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Original Research

Title: Support and services for perinatal low mood and depression: A qualitative study exploring women's and healthcare professionals' experiences

Running Title: Support for perinatal low mood

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Support and services for perinatal low mood and depression: A qualitative study exploring women's and healthcare professionals' experiences

Abstract

This study aimed to explore women's experiences of support and care received from maternity healthcare professionals for perinatal low mood or depression, and healthcare professionals' experiences of providing support and care for women experiencing perinatal low mood or depression. In this qualitative study, face-to-

face individual semi-structured interviews and focus groups were conducted with 15 women and 19 healthcare professionals living or working in Yorkshire and the Humber, England in 2019. Thematic analysis was used to analyse the qualitative data. The following themes were identified: 1) Lack of standardisation in identification and support for perinatal low mood and depression; 2) Unclear and non-standardised pathways for perinatal low mood and depression; 3) Enablers and barriers of receiving support and care for perinatal low mood and depression. Providing training opportunities for healthcare professionals, especially midwives, may be helpful for filling the grey area for women who do not need a referral to mental health services but require support from healthcare professionals. Improving the variety of psychological therapies for the treatment of perinatal depression may also be helpful to meet women's expectations of treatments.

Keywords: Depression; Postpartum; Pregnancy; Midwives; Health Visitors; Delivery of Health Care

Key Points

- There were variations in the provision of practical help and support for women with low mood, where referral may not be needed but support is.
- Most of the health visitors were knowledgeable about providing practical recommendations for women with perinatal low mood; however, a few midwives mentioned these activities in the interviews.
- Training opportunities for maternity staff to increase their knowledge on practical advice that they can offer to women experiencing low mood rather than depression may be helpful.

Introduction

Perinatal depression is a substantial public health concern because of its high prevalence (Woody et al., 2017), impact on women themselves, their children, and partners (Howard & Khalifeh, 2020) and its costs to the family and the wider society (Bauer et al., 2014). Effective support and treatment of perinatal depression is important not only for the woman herself and her family but also to decrease the detrimental economic costs to society.

In the UK maternity services, midwives are typically the first point of contact in early pregnancy and lead carer during pregnancy, birth, and the early postnatal period (first 28 days) (Nursing and Midwifery Council, 2021). The midwives have, therefore, the responsibility to detect women at risk of depression, ask about their current mental health, provide mental health support, advise women to see their General Practitioner (GP) or refer them to specialised perinatal mental health services (National Health Service England, 2016; Obe, 2015). The health visitors (specialist community public health nurses) have a similar responsibility with midwives. They should meet with women in late pregnancy (28 weeks) and then take over the care of the women from midwives in the postnatal period (within 14 days of birth) (Institute of Health Visiting, 2019) in the UK. The previous recommendations for health visiting services comprised six high impact areas including maternal perinatal mental health (Local Government Association, 2017). However, new recommendations address the vision of the National Maternity Review (National Health Service England, 2016) and include not only perinatal mental health but also partner/ fathers' and infants/children's mental health, suggesting flexible additional visits and reviews that can be tailored to individual needs (Institute of Health Visiting, 2019). Women are also advised to see their GP between 6 and 8 weeks postnatally. GPs should be checking the mother and the baby's wellbeing during the appointment and the women's mental health should also be reviewed (National Health Service, 2019). GPs can manage uncomplicated non-psychotic depression; for example, they often prescribe medication or refer to the Improving Access to Psychological Therapies (IAPT) service (Obe, 2015). For complex disorders, they refer women to perinatal mental health services if they are available in the area. In their absence, they can refer to general psychiatry services (Obe, 2015).

A number of national guidelines for the detection and management of perinatal mood disorders have been published, including those for England, Scotland, Australia, and the USA (Austin et al., 2017; National Institute for Health and Care Excellence, 2020; Scottish Intercollegiate Guidelines Network (SIGN), 2012; Yonkers et al., 2009). Although screening for depression is recommended to midwives, health visitors and GPs by National Institute for Health and Care Excellence (NICE) guidelines (National Institute for Health and Care Excellence,

2020) and written in the antenatal and postnatal notes booklets (Institute of Health Visiting, 2019, 2020), according to a national survey of women's experiences of maternity care involving 16,606 women, more than one-third of women (33%) responded 'no' or 'to some extent' to whether the midwives asked about their mental health during pregnancy and more than one-third of women (37%) responded 'no' or 'to some extent' to whether they were given information about perinatal mental health (Care Quality Commission, 2020). A previous study involving 1,738 women reported similar findings: more than one-third of women (38%) reported not being given any information or advice about mental health (Healthwatch, 2019). It is also clear from these studies that three out of five women 'definitely' had not spent enough time talking about their mental health at the 6-week check-up with their GP (Care Quality Commission, 2020). A previous study similarly reported that half of the women said they were not asked about their emotional or mental health at the 6-week appointment with the GP (The National Childbirth Trust, 2017).

