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Enhancing capacity and capability in research undertaken by midwives

Key words: Research capability, collaborative research activity, research support, evidence-based midwifery

As clinical academic careers for midwives become better articulated and funded, then some of the more significant impediments that have stood in the way of research are breaking down. The need for sufficient capacity and capability has been well explored, but attention must be paid to how the growing workforce of researchers are supported.

There are some positive signs of change and development. In the UK, the new Academy for Nursing, Midwifery and Health Visiting Research was launched in 2009. It has modest, but important ambitions and has declared its mission to be: '*An expert collaborative voice for all aspects of research involving nursing, midwifery and health visiting in the UK, including policy development, its implementation and evaluation through negotiation and dialogue with other key stakeholders*' (Academy for Nursing, Midwifery and Health Visiting Research, 2010).

The Academy has been established as a collaborative enterprise between midwifery, nursing and health visiting organisations, such as the RCM, RCN, and UNITE/Community Practitioners' and Health Visitors' Association. This is the first time that such organisations have joined together in common purpose and is a measure of how positively they see the development of competent research.

The need for a collective voice on matters relating to research is immediate. The necessary policy infrastructure to shape clinical academic careers is now in place in the UK (UK Clinical Research Collaboration, 2007) and a requirement to develop mentorship schemes and expert support for those developing their clinical academic career is important. The combined expertise of the Academy's collaborating organisations is powerful, as is their collective capacity to lobby for investment and change.

A re-emergence of clinical leadership as a force for innovation and improvement can also be seen across the UK and is particularly well highlighted by policy intentions from the recently elected UK government. A renewed purpose is beginning to emerge from that landscape, as well as renewed structures that will deliver research and development for health and social care. The Academy has a potentially unique part to play in shaping that landscape and can offer a strong platform of professional expertise in that it:

- Offers a UK perspective
- Can provide views from clinicians, practitioners, researchers, educators and those in the clinical arena
- Has strength through its multi-organisational composition
- Can help to articulate client/patient experiences of midwifery, nursing and health visiting research.

At its outset, the Academy developed three work streams – mentorship and leadership schemes for clinicians and practitioners in relation to their research activities; and a 'case studies' booklet of clinical academics who are midwives, nurses and health visitors demonstrating 'model careers'.

The Academy has held an annual colloquium event since its inception and at its most recent event in March of this year further refined its work streams, including a strategy to secure funding to continue the Academy's work. It is actively seeking such support for a senior academic appointment to join the team, as well as innovation fellowships.

Research leadership and capability is key for development:

- A 'think tank' was held in Manchester in June (jointly hosted by the Academy and Comprehensive Local Research Networks) to consider the career prospects of midwives and nurses working in clinical research centres. Our debate was assisted by the NMC and National Institute for Health Research
- In collaboration with the University of Cambridge and Cambridge University Hospitals NHS Trust, a series of lectures focusing on clinically-based research has been developed
- The Academy is seeking active engagement in the leadership development work of the Department of Health and the NHS Institute
- A Delphi survey of clinically-based senior midwives and nurses and those in academia was undertaken to develop a shortlist of research topics. Work is now underway to capture the views of service users
- A mentorship scheme for senior midwife and nurse leaders from the clinical arena and academia – initially funded by the Health Foundation – started in 2010 and will continue with funding from the Burdett Trust for a further three years
- The Academy is holding a second annual residential summit meeting for senior midwives, nurses and health visitors with the NHS Institute for Innovation and Improvement.

The Academy is proving to be a powerful alliance. Our work streams offer support to those embarking on their research careers, as well as those further on in their career development. Midwifery has a significant part to play in the continuing work of the Academy. It has proved to be a powerful partner and there is, of course much more to do.

Our combination of research, scholarship and purposeful leadership must now stand a strong chance of making change for the better. Midwifery must not wait for permission to lead or act, it must continue to seize the initiative itself.

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Organisational culture and routine midwifery practice on labour ward: implications for mother-baby contact

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Abstract

Background. This study examines labour ward culture on two British labour wards in terms of mother-baby contact and breastfeeding. This has not been empirically researched in the UK since 1985 (Garforth and Garcia, 1989).

Aim. To investigate the organisational culture, examine mothers' beliefs and experiences and midwives' knowledge, beliefs and practices.

Objectives. To compare organisational cultures; identify whether midwifery practice is evidence based, and what factors facilitate or detract from it; and identify mothers' preferences, beliefs and levels of satisfaction.

Study design. Ethnography with case study.

Method. Observation and interviews conducted in two separately managed maternity units. The sample of mothers (n=50) and midwives (n=51) was purposive. Ethical approval was obtained from the local research ethics committees of the Trusts for both units.

Results. Mother-baby contact after birth is usually interrupted for completion of tasks. Some babies have multiple contact episodes, which has not been previously described in the literature. Completion of routine tasks for transfer of mothers and babies to postnatal wards takes precedence because of organisational demands and insufficient resources. However, most mothers expressed feeling satisfied with contact achieved.

Conclusion. Findings of the study have contributed new insights and knowledge of labour-ward culture. It is not conducive to uninterrupted mother-baby contact and is not evidence based.

Recommendations. The development of a learning culture and clinical leadership to promote evidence-based practice and woman-centred care is recommended. The unique period after birth should not be disturbed in order to prioritise routine tasks.

Key words: Organisational culture, mother-baby contact, skin-to-skin contact, labour ward, routine practice, evidence-based midwifery

Background

Organisational culture is a recognised barrier to implementing policy and research-based evidence in the NHS and it is suggested that cultural change is needed for the adoption of new approaches to care (Department of Health, 2004, 2007; Richens and Thomas, 2004; McDonald, 2005). A recent review of the evidence has found some support for the concept that organisational culture and healthcare performance are linked, although difficulties in defining both variables are acknowledged (Scott et al, 2003; Dykes, 2005).

The term 'culture' can be applied to stable social units with a shared history or experience, such as the NHS. As a complex organisation, the NHS has many different cultures and norms due to differences in socialisation processes of professions; needs and expectations of client groups; local priorities; allocation of resources; and performance management (Iles and Sutherland, 2001). Definitions of organisational culture vary, but it broadly refers to the organisational paradigm and reflects basic values, beliefs, assumptions and norms of behaviour shared by its members. Language, dress codes, signs of status and authority, patterns of behaviour and rituals are included (Dawson, 1996; Davies et al, 2000; Johnson and Scholes, 2002; Scott et al, 2003).

Schein (1992) describes three levels of culture. At the deepest, unconscious level is the beliefs and assumptions that reflect what people think ought to be done.

Organisational values representing standards and goals are at the next level, with the physical and behavioural aspects of culture such as dress codes and artefacts (standard ways of doing things) manifesting more superficially and visibly at the third level. However, Schein (1992) suggests that beliefs and assumptions constitute the real essence of culture and are evidenced by the way people actually behave

– that is, culture-in-practice – rather than by statements of values and beliefs, in other words, espoused culture. In maternity care, for example, women's choice is espoused to be a determining factor (Department of Health, 1993; 2004; 2007). Whether it is achieved would determine if it is culture-in-practice or simply rhetoric (Mead, 2010).

Labour ward is an area of maternity care where members share common experiences and, over time, develop a subculture with beliefs and assumptions about management of care. Pragmatic midwifery routines developed over time may not easily accommodate evidence-based practice, for example, in support of early mother-baby contact after birth. This study focuses on routine practice on two labour wards in respect of such contact as illustrations of labour ward culture. Though described in a 1985 study (Garcia and Garforth, 1990), the specific focus on this unique and important time has not previously been studied in depth or from the perspective of organisational culture. The findings in relation to mother-baby contact are reported here; findings related specifically to skin-to-skin contact and breastfeeding will be reported elsewhere.

