Understanding perinatal mental healthcare referral decisions among midwives and health visitors

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Background to my research

Prevalence

- Estimated 20% women experience depressive episode
- PNMH problems include: AN/PN depression/anxiety, PTSD, OCD, tocophobia, Bipolar Disorder
- 1-2 per 1000 women experience postpartum psychosis
- Third of women with Bipolar Disorder are at risk of experiencing a postpartum relapse; at least a 1 in 5 risk of experiencing postpartum psychosis
- Death by suicide is a leading direct cause of maternal deaths in the UK
Inequity of provision

- NICE recommends clinical organisations provide specialist perinatal services in each locality (NICE, 2014)
- NHS FYFVMH objective to increase specialist MH support in all areas by 2020 to 2021
- Estimated 85% of Trusts had no service/did not meet NICE guidelines (NHS, 2017)
- 21 MBU in UK (MMHA, 2017)

Wider implications

Mother
- Future mental health issues
- Bonding and attachment
- Breastfeeding
- Poor engagement
- Engaging in unhealthy behaviours e.g. smoking, drugs and alcohol use

Baby
- Cognitive and emotional development
- Attachment
- Increased risk of developing mental health problems
- Compliance with child health programmes
Cost burden

- £8.1bn over the lifetime of each annual cohort of births; much of this cost relates to health and social outcomes of the child (PHE, 2016)

Previous research findings

- Estimated 50% of PNMH disorders could be undetected by HCPs
- UK and international research found that MWs/HVs require and desire training around PNMH disorders and their management
Aims of my research

- To explore MWs and HVs decision-making when referring women for secondary perinatal mental health care to understand the barriers and facilitators to accurate and timely referrals.

- To explore the impact of having a local specialist PNMH service on MWs and HVs approach to the full spectrum of PNMH care.
Overview of research: Mixed Methods Research Design

2 geographical areas selected based on their PNMH service provision.

Phase 1: Interviews with managers/clinical leads

Phase 2: Interviews with sample of MWs and HVs

Phase 3: Bespoke questionnaire open to all MWs and HVs

Blue = Area 1 with PNMH services
Green = Area 2 without PNMH services
Interviews

Qualitative Methods:

- Semi-structured interviews
- **Phase 1**: 5 interviews with managers/clinical leads
- **Phase 2**: 24 interviews conducted over a 6 month period. n= 16 MWs; n= 8 HVs (15 from Area 1; 9 from Area 2)
- Face-to-face or telephone
- Digitally recorded on encrypted Dictaphone
- Thematically analysed (Braun and Clarke, 2006)
## Length of interview according to location

<table>
<thead>
<tr>
<th>Location of interview</th>
<th>Average length of interview</th>
<th>Range of interviews in minutes</th>
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<tbody>
<tr>
<td>Face-to-face</td>
<td>34 minutes</td>
<td>14 - 81</td>
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<tr>
<td>Telephone</td>
<td>45 minutes</td>
<td>30 - 80</td>
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Demographic profile of participants

<table>
<thead>
<tr>
<th>Profession</th>
<th>Number</th>
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<tbody>
<tr>
<td>Midwife</td>
<td></td>
</tr>
<tr>
<td>HMW</td>
<td>12</td>
</tr>
<tr>
<td>CMW</td>
<td>4</td>
</tr>
<tr>
<td>Health Visitor</td>
<td>8</td>
</tr>
<tr>
<td>Years qualified*</td>
<td></td>
</tr>
<tr>
<td>0 - 5</td>
<td>3</td>
</tr>
<tr>
<td>6 - 10</td>
<td>5</td>
</tr>
<tr>
<td>11 - 20</td>
<td>4</td>
</tr>
<tr>
<td>20 + years</td>
<td>12</td>
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<tr>
<td>Qualification as a Registered Mental Health Nurse</td>
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<tr>
<td>Yes</td>
<td>2</td>
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<tr>
<td>No</td>
<td>22</td>
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Why choose Thematic Analysis?