The support and care provided by midwives and health visitors varied in the literature and there was insufficient information about what support these healthcare professionals (HCP) provide to women experiencing perinatal low mood or depression. Therefore, this study aimed to fill this evidence gap by exploring women's experiences of support and care for low mood or depression and the HCPs' experiences of supporting or caring for women with perinatal low mood or depression. The 'low mood or depression' term is used throughout the manuscript because some women may experience mild symptoms and may not fulfil the criteria for clinical depression. They also may not choose to seek help from HCPs and perinatal depression might not be diagnosed.

Methods

Qualitative approach and research paradigm

Individuals' perspectives and the context of data generated play a key role in this study for the creation of ideas and statements, therefore an inductive approach was preferred for the study (J. Creswell & Plano Clark, 2018). A theoretical-methodological perspective of symbolic interactionism was adopted (Blumer, 1998). The value of symbolic interactionism to qualitative inquiry is its well-defined focus on understanding interactions between people and the symbolic meanings that people attach to their social actions, interpretations, and reactions to their environment (Patton, 2015; Ritchie et al., 2014). The theoretical perspective of symbolic interactionism is congruent with, and often employed within, the methodological design of ethnography; therefore, ethnographic data collection methods, including interviews, observations, photographs with documentary data, were used in the study to better understand women's lives, behaviours and interactions while experiencing low mood or

depression and HCPs' caring practices for those women. This study was reported using the Standards for Reporting Qualitative Research framework (O'Brien et al., 2014).

Study settings, sampling and data collection

Women and HCPs were recruited from three areas within Yorkshire and the Humber in 2019. Women were recruited through advertisement posters placed at three NHS Trusts and online advertisements posted on a number of websites and Facebook accounts related to mothers. HCPs were informed about the study by email sent by the gatekeepers in each NHS Trust.

Study design and methods of data collection for both HCPs and women were developed through liaising with a research midwife and a research nurse who work in a Research and Development department at an NHS Trust. The recruitment strategies for HCPs and women were shaped after this meeting. All recruitment materials for women and HCPs, were improved with the involvement of two mothers to better explain the study to future potential participants. A pilot interview was conducted with a PhD student who is a mother and the flow of the questions in topic guides was redesigned as a result. Another pilot interview was conducted with a lecturer who works at a university and some changes were made after the interview.

A purposive sampling method was used to select women who have experience of perinatal depression, and HCPs (e.g., consultants, midwives, health visitors, General Practitioners, maternity support workers) who have experience of providing support and care for women experiencing perinatal depression. The aim was to continue sampling until code saturation occurred (Patton, 2015). The researcher planned to carry out sampling, transcribing and analysing iteratively until no or few new codes and themes emerged from the data.

Data collection methods

Although the aim was to conduct focus groups with HCPs so as to gather a rich source of data, it was recognised that focus groups were more time-consuming than individual interviews, so professionals might prefer to be interviewed individually. To minimise this issue, interviewing preferences (i.e., individual or focus groups) were given in the consent form and demographics form, to suit their availability. The HCPs were asked to bring to the interview perinatal mental health guidelines, maternity pathways, or mental health provision guidelines, if possible, that they use in maternity services. The individual face-to-face interviews with 13 HCPs ranged between 15 and 60 minutes, with an average of 30 minutes. One focus group with two HCPs lasted 40 minutes and another focus group with four HCPs lasted 52 minutes.

The researcher was aware that the mental health of women was of critical importance and that the potential participants would bring difficult life experiences to the interview situation. Individual semi-structured interviews were chosen rather than focus groups for this reason so that the researcher could immediately respond if an individual participant became upset. It was also for this reason that the 'assessment and management of risk protocol' was prepared and the first author implemented the Patient Health Questionnaire-9 (PHQ-9) (Kroenke et al., 2001) over the telephone (after securing their consent) to make sure that they did not have ongoing depressive symptoms, according to this protocol. If they scored between 0 and 9, they were eligible for an interview. None of the participants scored 10 or above on PHQ-9. The duration of individual face-to-face interviews with 15 women ranged between 25 and 65 minutes, with an average of 40 minutes.