Supporting evidence for mother-baby contact after birth includes a Cochrane review of four randomised controlled trials (RCTs) (Anderson et al, 2003), which found that unrestricted skin-to-skin contact increases newborn thermal stability and blood glucose levels. They recommend that infants remain in uninterrupted ventral-to-ventral skin contact, are thoroughly dried, and are covered across their backs with pre-warmed blankets. More recently, an experimental trial studying mothers and babies who were randomised to skin contact or routine care following caesarean section delivery concluded that there was no risk of hypothermia in the skin contact group (Gouchon et al, 2010).

Skin contact appears to promote long-term breastfeeding. Mothers in this group are twice as likely to be breastfeeding at one to three months after birth as those in control groups. In a non-randomised prospective trial, Righard and Alade (1990) found that babies' sucking technique was disturbed when mothers and babies were separated before the first feed. An RCT has since demonstrated that exclusive skin and suckling contact with mother for more than 50 minutes enhances the newborn's ability to recognise its own mother's milk (Mizuno et al, 2004). This may contribute to prolonged breastfeeding, although in another RCT, Carfoot et al (2005) found no significant skin-contact effect at four months. However, they found that mothers enjoyed the experience and added further support for its enhancement of neonatal temperature control. More recently, the findings of a prospective trial have suggested that skin-to-skin and/or suckling contact after birth has positive influences on mother-baby interaction one year later when compared to routines involving separation of mother and baby (Bystrova et al, 2009).

Babies' crying behaviour in relation to the presence or absence of body contact with mothers has been studied in two randomised trials (Christensson et al, 1992; 1995). Excessive crying may have untoward effects on newborn circulation, such as delayed closure of foramen ovale (Anderson et al, 2003), which clearly should be avoided. A recent RCT supports the suggestion that healthy full-term babies cry less following skin contact, and that its effect persists after separation (Ferber and Makhoul, 2004). NICE recommend unrestricted mother-baby contact, skin contact and breastfeeding from birth (NICE, 2007).

Methodology

The current study has an ethnographical research design (Hammersley, 1990; Atkinson and Hammersley, 1998), which is an appropriate methodology for studying organisational culture. Its origins are in anthropology, which focuses on understanding the culture and world view of a group of people (Polit and Hungler, 1999). The goal is to collect data from an emic (insider) perspective, with emphasis on seeing things from the perspective of those being studied, but also to step back and make sense of it as a researcher from an etic (external observer) perspective (Fetterman, 1998). Previous personal experience as a midwife working on labour wards like those studied has provided some emic insight into labour ward culture, though it is acknowledged that cultures evolve and may vary from one labour ward to another. An etic perspective was facilitated by not having worked on the labour wards studied and obtaining mothers' and midwives' perspectives on events.

Setting

Fieldwork for this study was conducted in two separately managed maternity units, both within teaching hospitals for medical, nursing and midwifery students. Maternity unit A, in an inner-London NHS Trust, provides general and acute services. It has approximately 3500 births annually and has the regional unit for high-risk neonates and mothers on site. Maternity unit B is located in a NHS hospital on the outskirts of London. It provides general acute and maternity services, with approximately 3400 births annually, some specialist services and a sub-regional neonatal unit. Both provide maternity services to women from a diverse range of socio-economic, ethnic and cultural backgrounds. Neither had World Health Organization/UNICEF Baby Friendly Initiative accreditation. Breastfeeding rates were similar for both maternity units at the time of study. The whole-time equivalent numbers of midwives was 111.06 for unit A and 90 for unit B. Both had midwifery vacancies and depended upon bank, agency and part-time midwives. Care of labouring women was centralised on labour wards, as is typical of UK maternity units.

Samples

Selection of the two study settings and sampling of women for observation and interview was purposive. Women with a singleton low-risk pregnancy, normal birth at term and wishing to breastfeed met inclusion criteria; women who had multiple pregnancies and instrumental or operative delivery were excluded. The sample consisted of 50 women (25 on each labour ward), who were serially selected in early labour on days when researchers were present, unless

their allocated midwives had already participated. A total of 130 women were invited to participate; 21% (n=27) declined, giving a good response rate of 79%. Mothers were invited to describe their ethnic origins at interview, in recognition of potential cultural influences on their preferences for mother-baby contact. Some did not adopt the recognised classifications and gave a range of nationalities and ethnic origins. The numbers were too small to draw meaningful conclusions in respect of maternal cultural influences. The sample of 51 midwives consisted of those who cared for selected women during the observation period (there were two in one case) and no re-entry data were included. In total, eight midwives declined to participate (five from unit A and three from unit B).

Data collection

Methods included non-participant observation of the first hour after birth and semi-structured interviews of mothers and midwives who provided care. Observation is frequently employed in ethnographic research as a means of systematically collecting data about people's behaviour and talk (Pope and Mays, 2000). It provides access to events as they happen and does not depend on reports by others, which may be distorted by perception or memory (Rees, 1997). However, there is potential risk for observers to impose their own interpretation on events, which has obvious implications for validity. A mixed-method approach has helped guard against such occurrence and participants have been interviewed to gain their perspectives and meaning of activity. Semi-structured questionnaires using interview technique were deemed the most appropriate method to achieve this. They allow for the possibility of concepts and variables emerging that differed from those anticipated (Britten, 2000).

Observation schedules and interview questionnaires were semi-structured to collect quantitative and qualitative data; they were piloted and refined as necessary in advance of the study and interviews were tape-recorded for transcription. Through triangulation of findings, observed midwifery practice as well as midwives' and mothers' expressed beliefs and values were investigated. Using different methods and sources of data are a means of achieving triangulation to validate findings through systematic comparison (Hammersley and Atkinson, 1995). However, observations and interviews provide different perspectives of events, so this approach can enrich the data also.

Ethical approval was obtained from both Trusts' local research ethics committees, which was the accepted procedure in place prior to the current Integrated Research Application System. An experienced research assistant/midwife helped with data collection, as the author was in full-time employment as a midwifery lecturer and undertaking the research on a part-time basis. The author assessed interview transcripts and tape-recordings for accuracy and two independent senior researchers checked a sample for reliability. Informed consent was obtained from all participants, data were stored safely and confidentiality and anonymity were maintained.

Analysis

Data obtained from each method and for each maternity unit were analysed separately for comparison purposes. Participants were allocated a number code that indicated chronological order, researcher and labour ward – for example, LW1 (unit A) or LW2 (unit B). Quantitative data entered on a Microsoft Excel spreadsheet enabled calculation of overall results, which were presented as descriptive statistics such as timing and duration of mother-baby contact. The editing analysis style was utilised for qualitative data such as ethnography (Polit and Hungler, 1999). Categories of related concepts were identified from interview transcripts and observational schedules, which were then listed and coded. Transcripts and schedules were then reread and corresponding categories recorded in the margins, line by line. Excerpts for each category or sub-category were then copied onto a separate Microsoft Word document. There were 26 categories in total identified from observational data, ten categories and 57 sub-categories from mothers' interviews, and 12 categories and 89 sub-categories from midwives' interviews. A second level of analysis was undertaken to further interpret data and identify emerging themes and patterns (Abbott and Sapsford, 1998). Overall, 34 themes were identified, 25 of which related to mother-baby contact. Quantitative measures were utilised to present data in tables: numbers of incidents and statements in each category were counted to illustrate patterns in the data as a whole (Silverman, 2000).

