview will involve a number of questions about your experience or perceptions of perinatal and infant mental health services, will take approximately 50 to 60 minutes and will be audiotaped.

### Risks

Your participation in this study involves attending an interview with the researcher. It is not expected that this should cause you any discomfort. If you are uncomfortable during the interview, remember that participation in this study is completely voluntary and you can withdraw at any time without any consequences.

### Benefits

While we intend that this research study will help improve perinatal and infant mental health services and ultimately improve women's experience of care during the perinatal period from conception to post delivery in the future, it may not be of direct benefit to you.

### Costs

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

### Voluntary Participation

Participation in this study is entirely voluntary. You do not have to take part in it. If you do take part, you can withdraw at any time without having to give a reason.

### Confidentiality

All the information collected from you for the study will be treated confidentially, and only the researchers named will have access to it. The study results may be presented at a conference or in a scientific publication, but individual participants will not be identifiable in such a presentation.

### Further Information

When you have read this information, Karen Myors will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact her on [redacted]

This information sheet is for you to keep.

### Ethics Approval and Complaints

This study has been approved by the Ethics Review Committee (RPAH Zone) of the Sydney South West Area Health Service. Any person with concerns or complaints about the conduct of this study should contact the Executive Officer on 02 9515 6766 and quote protocol number X10-0343.

**Thank you for considering this invitation**

# Appendix 18: **Consent Form - Key Stakeholders**

Locked Bag 1797
Penrith South DC NSW 1797 Australia

Professor Virginia Schmied
School of Nursing & Midwifery
College of Health and Science
v.schmied@uws.edu.au
Ph 61-2- 9685 9505
Fax 61-2- 9685 9835

## Perinatal Pathways:
## A study of a specialised integrated case management service for women at risk of poor perinatal mental health.

## CONSENT FORM FOR KEY STAKEHOLDERS

I, ........................................................................................................... *[name]*
of
.............................................................................................................*[address]*

have read and understood the Information for Participants on the above named research study and have discussed the study with Ms Karen Myors.

I have been made aware of the procedures involved in the study, including any known or expected inconvenience, risk, discomfort or potential side effect and of their implications as far as they are currently known by the researchers.

I understand that the focus group discussion will be audiotaped, and I agree to this.

I freely choose to participate in this study and understand that I can withdraw at any time.

I also understand that the research study is strictly confidential.

I hereby agree to participate in this research study.

**NAME:**
**.........................................................................................................................**
**SIGNATURE:**
**.........................................................................................................................**
**DATE:**
**.........................................................................................................................**
**NAME OF WITNESS:**
**.........................................................................................................................**

**SIGNATURE OF WITNESS:**
**.........................................................................................................................**

# Appendix 19: **Participant Information Sheet - Women Service-users**

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University of Western Sydney

## Perinatal Pathways Study

## INFORMATION FOR WOMEN

### Introduction

You are invited to take part in a research study about the process and impact of being a client with a perinatal and infant mental health service. In NSW it is routine to ask all women before and after birth about their social and emotional wellbeing. Women who identify as having some emotional or social difficulty at these times are often referred to a specialist perinatal and infant mental health service.

The purpose of this study is to explore women's experiences of these specialised services, the interventions or treatments that were used and the outcomes for women and their infants at the end of the service use.

The study is being conducted within this institution by Professor Virginia Schmied (University of Western Sydney), Professor Maree Johnson (University of Western Sydney), Associate Professor Michelle Cleary (University of Western Sydney) and PhD candidate Ms Karen Myors (University of Western Sydney).

### Study Procedures

If you agree to participate in this study, you will be asked to sign the Participant Consent Form. You will then be asked to:

1. Participate in an interview with the researcher. The interview will involve a number of questions about your experience or perceptions of the perinatal and infant mental health service that you received. The interview will take approximately 30 to 60 minutes and with your permission will be audiotaped. This will occur at a time and place convenient to you.

2. Allow the researcher to review your medical record for the time you were a client of the perinatal and infant mental health service.

### Risks

Your participation in this study involves an interview with the researcher and a review of your medical records. It is not expected that this should cause you any discomfort. If you are uncomfortable being interviewed, remember that participation in this study is completely voluntary and you can withdraw at any time without any consequences. Should you experience any discomfort, a referral will be suggested for counselling through your local community health centre.

In the event of any disclosed child protection concerns or illegal activity, the researcher is obligated to discuss this with the research team and make a report to the relevant authority.

### Benefits

While we intend that this research study will improve perinatal and infant mental health services and ultimately improve other women's experience of care during the perinatal period in the future, it may not be of direct benefit to you.

### Costs

Participation in this study will not cost you anything. In recognition of your time, a Coles/Myer Gift Voucher will be provided after the interview with the researcher (voucher to the value of $20).

### Voluntary Participation

Participation in this study is entirely voluntary. You do not have to take part in it. If you do take part, you can withdraw at any time without having to give a reason. Whatever your decision, please be assured that it will not affect your medical treatment or your relationship with the staff who are caring for you or who will care for you in the future.

### Confidentiality

All the information collected from you and your medical records for the study will be treated confidentially, and only the researchers named above will have access to it. The study results may be presented at a conference or in a scientific publication, but individual participants will not be identifiable in such a presentation.

### Further Information

When you have read this information, Karen Myors will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact her on [redacted]

This information sheet is for you to keep.

### Ethics Approval and Complaints

This study has been approved by the Ethics Review Committee (RPAH Zone) of the Sydney South West Area Health Service. Any person with concerns or complaints about the conduct of this study should contact the Executive Officer on 02 9515 6766 and quote protocol number X10-0343.

**Thank you for considering this invitation**

# Appendix 20: **Consent Form – Women Service-users**

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Ph 61-2- 9685 9505
Fax 61-2- 9685 9835

University of Western Sydney

## Perinatal Pathways Study

## CONSENT FORM FOR WOMEN

I, ........................................................................................................................ *[name]*
of
........................................................................................................……*[address]*
have read and understood the Information for Participants on the above named research study and have discussed the study with Ms Karen Myors.

I have been made aware of the procedures involved in the study, including any known or expected inconvenience, risk, discomfort or potential side effect and of their implications as far as they are currently known by the researchers.

I understand that the interview will be audiotaped, and I agree to this.

I understand that my participation in this study will allow the researchers, as described in the Information for Participants, to have access to my medical record, and I agree to this.

I freely choose to participate in this study and understand that I can withdraw at any time.

I understand that the research study is strictly confidential, however, I also understand the investigators' obligation to report child protection concerns and details of illegal activity disclosed to them to the relevant authorities.

I hereby agree to participate in this research study.

**NAME:**
**..........................................................................................................................**

**SIGNATURE:**
**.........................................................................................................................**

**DATE:**
**..........................................................................................................................**

**NAME OF WITNESS:**
**........................................................................................................................**

**SIGNATURE OF WITNESS:**
**..........................................................................................................................**