Data analysis

The first author carried out sampling, transcribing, and analysing iteratively until no or few new codes and themes identified from the data. All interviews were audio-recorded with a password-protected audio recorder. Interviews were transcribed verbatim by the first author or a professional transcriber and transcripts checked for accuracy with the audio and amended as needed.

NVivo 11.3.2 was used to manage the data (IT Services & University of York, 2017). The reflexive thematic analysis approach was used to identify the commonalities and patterns from individuals' verbatim transcripts (Braun & Clarke, 2013, 2019). The reflexive TA approach is underpinned by only qualitative philosophy and stresses that meaning is contextual, reality is multiple and the researcher is the main resource in the knowledge-generating process (Braun & Clarke, 2013), all of which are in a harmony with the chosen theoretical approach for the study. Coding using reflexive thematic analysis is an iterative process; therefore, the initial similar codes could be merged with other codes and can be recoded or separated into other codes.

Techniques to enhance trustworthiness

The coding process and thematic map were evaluated by consulting second and third authors, with a sample of transcripts to ensure the rigour of the analysis and interpretation, and changes were applied when needed (J. W. Creswell, 2003). Triangulation of sources was used in exploring available treatment and referral options: through collecting perinatal depression care pathways used across the three research sites; asking HCPs about the treatment and referral pathways that they often use in the community, hospital and health visiting services; through interviews and focus groups and asking women about the treatment options and referral process and if any had been offered to them by HCPs; through interviews, and in comparing these three sources during the data

analysis process. In addition to this, findings across the three research sites and between two different participant population, women, and HCPs, were compared and contrasted. Having a variety of HCPs working in nine different roles in NHS services, community services and GP services provided different perspectives, rich and varied data. To ensure a rigorous analysis application, a 15-point checklist of criteria for good thematic analysis was used (Braun & Clarke, 2006).

Ethical considerations

All potential participants were sent an information pack by mail including a pre-paid stamped-addressed return envelope. They were able to read the participant information sheets before informed consent was sought and obtained. Only those who returned their signed consent form by mail were considered. Ethical approval was granted by Yorkshire and the Humber – Leeds West Research Ethics Committee (IRAS ID:237021; REC reference:19/YH/0004).

Findings

Nineteen HCPs and 15 women participated in the study. Table 1 shows the characteristics of HCPs and Table 2 illustrates the characteristics of sample of women. Eight women reported experiencing *perinatal* depression. Six had been formally diagnosed (self-reported), and two women did not have a diagnosis of perinatal depression. The reported duration of perinatal depressive symptoms varied from two months to three and a half years. Seven women reported experiencing only *postpartum* depression. Five had a diagnosis of postnatal depression (self-reported) while two women had not. The duration of postnatal depression symptoms ranged from five months to three years. The following key themes were identified from the data from women and HCPs:

1) Lack of standardisation in identification and support for perinatal low mood and depression

Women's experiences of care by midwives

Reports regarding midwives asking pregnant women about their mood or how they were feeling, were quite varied. Some women reported them not asking about their feelings antenatally or being given a questionnaire to fill in, while others expressed being given a questionnaire to fill in and/or being asked verbally how they were feeling.

"…Yeah, the nurses and the midwives suspected that something wasn't right but they didn't act on it. They didn't do anything. They just sort of kept trying to bring [name- the baby] to me and I just didn't want her. I didn't want to have her near me…" (W C 8)

Women who received support from their midwives expressed being given advice to attend groups specific for pregnant women, making an appointment with their GP, calling the talking therapy services, and calling the midwives if they needed.

Women's experiences of care by health visitors

The majority of women expressed that the health visitors asked about their mood verbally or gave them a questionnaire to fill in, while a few of them stated that the health visitors did not ask about their mood and did not give appropriate advice when they sought help from them. As one woman stated, *"…I remember it was all very much focused on how's the baby doing, what size is the baby. Is the baby growing as it should be? Focused on measurements and scans. No there was not really a focus on asking how I was at all…"* (W B 9)

Many women stated that their health visitors were good at giving practical advice on how to deal with postpartum low mood or depression and giving advice on other professional help sources that would be helpful. The reported practical advice given by most health visitors included: talking to partner, family, and friends about it; asking for physical help from family and friends on housework; not putting too much pressure on themselves; attending mother and baby groups; going out of the house for whatever reason; eating and drinking healthily and sleeping properly; and having time for themselves. The reported advice on professional help and support sources given by the health visitors included: making an appointment with their GP; calling IAPT or 'Let's Talk' services for receiving talking therapy; and providing information to women about starting medication and its side effects in the first couple of weeks. Other advice provided to women included: supporting the mother in dealing with the older child's behaviour and dealing with the child's sleeping problems.