It is acknowledged that data are interpreted from a personal perspective. The researcher is not a neutral research tool, having in this case been influenced by personal experience of working as a midwife for 11 years before becoming a midwifery lecturer. This can be advantageous in authenticating findings, but may also result in overlooking certain nuances or ambiguous issues (Roberts et al, 2006). The phenomenological research strategy of bracketing was utilised, whereby personal experience, judgments and beliefs were suspended and any presuppositions made explicit. Alternative explanations of findings have been provided where possible and deviant cases sought to refine analysis. Trustworthiness of findings may also be affected by the Hawthorne effect or reactivity (Abbott and Sapsford, 1998). The observer's presence and behaviour may alter the situation observed and interviewees may seek to provide the 'right' answers when interviewed by a researcher or a known (by some) midwifery lecturer. However, there was no conflict of interest to affect midwives' behaviour and it is seen as a positive effect to discover their best behaviour, as observed by Kirkham (1989). In an attempt to reduce the potential impact of their presence, researchers made themselves as unobtrusive as possible during observation.

Findings

Mother-baby contact at birth

Mothers were given their babies within a range of times (immediately to 57 minutes after birth), but mostly it was immediately or soon after birth (median: 8 minutes, mode: <1 minute). The majority (n=43) said that they had the

kind of contact wanted, with most (n=34) wanting to hold or see their baby immediately. A minority had not considered it (n=5), preferred the baby to be cleaned (n=5) or wrapped (n=3), or wanted the father to hold the baby (n=1) and cut the cord (n=1). Seven did not achieve the wanted/expected contact, including one who felt too tired and five whose babies had paediatric examination immediately or soon after birth because of meconium-stained liquor. Mothers were generally accepting of not having preferred contact, but one (2.12 – LW2) expressed disappointment. She had briefly held her baby before paediatric examination and resumed contact some 13 minutes later but, when feeling nauseous, had to relinquish her to her partner. She did not hold her again for almost an hour, but only briefly before going to theatre with retained placenta:

"I hated it [having to go to theatre], which is why I was told yesterday to take the baby out of my bed, [she's] staying in bed with me, because I missed that initial [contact]" (2.12 – LW2).

Another mother (2.24 – LW2) expressed dissatisfaction when her baby was dried and wrapped by the midwife instead of being birthed onto her abdomen, as had happened with her previous baby. The midwife believed that she was complying with the mother's wishes, but acknowledged that she had not enquired.

Overall, the majority of mothers and midwives agreed that mothers' wishes for immediate contact should be accommodated. Both groups referred to it as being instinctive or natural and that it was reassuring to mothers that babies were healthy. Some mothers spoke about the joy of holding their babies, the need to see them and how it gave a sense of security to mothers and babies after the trauma of birth:

"It's such a wonderful moment; I don't think it should be ruptured at all" (2.47 – LW1).

Delayed first contact

First contact after birth was delayed for some mothers and babies for various reasons. A total of 15 babies, mostly on LW2 (n=11), were placed by midwives on the bed immediately after birth for drying, wrapping, applying cord clamp and/or airway suction. Fathers cut the umbilical cord in six observations (four on LW2, two on LW1), with the baby lying on mother's abdomen or, more frequently, the delivery bed. Another reason for delayed contact was when mothers (n=6) declined when feeling unwell or fatigued or preferring the baby to be wrapped or examined for abnormality. As previously mentioned, another reason for delayed contact was paediatric examination. In total, eight were examined immediately or within minutes of birth; in five cases, this was before contact with mothers.

Midwives' reasons for delayed mother-baby contact after birth

When asked why well mothers and babies might not have close contact after birth, the majority (n=38) of midwives stated that mothers may not wish to hold their babies for various reasons, such as maternal emotional, physical and social problems; cultural preferences; wanting the baby cleaned or dressed first; wanting the father to hold the baby; or during placental delivery or perineal repair. Midwifery workload was the next most common response (n=20), which included the need to do routine tasks (n=9) or care for another woman in labour (n=3). Observational data were incongruent in that most mothers held their babies soon after birth, but it is suggested that midwives meant that it would interfere with later mother-baby contact. When asked why close contact between a well mother and baby might be interrupted, the majority of midwives referred to midwifery workload, completion of tasks and pressure to clear the delivery room (see Table 1):

"I have been trained in this way, that you get on and do things, you cut and clamp the cord, you sort the baby out, you do that [because] that's important and then mum has got all the time in the world for the baby.… You just want to have done your work, so you feel in control" (2.34 – LW1).

A minority (n=14) indicated that midwives varied in their priorities for care and following routines, including one who said that workload was no excuse for not facilitating mother/baby contact:

"If these women aren't asking to hold their babies, midwives tend to get very task-orientated and get [babies] cleaned and dried and everything done and there's pressure on them to get the room emptied" (1/2.14 – LW2).

Some midwives implicitly referred to organisational culture, suggesting that even when labour ward was not especially busy, there was pressure to carry out tasks. Midwives were seen to be efficient and hard-working if they completed things quickly, and may be criticised otherwise:

Table 1. Reasons for interrupted mother-baby contact (midwives' interview data)

Reason	LW1 responses	LW2 responses	Total
Tasks to be undertaken	16	15	31
Transfer to postnatal ward	9	8	17
Busy labour ward	4	6	10
Pressure to hurry	2	6	8
Midwives' routine/priorities	7	3	10
Maternal condition/wishes	7	10	17
Wish for relatives to hold baby	5	4	9
No reason for interrupted contact	2	0	2

"A midwife would rather be seen that all her work is done… you know the quicker you do that, the better midwife you are… but a lot of midwives [are] under pressure to transfer them down to the ward and I think that's where you look a much harder working midwife, if you get it done within half an hour" (2.35 – LW2).

Two midwives, one from each labour ward, spoke of the need to resist such pressure and be assertive:
"You've got a sister outside saying "why haven't you done this, why haven't you done that?" I just felt the other day, actually I had to be quite assertive to try to say, "Well basically, she's feeding at the moment""(2.49 – LW1).

However, another said that mother-baby contact could not be legitimately defended as a reason for delaying completion of tasks. A minority of midwives (n=10) referred to experiencing pressure from senior staff to complete tasks. They were mainly from LW1, but midwifery managers were observed to inform parents and midwives of the need to hurry on LW2 also.

Duration of first mother-baby contact

Observational data showed that duration of the first period of mother-baby contact varied considerably for the majority (range <1-54 minutes). One mother chose not to hold her baby until 57 minutes after birth, but two had ongoing contact from birth until beyond the one-hour observation period. Both had birthed on LW1, although one on LW2 had first contact lasting 54 minutes. The median length of first contact was eight minutes and the mean approximately 11 minutes for the 47 mothers and babies where contact was interrupted.

When midwives were asked if the length of early mother-baby contact mattered, the majority agreed (n=19) or strongly agreed (n=18) that it did, with a minority unsure (n=11) or disagreeing (n=2). (There were no data recorded for one respondent). Reasons given in favour of maintaining contact included maternal wishes; giving time for 'bonding'/mother-baby relationship; skin-to-skin contact and breastfeeding; and the opportunity for mothers to see, touch and examine babies and keep them warm. Those not in agreement said that mothers would bond with their babies anyway; that a few minutes of contact were sufficient; and that other tasks had priority.

Mother-baby contact episodes

Mother-baby contact was interrupted in almost all observations (n=47). For some, it was more than once and for variable periods. The majority (n=41) went on to have a second contact episode, 17 of which lasted for the remainder of the observation period. However, contact was interrupted a second time in almost half the sample (n=24) of mothers and babies; 18 were returned for a third contact episode. A minority (n=6) went on to have a fourth contact episode during the observation period.