Consistent with the epistemological position of my research

Data analysed using Thematic Analysis (Braun and Clarke, 2006)

Themes discussed and reviewed with supervisory team
Example of coding
Key: yellow = semantic
Pink = latent
Orange = facilitator
Green = barrier
Themes

- IDENTIFYING NEED
  - CONTINUITY OF CARER
  - DISCLOSURE
  - TIME

- EDUCATION, SKILLS AND EXPERIENCE
  - CONFIDENCE AND INTUITION
  - TARGETING RESOURCES

- REFERRAL PATHWAYS
  - USE OF TOOLS
  - KNOWLEDGE OF REFERRAL PATHWAYS
Identifying Need

“I’m all about the relationship. All about it... How on earth can you expect someone to come to you [and say] ‘I feel rubbish... or this is happening to me’ without building up that relationship I will never know. So that is the big thing for me and it’s very difficult for health visitors to pick these initial concerns up erm...without that” (HV6) Continuity of carer

“I’m a firm believer that clients tell you want they want you to hear, no matter how open [you are], how ‘You can tell me anything’ you are, you are going to get those who feel that they can’t say that to you [disclose PNMH problems]” (HV4) Disclosure

“Time is the biggest killer for us really. We’re limited... we haven’t got sufficient staff to cope... so I can’t honestly say, I know hand on heart these women get enough time” (MW3) Time
“...our services are very stretched. We’ve got a lot less health visitors. We can’t provide the service that we could historically … we try to target the ones that are most vulnerable” (HV1) Targeting Resources

“Sometimes you just think in your stomach that something is not quite right”. (MW3)

“… it’s difficult to quantify but you get a feeling that somethings not quite right”. (MW1)

“...I think I rely on my common sense … it’s your gut feeling at the end of the day that prompts you into doing whatever you do [referring]”. (HV6)

Confidence and Intuition
Referral Pathways

"We use the universal PNMH scoring system” (HV7)

“Yes, so if it’s someone that actually is very low, I will use the GAD or the PHQ”. (HV2)

“Well I ask the appropriate questions, the universal questions at the designated times, the universal times” (HV8)

“The promotional guide is very much my tool [used for assessing PNMH]” (HV1)

“I’ve used the GAD as well” (HV3)

Erm, structured tools? No, I don’t think that there are” (MW11)

Use of Tools

“I think a more straightforward referral pathway would be better” (MW8)

“.. the trouble is, we are in a process of change at the moment and the guidelines need updating and they need to be easier to read...” (MW9)

“...there needs to be a clear pathway of referral and follow up that’s fed back to the midwife” (MW12)

“I just think the referral system could be a little bit more streamlined” (MW13)

Knowledge of Referral Pathways
Phase 3: Quantitative Questionnaire

- Bespoke questionnaire informed by qualitative data
- 99 responses; MWs n= 56, HVs n= 43 (response rate 11.13%)
- Data Analysis: SPSS using descriptive statistics
- 14 questions (45 individual items included closed, dichotomous, multiple choice and ‘likert scale’ questions - generated nominal, ordinal and categorical data)
- Pilot: Academics in psychology and midwifery and with registered practitioners (MWs/HVs); Experts in perinatal psychiatry and experienced researchers
Strengths and Limitations of Qualitative Research

**Strengths**
- First study to explore professional decision-making among HCP with unprecedented access to women in perinatal period
- Insider researcher perspective
- Robust methodological approach
- Accurate representation of participant voices
- Data saturation achieved
- Rich, in-depth data
- Employed a reflexive approach

**Limitations**
- Under representation of CMWs
- Length of interviews
- Some data not used to preserve anonymity
- Recruitment challenging
Contribution to knowledge

What will my data reveal?
- What are the main barriers/facilitators to referring women for secondary PNMH care?
- Are there difference/similarities between professional groups?
- Are there difference/similarities between geographical areas?
- Does provision have any impact on professional decision-making when referring women for PNMH care?
Thank you for listening

For references and further information contact:
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