"…We had a really nice health visitor who came out who weighed my daughter, asked about mood, asked about feeding, things like that…" (W C 7)

Some women were aware that there was a lack of proper mental health and support services for partners who experienced mental health problems in the perinatal period, and they noted that HCPs typically did not ask how partners were doing.

2) Unclear and non-standardised pathways for perinatal low mood and depression

Healthcare professionals' experiences of caring for perinatal women with low mood or depression

HCPs were asked in the interviews about what signs they look for to identify low mood or depression. Some of them (i.e., mostly obstetricians, health visitors and antenatal clinical support workers) reported looking for body language (e.g. look sad, tearful, quiet, subdued, look away and not holding eye contact, not talking or engage the conversation), women's description of their hopes and fears about pregnancy and the baby, whether having sleeping problems, eating or drinking problems or bonding problems with the baby, if they feel low, depressed, overwhelmed or worried about going out, not wanting involvement with the baby, isolating themselves, not wanting to engage in their usual activities or appointments, not wanting to leave the house, not having people around supporting them, not having a shower and/or staying in their pyjamas in the afternoon. Other HCPs (i.e., mostly midwives) reported using certain enablers to identify depression and encourage women to talk about their mood and disclose their true feelings: asking Whooley questions (Whooley questions comprise the first two questions of the PHQ-9. The only difference is the time frame: past month vs. last two weeks) for the screening of low mood and anxiety and making clear that asking these questions is part of their job and that they ask every woman; asking PHQ-9 and GAD-7 for further exploration if they suspect depression and anxiety; generalising depression in conversation with women by saying that *"you know what, depression affects 1 in 4 people and it can be fleeting"* (HCP A 1); building a rapport with individual women and getting to know them quite well; seeing women at their home environment (health visitors). They mentioned other indirect enablers, such as: extensive professional experience of HCPs; increased awareness of perinatal mental health on public; experiencing depression in the past (personal experience); sharing a personal story; talking about things like adjustment to parenting; telling women that they have got enough time to listen to them; explaining to women very clearly that they are there to support them; and encouraging women to be open about their feelings.

When asked about the identification and referral processes, a few HCPs brought with them the perinatal mental healthcare pathways documents that they use and the researcher took photos of the pathway and guidance (with permission from the staff), showing the referral process seen on the noticeboard at a hospital. The pathway for

perinatal mental health consists of asking Whooley questions and then PHQ-9 and GAD-7 if needed; however, the timing of asking questions was not clear. Then, advice, support, extra visits and self-help sources are offered, and women are referred to IAPT, Let's talk, counselling services or GP if the risk is mild to moderate (mild to moderate symptoms), and are referred to perinatal mental health midwife (if one exists), specialist perinatal mental health team (if available), crisis team, or Accident & Emergency if the risk is high (moderate or severe symptoms). The pathways were also unclear in terms of the cut-off scores on the PHQ-9. For example, a pathway suggested a referral with consent to Primary Mental Health Services if women score 0 to 10 on the PHQ-9. This pathway accepts 0 to 10 scores as *'mild to moderate mental ill health'*.

The HCPs who participated in the study described the support and care that they provide to women who experience perinatal low mood or depression. Their advice to women was: to seek support from family; to eat and drink regularly; quality sleeping; to attend activities; to attend antenatal and postnatal classes and groups; to exercise; to get outside in the fresh air; to do yoga or mindfulness; to walk; and *"making sure you're not trying to carry on at your 100 percent life style working full time doing everything else and coping with this and just accepting that you need to slow down a little bit to look after yourself"* (HCP C 16). Other advice included: using social media to find support groups; suggesting Pandas, Mood Juice, Mind, Papyrus, Home Start, Samaritans and other locally available charities supporting women with postnatal depression (names omitted here to maintain confidentiality). While most health visitors expressed a detailed description of the advice that they provide to women experiencing perinatal low mood or depression, midwives stated a general description.