To gain further insight into mothers' and midwives' attitudes to uninterrupted contact, respondents were asked to comment on two contrasting fictitious case studies. Case study one consisted of the baby being dried and wrapped by the midwife and being given briefly to mother before the performance of routine tasks. In the second case study, the baby was dried and had ongoing skin-to-skin and suckling contact with the mother before separation. The majority of mothers (n=28) preferred case study two, with a minority preferring case study one (n=11) or expressing uncertainty (n=9). The majority of midwives (n=40) also preferred case study two, although more midwives on LW1 saw it as ideal practice. The majority (n=39) described case study one as less than optimal, in that there should be more mother-baby contact, including skin-to-skin and breastfeeding, before routine tasks. However, some stated that it could not always be achieved because of maternal preferences and labour ward pressures.

Reasons for interrupted mother-baby contact (observational data)

Observational data showed that reasons for interrupted mother-baby contact were numerous and often multiple for the same woman. Separation of mother and baby was at midwife and/or mother's suggestion. Many babies (n=26) were given to relatives or friends to hold, although in the majority of cases (n=20), separation was for other reasons, such as the delivery of placenta, as well. Commonly, it was so that routine tasks could be undertaken; sometimes they were initiated during separation for other reasons. Most common tasks included weighing, wrapping/dressing and hygiene of babies, and attending to mothers' comfort.

The weighing of babies was the most common reason overall for interrupting contact, the majority being on LW1. Mothers (n=13), relatives (n=13) and/or midwives (n=9) raised the issue soon after birth. A minority of midwives (n=7) and student midwives (n=2) indicated their intention to weigh the baby, although one mother declined as she preferred to hold her baby. One midwife referred to needing to weigh the baby before going off duty, while another said that the baby 'looked a bit small'. Babies were often wrapped and dressed during periods when contact had been interrupted for other tasks, such as examination and weighing. A minority of mothers/relatives enquired about cleaning babies after birth (n=12). Some midwives (n=6) discouraged bathing babies when requested by the parent/s, indicating that they wanted to perform another task first or were concerned about neonatal hypothermia risk. A minority of midwives suggested bathing the baby to parents (n=6) or bathed the baby as part of their routine (n=3). Addressing mother's comfort was another common reason for interrupting contact, for example to change sanitary pads, clothing and bedding.

During separation, babies were not always close enough for mothers to see or touch them. Some fathers or other relatives (n=13) held babies at a distance from mothers, while others positioned (n=3) or repositioned (n=10) themselves to be closer. A total of 13 babies were cared for by midwifery staff in a cot or on a resuscitaire at a distance, five of whom had their backs to mothers; two midwives draped a towel over the side of the cot, which further

obstructed the mother's view. One student midwife with her back to the mother was instructed by the midwife to reposition the cot for the mother's benefit. Seven babies were placed in cots out of reach/sight of mothers; one was moved further away by a midwife who had come in to collect equipment. Some 13 babies in cots were positioned close to their mother's bedside, including two out of the seven babies previously placed at a distance, so that they were close enough to see or touch them. Some babies were crying/unsettled (n=14) and/or sucking their fingers/rooting (n=10) while in their father's arms, being weighed/examined or lying in the cot. One was noted to scream loudly when removed briefly from the mother.

Table 2. Mother-baby contact during routine tasks (observational data)

Mother holding or feeding baby during routine tasks	LW1	LW2	Total numbers
Mother being made comfortable	4	1	5
Assessing baby's temperature/ applying ID	2	4	6
Delivering placenta	6	4	10
Assessing for perineal tears	4	5	9
During perineal repair	0	1	1
Maternal observations	2	2	4
Setting up IV infusion	0	1	1
Examination of baby	1 +1 on mother's bed	1 +4 on mother's bed	2 +5 on mother's bed

Mother-baby contact during routine tasks

Some midwives attempted to facilitate mothers seeing and touching their babies during routine tasks. Five babies were examined on the mother's bed, with another five being examined, weighed or bathed at the bedside. Four babies on resuscitaires were moved closer to the mothers' bedsides. In some cases, routine tasks were performed when mothers were holding and/or breastfeeding babies (see Table 2).

Discussion

Findings demonstrate some consistency with other studies and relevance to current discourse, as well as contributing to the body of knowledge in respect of new information. These will be highlighted during the following discussion through inclusion of relevant references.

For the majority, mother-baby contact comes immediately or soon after birth. Although a minority of mothers declined to hold their babies immediately and/or specified the kind of contact they wanted, it is usually initiated by midwives. This finding may demonstrate a culture of ongoing acceptance of midwifery authority and is consistent with that of Garcia and Garforth (1990). As an alternative, babies could be birthed onto the bed for mothers to pick up when ready. Almost all mothers were satisfied with the contact achieved, although this may indicate socialised acceptance of care received, as described by Lipsky (1980), Kirkham (1989) and Machin and Scamell (1997).

Mothers and midwives largely gave similar reasons for achieving early mother-baby contact, the most common being the promotion of the mother-baby relationship and compliance with maternal wishes. Some mothers spoke of the joy of holding babies for the first time and their need to see them and feel secure, so it is important for midwives to facilitate such contact. Many midwives and mothers used the terms 'bond' or 'bonding', which may reflect awareness of an unproven theory expounded in the 1970s that had a real influence on maternity care in respect of increasing mother-baby contact after birth (Klaus and Kennell, 1970).

Espoused culture versus culture-in-practice

When shown the case studies depicting different models of care, a sizeable minority of midwives commented that it was routine practice to interrupt mother-baby contact, with some referring to pressures/time constraints to complete other tasks. They implied a tension for midwives between achieving optimal care and labour ward pressure to complete tasks and transfer mothers and babies to the postnatal ward, which has been suggested by other UK studies (Mackin and Sinclair, 1998; Hughes et al, 2002; Lavender and Chapple, 2004; Deery, 2005). A minority indicated that either case study was acceptable, as mother-baby contact and breastfeeding were achieved, which implies a task-oriented approach, also described by others (Kirkham, 1989; Garcia and Garforth, 1990; Hunt and Symonds, 1995; Walsh, 2006).

Half of midwife respondents said that maternal wishes would guide their practice, although clearly the tensions

already mentioned could place constraints on its achievement. Some showed frustration at being unable to provide optimum care, which could lead to a sense of dissonance and conflicting ideologies, as suggested by Hunter and Deery (2005) and Kirkham (1999). Thus, midwifery satisfaction may be adversely affected. However, a minority referred to midwives' power and control in deciding priorities on labour ward and contrasted it to home birth, where mothers exercise control in their own environment. The implied criticism was that midwives may not prioritise women's needs in hospital. Despite most midwives and more than half the sample of mothers expressing support for uninterrupted mother-baby contact, observational data found that the majority of babies are separated from mothers before first breastfeed. This suggests that espoused culture is not culture -in-practice (Schein, 1992).

Episodic mother-baby contact

Almost half the sample of mother-baby dyads had contact interrupted more than once, with a sizeable number having a third contact episode and a few even having a fourth. The episodic nature of mother-baby contact has not been described previously and demonstrates the frequency of separation. Maternal choice was exercised in this respect, although mothers may take their cue from midwives perceived to be busy. Midwives held directly opposing beliefs as to whether length of contact promoted the mother-baby relationship; workload appeared to be an important influence. Although evidence recommends ongoing contact if mothers wish it, findings suggest that the cultural norm on both labour wards is to interrupt mother-baby contact. A recent national survey of midwives in Australia had similar findings (Cantrill et al, 2004).

Babies' proximity to mothers

The finding that a minority of babies are placed at a distance from their mothers has been described previously (Garcia and Garforth, 1990), suggesting an aspect that needs greater midwifery awareness and sensitivity. Relatives could be encouraged to take up closer positions when holding babies and, as demonstrated by some midwives, routine baby care could be undertaken in the mother's arms, on her bed or at her bedside when she is not willing or able to hold her baby.