From the professional perspective, the midwives concurred that there was no formal screening for partners regarding their mental health in the antenatal period but that this *was* now on the agenda. The midwives also stated that at the first booking appointment they asked the woman if there was a family history or partner history of mental illness. They stated that if the partner had a mental illness and presented at the appointment, they would give support she/he needed, would also ask GAD-7 and PHQ-9 to be given to their partner and make a referral to the IAPT or GP if appropriate. They pointed out that *"it's more a bit of a supportive role rather than a huge amount of responsibility for it"* (HCP B 9).

3) Enablers and barriers of receiving support and care for perinatal low mood and depression

Some women stated feeling like they were surrounded by healthcare professionals who work in maternity services and health visiting services and that this made it a lot easier to receive information about perinatal low

mood or depression. Easy accessibility of healthcare professionals (e.g. health visitors, GPs), medication and psychological therapy services (e.g. Let's Talk, IAPT) were other factors that facilitated reaching out to these services. The personal characteristics of individual healthcare professionals and their approach to women were mentioned as important in building a relationship and trust, all of which affected their treatment preferences.

Some women identified factors that affected their choice of treatment and facilitating aspects of receiving medication and talking therapy. Table 3 illustrates these facilitating aspects. The most frequently mentioned was being given information about the available treatment options, their pros and cons and potential effect on the foetus or breast milk.

Most of the women expressed some concerns about perinatal mental health care services and support provided by midwives and/or health visitors and/or GPs, expressed dissatisfaction and/or stated that the provided treatment options by HCPs did not meet their expectations. Table 4 shows the barriers to women receiving support and/or treatment. Most women described the barriers as related to themselves (i.e. not admitting the illness, not disclosing/ hiding their feelings due to stigma and fear of social services), related to HCPs (i.e. not being asked about their mood; their approach to them, such as being neglected or dismissed when asked for help or saying it is normal and hormonal) or related to services (i.e. not enough options to choose from and long waiting list).

Discussion

The key contribution of the study was synthesising the women's experiences of care and support received from HCPs for perinatal low mood or depression and HCPs' support and care practices for those women. The study findings showed that there was a variation among research sites and HCPs in the identification of perinatal depression. Some HCPs used certain enablers to encourage women to talk about their mood, while others used indirect methods, such as women's body language or description of their hopes and fears about pregnancy or the baby. Some women did not appreciate this indirect method and were reluctant to share their feelings. For perinatal care in England, the NICE (National Institute for Health and Care Excellence, 2020) guideline advises HCPs to ask Whooley Questions at the first contact or booking visit, and during the early postnatal period. If a woman says 'yes' to either of these questions, the NICE guidelines (Institute of Health Visiting, 2019, 2020; National Institute for Health and Care Excellence, 2020) suggest offering self-reporting questionnaires such as the Patient Health Questionnaire. Although the National Maternity Review (National Health Service England,

2016) recommends HCPs to review the women's mental health at every contact, the pregnancy notes and postnatal notes booklets have only two boxes for the recording of responses to the questions (Institute of Health Visiting, 2019, 2020). These notes are widely used in NHS services in England but are not fully adopted nationally. Two different NICE guidelines provide two different views about when these two boxes should be completed. The recent guideline 'Antenatal and postnatal mental health: the NICE guideline on clinical management and service guidance' (National Institute for Health and Care Excellence, 2020) suggests completing at the first appointment and during the early postnatal period, while another guideline 'Antenatal care for uncomplicated pregnancies: Clinical guideline' (National Institute for Health and Care Excellence, 2019) suggests completing at the first and before or at the 36-week appointments. Therefore, there appears to be potential confusion with regards to how regularly HCPs should ask about women's mental health and if they should be asking at every appointment, how they should record and do so except for re-using the Whooley questions. It is important to provide HCPs a nationally standardised guideline to fill this gap.