Midwives' beliefs about delayed mother-baby contact

Midwives gave various explanations for delayed mother-baby contact. The majority said that mothers may not wish to hold their babies, for various reasons previously outlined. Some were not overtly in evidence during observations, but may reflect midwives' previous experience, such as maternal emotional and social problems. However, others were supported by observational and/or maternal interview data, for example, maternal fatigue, pain, or nausea, as well as mothers wanting the baby to be examined or dried/cleaned before contact. These findings suggest that some mothers have other needs or priorities and not all wish or feel able to have immediate contact with their baby.

Organisational demands were a common theme identified by midwives, as a factor in delaying and interrupting mother/baby contact. Various routine tasks are undertaken, for example, weighing the baby, for completion of computerised labour records before transfer of mothers and babies to the postnatal ward. Midwives and delivery rooms have to be freed up to provide carer and beds for other labouring women. The unpredictability of numbers involved makes it imperative to ward mothers and babies quickly after birth – centralised birthing facilities detract from one-to-one care (Walsh, 2006). Thus, needs of the system are put before individual needs of mothers and babies, which has ethical implications. Mothers are vulnerable having just experienced their baby's birth in a strange environment and rely on healthcare providers to protect them from undue interference.

A minority of midwives referred to experiencing pressure from labour ward managers to get mothers and babies transferred. Some believed that midwives were seen to be efficient and hard-working, if they completed tasks quickly, but could be criticised if slow. It is unknown if they were making projections, or had actually experienced being blamed, as they did not say explicitly that managers had admonished them. Such findings reflect the hierarchical nature of authority and the expectation of role compliance in bureaucracies (Kirkham, 1989; Handy, 1993; Mullins, 2002). Midwives may feel inadequate and/or experience shame and blame, as a consequence, which has been found in other studies (Kirkham, 1999; Hughes et al, 2002; Hunter and Deery, 2005).

Observational data provide some evidence that managers exert pressure, when the labour ward is busy. A few were observed to tell midwives that they needed to hurry and/or help out with certain tasks. Recent evidence from midwives working in consultant-led maternity units supports their experience of feeling the need to rush to complete tasks quickly (Lavender and Chapple, 2004). The conveyor belt analogy of Fordism and the scientific management model of Taylorism as a technique to oversee Fordism, may be applicable in respect of labour ward direction (Sandall, 1995; Walsh, 2006). Taylorism, as a means of maximising industrial output and raising worker productivity means that employees are closely monitored by managers to ensure efficiency (Giddens, 2001). Such management is hierarchical, detached from worker activity and focused on procedures and product outcomes. Mother-baby contact may be seen to interfere with achieving management objectives of efficient labour ward throughput by managers, who are removed from direct care and potential appreciation of individual needs. However, a minority of midwives conveyed a sense of professional autonomy at interview, which challenged managerial control, when they spoke of the need for assertion in supporting women. Such midwives can provide good role models for those who lack confidence to resist cultural pressure (Kirkham, 1989; 1999).

Some suggested that midwives could be routine or task-orientated and that there was a culture of rushing, even

when labour ward was not busy. Practitioners may become socialised into a 'culture of busyness' and use routine as a coping strategy to gain control, as suggested by Lipsky (1980), Bate (1984), Wilson (2000) and Walsh (2006). However, routines are driven by organisational demands and can become so fixed that midwives cease to be flexible and responsive to mothers' wishes (Garcia et al, 1987). Emphasis on midwives' control detracts from the women-centred approach, espoused by government policy (Department of Health, 1993; 2004; 2007). 'Doing' rather than 'being' is emphasised and the emotional and subjective of women's experience is neglected (Garcia and Garforth, 1990; Fahy, 1998; Hunter and Deery, 2005; Walsh, 2006). Mothers are treated as 'passive work objects', with speed being seen as a virtue and a bureaucratic tendency to over-emphasise procedure and process (Kirkham, 1989; Garcia and Garforth, 1990; Hunt and Symonds, 1995; Mullins, 2002).

However, findings suggest that midwives exhibited different approaches to care and some implicitly distinguished themselves from those who were routine focused. Conceivably, midwives may espouse beliefs, but not exercise them in practice. The focus on routine may reflect affective neutrality with professional detachment from individual women's needs when faced with insufficient resources, as described by Hunter and Deery (2005). In contrast, those who are not bound by routines may exhibit affective awareness and prioritise individual needs.

Conclusion

The period after birth has been a fruitful focus of study to examine organisational culture and demonstrate aspects not previously examined in depth. It has helped to draw out midwifery beliefs about practice, which underpin culture at its deepest and unconscious level and reflect taken-for-granted basic assumptions about what ought to be done (Bate, 1984; Schein, 1992; Zwelling and Phillips, 2001). Cultures of the selected labour wards may not be the same as others, but it is hoped that findings will help to illuminate practice and readers may decide for themselves if they are transferable.

Labour wards enable staff to provide acute care for labouring women and allow limited resources to be concentrated in one area. However, mothers and newborns must then transfer to the postnatal ward and midwifery routines result in interrupted mother-baby contact for the majority. Midwives need support and guidance to adopt flexible routines and evidence-based practice, with more balance achieved between operational management and clinical leadership. Alternative models of care, such as midwifery-led care and home birth could facilitate a more woman-centred approach and bring about change in the organisational culture (Spurgeon, 1999; Coyle et al, 2001; Newburn, 2003; Walsh, 2006). Education and/or development opportunities should be encouraged in a learning organisation context (Mackin and Sinclair, 1998; Steele, 1997). Some evidence suggests that midwives' morale is heightened by working environments with a strong commitment to evidence-based practice (Lavender and Chapple, 2004). However, mother-baby contact can be improved through greater midwifery awareness and sensitivity of mothers' needs. More emphasis on the importance and uniqueness of mother-baby contact after birth is needed. It should not be treated as a marginal activity with organisational needs prioritised; cultural change on labour wards is indicated.

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Action research: a process to facilitate collaboration and change in clinical midwifery practice

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Abstract

Background. Midwifery practices are increasingly research based from applied knowledge emanating from primary research. However, there has been a realisation that the outcomes of research gained in controlled and removed environments are not always applicable to the practice setting in which midwifery care is provided.
Aim. This paper describes a modified action research approach as a means of addressing some of the challenges facing contemporary clinical midwifery practice.
Method. The approach to action research described in this paper is based on the methodology proposed by Kemmis and McTaggart (1982). Parents, midwives and researchers collaborated to develop actions to improve education and support for parents in the early postnatal period. Three specific actions were developed, implemented on a postnatal ward and evaluated. Based on the appraisal of parents, the actions were found to be relevant and beneficial. Reflective comments from the midwives indicated that the process contributed to their personal and professional development.
Implications. Action research provides a democratic, collaborative and dynamic framework for research enquiry and has the potential to bring change and improve practice by responding to the needs of people and practitioners. Action research should be considered as an appropriate methodology to engage researchers and midwives in collaboration and change to improve maternity care.

Key words: Action research, midwifery, evidence-based practice, collaboration, change, evidence-based midwifery

Background

Providing optimal maternity care is complex. Solutions developed in one context may not be readily employed in another. In a response to the complex issues facing maternity care, Enkin (2006: 268) asserts: '*First and foremost, we need to accept the uncomfortable reality that there are no comprehensive formulas. A cookbook for maternity care is not on the cards*'. Enkin (2006: 268) continues: '*We must allow new forms of research to evolve, to produce new kinds of evidence and to accept the value of this new evidence.*' There is a need to build on well-established approaches in research and to complement forms of evidence already accepted (Enkin, 2006). Action research is an established method of developing this new kind of evidence.

Action research

Action research provides a research process that brings theory and practice together. It enables researchers and practitioners to identify and address problems faced in practice and collaboratively develop solutions that can be evaluated, providing evidence to support practice (Lewin, 1946; Kemmis and McTaggart, 1982; Greenwood, 1994a; Owens et al, 1999; Wilkinson and Ehrich, 2000; Waterman et al, 2001). It provides a people-centred approach to research that addresses the needs of the vulnerable through research that is democratic (Hart and Bond, 1995; Meyer, 2000). Through collaboration it guards the researcher from becoming self-serving. Further, action research provides a means for intuitive knowledge to be validated and avoids a 'cookbook' approach to evidence-based practice by systematically evaluating actions in practice (Closs and Cheater, 1999). It also emphasises the value of critical reflection and encourages personal reflection and self-evaluation (Winter and Munn-Giddings, 2001).

Particularly appealing, is the potential for action research to be implemented by midwives themselves (Coghlan and Casey, 2001). Action research engages similar processes already utilised by midwives to assess the needs of women and their families, as there is a constant requirement to enquire, assist and review throughout the provision of midwifery care (Hart and Bond, 1995). Midwives may be able to participate in research both as 'insider-practitioners' and as partners with 'outsider-researchers', providing opportunity to address problems that are important for their practice and to engage in achieving change at a local level, in partnership with local people and other practitioners. This will equip midwives to practise more effectively within the research environment, result in benefits for families receiving care and will contribute to the development of midwifery knowledge that may well have benefits beyond the local environment itself. Additionally, there is the potential to foster a research-aware culture among midwives by including them in research that is conducted alongside everyday practice and contribute to the academic outcomes of the midwifery profession by enlarging the theoretical base underpinning practice (Greenwood, 1994a; Winter and Munn-Giddings, 2001).

Examples of action research in midwifery

It is useful to consider examples of action research within midwifery practice. Fraser undertook an action research study with the aim of improving pre-registration curricula for midwifery programmes in England (Fraser, 2000a; 2000b). It was recognised that in order to facilitate change, collaboration would be beneficial. The collaborative process enabled lecturers, midwifery students, preceptors, experienced midwives and mothers to

identify issues and discuss appropriate changes. Fraser (2000a; 2000b) concluded that action research provided a means to effectively assess and continually improve pre-registration curricula. Similarly, Choucri (2005) documents the journey of a group of education and practice development midwives, who engaged in action research to explore their own role in practice development, while improving care provided to women. Through collaboration, a number of strategies were proposed, including the development of an audit tool to assess whether midwifery practice had been improved following in-service training. The group acknowledged that the process of action research was consuming at times, but contributed significantly to their practice (Choucri, 2005). Both these studies demonstrate the beneficial application of action research in midwifery practice, leading to improved practice outcomes.

Current action research: a synopsis of the PREPARE project

Parents reflection on education postpartum: an action research enquiry (PREPARE) provides an example of the action research process that was implemented to enable midwives to engage in collaborative research and enhance their practice. This paper describes the PREPARE action research study and illustrates the benefits of action research in midwifery practice.

Method

The PREPARE study followed the action research cycle, as described by Kemmis and McTaggart (1982), of planning, action, observation and reflection to explore the provision of education and support to parents during the early postnatal period in order to develop, implement and evaluate strategies to improve postnatal care for mothers and fathers.

Ethics approval was gained from the Children, Youth and Women's Health Service (CYWHS) and the University of South Australia Human Research Ethics Committees. Communication with the Postnatal Unit Head (PUH) and midwifery staff resulted in support for the study. The issue of rigour in this study has been addressed through triangulation of data collection methods, peer debriefing and review of the study findings with participating parents (Polit and Hunger, 1995).

Planning

The planning phase of the study was initiated by the researcher in response to concerns identified within contemporary postnatal midwifery practice. The researcher sought to facilitate collaboration with stakeholders, in order to explore the challenges facing the provision of effective education and support following childbirth. Stakeholders included mothers, fathers, hospital midwives, domiciliary midwives, education midwives, the PUH and the fatherhood support worker (FSW), who provided antenatal education to fathers at the participating hospital. Stakeholders were invited to participate in the planning phase through questionnaires, focus groups and telephone interviews. The planning phase was conducted in three stages.

Planning stage one

Stage one explored the experiences of mothers and fathers by conducting anonymous self-report questionnaires that parents were asked to complete at home. Two questionnaires were purposefully designed for mothers and fathers respectively. The questionnaires provided parents with an opportunity to reflect on their own experiences, with particular emphasis given to the provision of education and support during the early postnatal period. The questionnaire collected demographic and clinical data through a range of closed, scaled and open-ended questions. For example, women were asked: 'How would you best describe the advice/information provided to you about caring for your baby while you were in hospital?' Men were asked: 'What information would have helped you to prepare for life at home with a new baby?'

Parents were recruited to the study through invitation by the researcher when admitted to the postnatal ward of the CYWHS, a large city hospital in Adelaide, South Australia. The study used a convenience sample of parents who fulfilled the selection criteria (see Table 1). Each parent was provided with a letter detailing the study and asked to complete individual written consent giving permission for their address to be recorded by the researcher and a further letter and questionnaire forwarded to their postal address.

In stage one of the planning phase, 150 parents were approached over a period of two months. Of this, 124 parents consented to take part in the study and were mailed a questionnaire two weeks after the birth of their baby. A total of 85 (68.5%) parents returned completed questionnaires within six weeks of the birth. Numeric data from the questionnaire were entered into SPSS 12 and analysed using simple descriptive statistics. Thematic analysis was employed to analyse the open-ended questions in relation to common and recurring themes (Morse and Field, 1996). Through the analysis of the questionnaires, the following issues relating to the educational needs of mothers and fathers were identified:

- Mothers reported they were not given sufficient time to interact with a midwife while in hospital and 34 (65.4%) mothers suggested that more personal time with a midwife would be beneficial
- Fathers indicated that they were not adequately included in postnatal services and 19 (57.6%) fathers identified a need for father-specific information.

The findings from the questionnaires combined with a review of literature, contributed to stage two of the planning phase.

Planning stage two

An action research group (ARG) was established to review the

Table 1. PREPARE study parent selection criteria

• Mothers and/or fathers, where the mother was admitted to the postnatal unit for a minimum of 24 hours post-birth
• Had a live baby
• Gestation greater than 37 weeks
• The baby did not require level two or three nursery care (special care/intensive care)
• The mother did not experience significant postnatal or other complications ('significant' will be determined by any condition where involvement in the survey may be potentially harmful).

findings, strategise and develop specific actions to enhance the provision of education to parents in the early postnatal period. The ARG consisted of six midwives from the postnatal ward, including the unit head, the FSW and an infant and perinatal mental health nurse (PMHN). The initial intention was that parents would participate in stage two of the study, however on further exploration, parents declined due to difficulties organising a time that was suitable to both midwives and parents; as recommended, parents' contribution guided the ARG discussion via stage one of the study (Greenwood and Levin, 2007). The ARG followed a focus group format, allowing each participant to contribute their experiences and ideas. Specifically, the ARG provided midwives and practitioners with an opportunity to respond to the identified needs of parents and address some of the problems they perceived in their work environment. Several key themes emerged from the ARG discussions including:

- The lack of time available for midwives to provide postnatal parent education
- Midwives' perceived inability to find adequate time to meet the needs of new parents, due to the demands of other tasks and institutional requirements
- Midwives needed more time and increased support.

In summary, midwives felt there was a need to individualise the education and support offered to both mothers and fathers, as a means of addressing the concerns identified by parents. Through the process of the ARG, a number of actions to improve the provision of postnatal education and support were proposed. These actions included the use of an educational brochure for mothers titled *Congratulations! You're a mother* and informational postcards, *My dad…* for fathers. The resources aimed to provide concise, relevant and easily accessible information in the immediate postnatal period specific to the needs of both mothers and fathers. A postnatal planner booklet, *Coming ready or not!* was also developed. The primary purpose of the booklet was to customise the care and education provided to families while in hospital.