Interviews with women showed that the provision of help and support sources varied between the midwives and health visitors. For women with the moderate and severe depression, there was consistency between the midwives and health visitors in signposting women to the appropriate mental health services. For women with low mood or mild depression, where referral may not be needed but support is, there were variations in the provision of practical help and support. The same finding emerged from interviews with midwives and health visitors. Most of the health visitors were knowledgeable about providing practical recommendations for women with postpartum low mood or mild depression. For instance, talking to family and friends, asking for physical help from them with housework, going out of the house for whatever reason, attending mother and baby groups, eating, and drinking healthily and sleeping properly, and having time for themselves. However, the midwives barely mentioned these activities in the interviews, except for advising women to attending pregnancy groups and have support networks. Previous studies have also reported similar concerns. In these studies, HCPs stated that they had received insufficient training about managing perinatal mental health difficulties and lacked the confidence to talk about perinatal mental health with women (Boots Family Trust Alliance, 2013; Noonan et al., 2017). Uniquely, in this study, the midwives expressed their desire for more training about the basic suggestions that they could make in cases of low mood or mild depression. The Royal College of Midwives (2012) published a good practice guide for midwives that includes a guideline on how midwives can support pregnant women with depression. The recommendations presented in the guide are: encouraging the woman to see her GP; listening to the woman's feelings and concerns and reminding her that recovery takes time but the treatment

is also important for her and her baby; supporting women to use mindfulness techniques to increase the awareness of feelings and to concentrate the mind; encouraging women to contact local groups supporting pregnant women with depression (Royal College of Midwives, 2012). There is very little information in the literature presented in this guideline for midwives about giving practical advice to women that can help them relieve some of the symptoms of depression. The guideline is more about signposting women to the appropriate services according to the severity of symptoms. It is, therefore, important to provide training opportunities for midwives to increase their knowledge on practical advice that they can offer to women experiencing low mood rather than depression.

Almost all the women who participated in the study stated that the treatment options did not meet their needs. They stated that there were not enough options to choose from; they were either offered medication or referred to the IAPT services. A broader, recent review (Bayrampour et al., 2018) of the barriers to addressing perinatal mental health issues in midwifery settings, identified some of the findings observed in this study, including the scarcity of available referral options. However, this review did not provide detail on women's expectations of treatments. In this study, this gap was filled by asking women about their expectations from treatments. The women expressed willingness to receive psychological support from their maternity team or health visiting team that they are familiar with. However, they highlighted that there should be more treatment options for low mood or depression. For example, there should be face-to-face, group or telephone-based treatment options and continuity of care from pregnancy to the end of the postnatal year or two years postnatally. In addition, the provider should be easily accessible and there should be a direct phone number to access them. When they were asked whether they would like to go somewhere to receive the support or they would prefer the HCP to visit them at home, some women preferred the latter while others stated that the HCP should have an office at hospital or within a Children's Centre, where they can call in and talk about their mood confidentially. In addition, women stated that the support should include information specific to perinatal depression. Listening to patient preferences is broadly acknowledged as a fundamental component of evidence-based practise in psychology and patients are more likely to engage in the treatment of depression if the provided treatment is their preference and modified according to their needs.

Implications

HCPs require training on the management of perinatal depression, available help and support sources, what these sources provide for women and how the self-referral process works if a woman chooses to self-referral to

these services, as well as any changes made to the referral process (Forder et al., 2020). HCPs may also be responsible for the referral process on behalf of the woman (with her consent) rather than expecting the woman to self-refer to a mental health service.

A gap in care exists for women experiencing low mood and who do not need a referral but would benefit from support from the HCPs. While some women experience clinical depression, others may experience mild symptoms, which does not need a referral but support. Indeed, the NHS is currently not providing care to decrease the incidence and the effect of perinatal mental illness on women and their families (Maternal Mental Health Alliance et al., 2018). In this regard, HCPs, especially midwives, may be trained in managing perinatal low mood that does not need a referral but require support from the HCPs.

Limitations

In this study, attempts were made to recruit a variety of women, including different age groups, ethnicity, socioeconomic status, and experience of low mood or with a diagnosis of depression antenatally, postnatally, or perinatally. The intention was to also recruit women with different treatment experiences, including those who had received psychological or pharmacological treatment and those who had received neither. Another criterion was the duration of depression and depression severity (i.e., mild, moderate, severe). However, only a few of these diverse criteria were not achieved. All the women were older than 28 years, and all were white British, thereby limiting the transferability of the findings to younger women or ethnic minorities. The spread of women in the other categories (i.e., socioeconomic status, the experience of low mood or with a diagnosis of depression antenatally, postnatally, or perinatally, received psychological treatment or not, received pharmacological treatment or not, duration of depression and depression severity) was reasonable.