Essentially, the booklet provided parents with a list of topics so that they could nominate the areas specific to their need and seek further individualised discussion with a midwife. A separate page – *Specifically for fathers* – was included to encourage fathers to seek information as necessary. It was hoped that this booklet would facilitate increased focused time with a midwife to meet each family's particular information needs.

Planning stage three

Mothers and fathers were invited to contribute further to the study and comment on the proposed actions through telephone interviews. A total of 11 parents were provided a copy of the booklet to review and comment. Telephone interviews were conducted as this was the most practical means of dialogue with parents at this stage. Five mothers and one father participated in the telephone interviews. Additionally, a focus group for fathers was organised by the FSW to discuss the findings from the questionnaire and contribute to the development of postcards and booklet. Nine fathers attended this focus group and contributed to the improvement booklets. Midwives on the postnatal ward were also provided a copy of the booklet and asked to document comments and feedback. Through the collaborative process, coordinated through each stage of the planning phase, actions were proposed, developed and refined.

Action

During the action phase, three specific actions were implemented on the postnatal unit of the participating hospital. The actions included:

- The brochure, *Congratulations! You're a mother*, which provided concise and easily accessible information relevant to the immediate postnatal period
- The postcards, *My dad…*, which provided concise and relevant information specifically for fathers
- The booklet, *Coming ready or not!* provided a means to customise the care and education provided to parents by enabling them to nominate the type of care and information they sought. This booklet was designed to encourage midwives and women to reach consensus about a plan of care.

Funding was sought and gained to support implementation of the actions from the University of South Australia and Bayer Pharmaceuticals. Two instructional sessions were provided for midwives to facilitate implementation on the postnatal ward.

Observation

Data were collected while the actions were being implemented, to assess whether the actions provided a benefit in the provision of postnatal education and support for parents through midwifery practice. The actions were reviewed by parents, using a variation of the anonymous self-report questionnaires developed in the planning phase but with specific questions regarding each action. Development of the evaluation questionnaires followed the guidelines for evaluating health information resources distributed to consumers produced by the Centre for Health Promotion (CHP) (2003). Consequently, the resources were evaluated for their appeal, readability, content, and perceived usefulness from the perspective of parents. The findings in relation to these criteria contributed to an assessment of the effectiveness of the actions. The questionnaires also provided parents with an opportunity to reflect on their experience in the early postnatal period with regards to education and support. A number of questions from the first questionnaire, used in the planning phase, were repeated in the evaluation questionnaires.

Inclusion criteria for parents and implementation of the questionnaire remained the same. A total of 258 parents were approached over a period of four-and-a-half months. Of this, 205 parents consented to participate in the study and were mailed a questionnaire two weeks after the birth of their baby. Some 122 (59.5%) parents completed the second questionnaire. The participants consisted of 77 (63.1%) mothers and 45 (36.9%) fathers. Based on the appraisal of parents, the resources were found to be quality health education resources and parents indicated that they were helpful and relevant to their needs during the postnatal period. Furthermore, in the evaluation questionnaire following the implementation of the actions, there was a 13.0% reduction in the number of mothers who indicated needing more personal time with a midwife compared to the initial questionnaire. Also, in the evaluation questionnaire, there was a 13.0% increase in fathers who nominated having been included in

discussions and education by the midwife compared to the initial questionnaire. The study concluded that the resources developed were beneficial to midwifery practice in the provision of education and support during the early postnatal period. The findings from the questionnaires contributed to the process of evaluation and reflection.

Reflection

The reflection phase incorporated two distinct focus groups: ward midwives and ARG midwives, allowing them to review the actions and the findings from the questionnaires as a basis for critical reflection. It also provided a means to determine the need for ongoing cycles and further changes. The ARG midwives reported that they had effectively utilised the actions in practice and believed the actions were beneficial to midwifery practice. Further, they agreed that the process of being involved in the ARG was invaluable and provided a means of support and both personal and professional development. The postnatal ward midwives were less positive about the actions and identified a need to be more involved in the process of change, in order to benefit more fully from the strategies implemented.

Additionally, the reflection phase provided the researcher with opportunity to review the study in the broader context of midwifery practice. The reflection phase enabled the researcher to consolidate the acquisition of new knowledge and insights, leading to the articulation of recommendations that may contribute to further exploration and enhancement.

Discussion

One of the implications for both research and practice arising from this study is the possibility of using action research as a means to address various issues in midwifery practice. Action research enables problems to be identified in practice and provides a suitable framework to develop ways to improve practice (Meyer, 2000). The philosophical underpinnings of action research resonate with the ideals of women- and family-centred care, providing midwives with an opportunity to sensitively pursue evidence-based practice. The distinctive way in which the research process was modified and followed in this study may provide a model that is user-friendly for midwives wanting to engage in action research themselves. Rather than attempting to move through numerous cycles, this study followed a single action research cycle. Mini-cycles of planning, action, observation and reflection occurred flexibly within each phase but, by designing the research around one distinct cycle, the researcher was able to facilitate the study more simply. For example, the planning phase sought to explore the needs of parents during the postnatal period and to provide midwives with a process to respond to these needs. Following a one–cycle design in this study provided boundaries within which to contain a potentially complex research process. Once the cycle is completed, further cycles can be undertaken as necessary and at a time that is beneficial to all stakeholders. This may enable an increased uptake of research activity by practising midwives. Figure 1 (overleaf) provides a framework that midwives could contextualise and modify.