Although the priority was to include women who had recently experienced perinatal low mood or depression, the youngest child was 2.3, which potentially raises the issue of the data being limited over this time period. However, the literature review and interviews with HCPs supported the study findings that perinatal low mood and depression is an ongoing problem and available help and support sources remain limited. It was identified as an issue that needed to be addressed as a matter of urgency.

Conclusions

This study identified a gap in provision, where women experiencing low mood who do not need a referral to mental health services but simply support from HCPs, especially midwives, may fall through the gap. The treatment options for perinatal depression were also found to be limited to medication and IAPT/Let's Talk. Providing training opportunities for HCPs and improving support and treatments for perinatal low mood and depression is crucial to address women's psychological needs during the perinatal period.

Author Contributions

Study Design: Semra Pinar, Helen Bedford, Dean McMillan, Steven J. Ersser

Data collection: Semra Pinar

Data analysis: Semra Pinar

Manuscript writing: Semra Pinar, Steven J. Ersser, Dean McMillan, Helen Bedford

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Support and services for perinatal low mood and depression: A qualitative study exploring women's and healthcare professionals' experiences

Table 1: Characteristics of HCPs participated in interviews

Participant number	Research sites	Job role
HCP A 1	A (individual interviews)	Consultant obstetrician
HCP A 2		Perinatal mental health midwife
HCP A 3		Antenatal clinic midwife
HCP A 4		Antenatal clinic midwife
HCP A 5		Bereavement midwife
HCP A 6		Antenatal clinical support worker
HCP A 7		Antenatal clinical support worker
HCP B 9	B (focus groups)	Community midwife
HCP B 10		Community midwife
HCP B 11		Health visitor
HCP B 12		Community midwife
HCP B 13		Community midwife
HCP B 14		Registrar Obstetrician
HCP C 8	C (individual interviews)	General practitioner
HCP C 15		Lead midwife
HCP C 16		Community midwife
HCP C 17		Perinatal mental health midwife
HCP C 18		Health visitor
HCP C 19		Health visitor

Table 2: Characteristics of women participated in interviews

Participant number	Research sites	Age	Ethnicity	Deprivation score[1], 2019	PHQ-9 score	Age of youngest child	Number of children
W A 1	A	31	White British	1,458	5	1	1
W A 4		35	White British	24,324	2	3	1
W A 10		28	White British	11,591	1	1	2
W A 11		30	White British	11,300	6	3	1
W A 14		30	White British	6,904	1	1	2
W B 9	B	36	White British	26,356	0	2	1
W C 3	C	33	White British	17,329	0	4	1
W C 6		-	White British	29,202	2	1	1
W C 7		41	White British	26,120	1	3	1
W C 8		28	White British	17,024	3	4	1
W C 13		37	White British	29,684	2	3	1
W C 15		38	White British	13,045	2	1	2
W C 5		41	White British	25,922	2	1	2
W C 16		35	White British	20,541	1	3	1
W C 17		34	White British	28,981	3	4	2

[1]Public Health England, Index of multiple deprivation: A score of 1 reveals the most deprived area and 32,844, the least deprived.

Table 3: Facilitating aspects of receiving treatment for women

Factors affecting women's treatment choice/s and facilitating aspects
• the HCPs explaining the treatment options clearly and their pros and cons, which helped them to make a decision and start medication and/or talking therapy • some GPs had supportive attitudes towards women to taking medication, which affected women's decision to take them • a few women found it easier to take medication every day at the same time, rather than going somewhere for a talking therapy • some women found it easier to understand the underlying cause of their depression through talking therapy • the phone number of 'Let's Talk' was written in the given Personal Child Health Record (the red book).

Table 4: Barriers to receiving support and/or treatment

Related to women themselves: • not admitting the illness • not disclosing their feelings to the HCPs due to stigma • fear of social services involvement • women's fear of medication contaminating breast milk and its potential harmful effect on the baby • women's fear of becoming addicted to the medication
Related to HCPs: • not asking outright how the woman is feeling • not paying attention to the women's needs when women disclosed their feelings • being neglected or dismissed by HCPs when asking for help • thoughts that HCPs will dismiss the feelings as normal and hormonal • being asked to self-refer to IAPT/ 'Let's Talk' which women felt was not possible in that mind space • not being informed about the support and treatment options and their pros and cons
Related to services: • not having enough options to choose from except medication and IAPT/'Let's Talk' • finding attending a face-to-face talking therapy impractical with a baby • long waiting list in IAPT • finding the content of IAPT unhelpful and unrelated to postpartum depression.