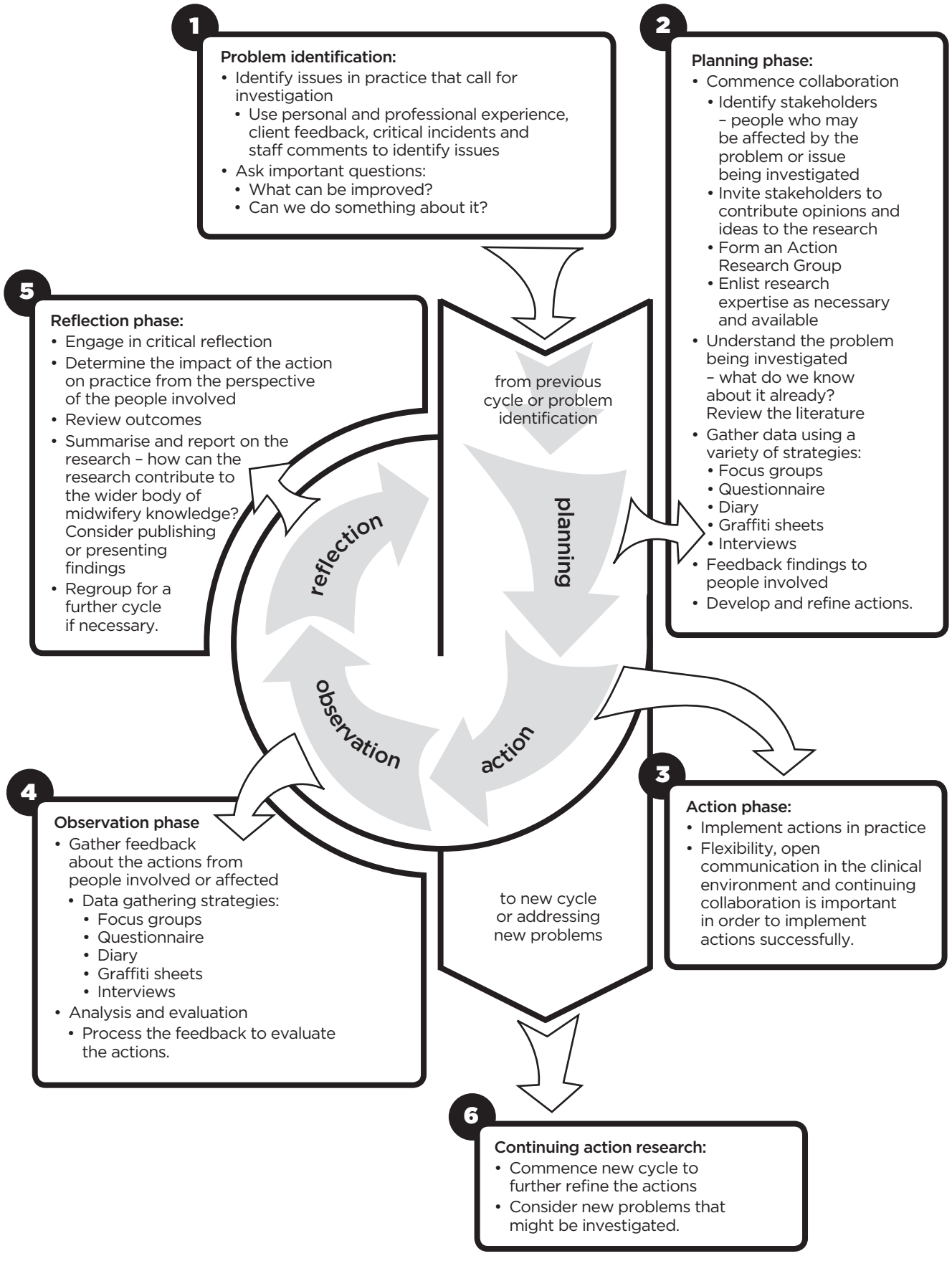
There has been debate about the appropriateness of practitioners undertaking research within their own practice environment. Action researchers have come more commonly from outside the field of enquiry, but there is a growing acknowledgement that they may arise from within the research environment (Coghlan and Casey, 2001). Coghlan and Casey (2001: 2) suggest that encouraging practitioners to engage in action research is 'opportunistic research', while McNiff and Whitehead (2006) actively encourage educational practitioners to engage in action research and identify practitioners as legitimate contributors to the body of knowledge.

The benefits of practitioners engaging in research opportunities are numerous. Practitioners who choose to undertake action research usually do so because they have observed difficulties in practice and have a desire to enhance the quality of care provided (Coghlan and Casey, 2001). The first-hand recognition of problems – insider knowledge – developed through experience and understanding the specific research environment, and the innate desire to improve practice creates a willingness to embrace change. These factors make the process of collaboration and implementation more successful and contribute immensely to the capacity of the research to bring sustainable change (Hart and Bond, 1995; Coghlan and Casey, 2001). Additionally, there are personal benefits for practitioners engaging in action research including professional support, gained through collaborating with like-minded colleagues, confidence to reflect critically on their own practice and satisfaction from the capacity to generate change (Choucri, 2005). In midwifery practice, this may foster a community of midwives who are open to change and committed to continuing improvements in standards of care. Certainly, within this study, the midwives who participated in the ARG identified significant benefit to their own practice. Involvement in the ARG provided midwives with a sense of ownership and empowered them to embrace change in practice. Notably, this contrasted with the response from the ward midwives who were reluctant to take on the changes proposed.

It must be acknowledged that some problems may arise from practitioners engaging in action research. For instance, one of the difficulties in practitioners taking on the role of researcher may be that their primary focus is on practical change at the expense of knowledge development (McNiff and Whitehead, 2006). It is important that practitioners understand the requirements of rigour in research and the need to contribute to academic knowledge. Nevertheless, action research provides a methodology that is flexible. It allows data to be gathered in a variety of ways that reflect the social context of participants. It enables practitioners to contribute to knowledge by documenting the story of their action research journey, which may involve recounting the discourse of participants and detailing the processes followed to achieve change (McNiff and Whitehead, 2006).

One of the most problematic issues for practitioners engaging in action research may be the necessity of fulfilling two roles, both researcher and practitioner (Coghlan and Casey, 2001). This may result in tension in the practice environment and increased workload demands. As action research is undertaken in the clinical setting, there may be obstacles and unexpected outcomes as the research progresses (Hart and Bond, 1995). It is possible, that the research may interrupt the day-to-day practice of health professionals. It may, for instance, create extra workloads for midwives who are already engaged in busy work schedules. In this study, some of the ward midwives reported

Figure 1. A modified action research process applied in midwifery practice (Based on the work of Kemmis and McTaggart, 1982)



in the final focus group that they had initially thought this research would increase their workload. On reflection, they realised that it had the potential to benefit their practice.

Action researchers typically ask difficult questions, such as 'what is wrong?' and 'what can we do?' Some midwives may not be comfortable with this organisational hierarchy and, consequently, may be reluctant to engage with the research (Greenwood, 1994b; Williamson and Prosser, 2002; Greenwood and Levin, 2007). It is also possible that an increased awareness of problems may result in conflict in relationships and difficulty in collaboration (Waterman et al, 2001). Further, the process of change is rarely simple. Change on one level often impacts on another. It is recommended that any practitioners engaging in action research should carefully consider the appropriateness of the research issue in the light of the time and resources available (Coghlan and Casey, 2001). Some research issues, for instance, may not be suitably addressed by practitioners alone and may benefit from external objective outsider input. It has been proposed that the combination of practitioner and researcher as a dual team may address some of these issues and enable the action research process to be undertaken more successfully (Titchen and Binnie, 1993). A partnership approach may also enhance the rigour of the research and assist with its dissemination, by ensuring that the study is grounded on theoretical principles and ethical guidelines, particularly if the practitioner lacks adequate experience in academic research practice (Coghlan and Casey, 2001). This study started with a strong partnership between the researcher and PUH, which facilitated a practice environment committed to the purpose of the research. Unfortunately, during the study there was a change in unit head. The new unit head had not been part of the original ARG and came to the position with institutional directions and priorities, which did not include the focus of this study. This resulted in some implementation difficulties and extended the time of the research. Clearly, while there are numerous benefits, there are challenges in undertaking research in practice, both as a practitioner and in partnership with a researcher. In light of these challenges, it is important to identify appropriate processes by which midwives and researchers alike may be able engage in research in practice. Arguably, action research provides a framework that, when employed with commitment and integrity has potential to mobilise midwifery practitioners to engage in beneficial research within their practice environments. It also provides a context by which researchers and practitioners can democratically partner together for positive outcomes.

Conclusion

Action research is a dynamic and empowering research process that seeks to influence the world of practice by uniting theory, research and practice. It calls for a commitment to critical reflection, collaboration and change. Specifically, it provides a forum to address the diverse issues facing the midwifery environment, by involving stakeholders and improving practice through knowledge development and positive change. The modified approach to action research as outlined in this paper provides both midwives and researchers with a framework to actively participate in collaboration and change to improve midwifery practice.

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Perceptions of group practice midwifery from women living in an ethnically diverse setting

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Abstract

Objective. To explore women's perceptions of care with a midwifery group practice compared to experiences of standard maternity care in an ethnically diverse area.

Design and methods. A grounded theory approach was used, including semi-structured interviews with women who had received group practice care or the standard maternity care within a single NHS Trust (n=18). This paper focuses on the women's experiences and views of care. Ethical approval for the study was obtained from a local NHS research ethics committee.

Setting. A suburban NHS Trust in the UK serving a diverse population. The midwifery group practice was based in a neighbourhood with a large established South Asian community. The maternity service was provided by a large, consultant-led unit, which had recently experienced an increase in birth numbers following closure of a small, local obstetric unit.

Participants. A purposive sample of women (n=8) who had received group practice midwifery care (based on GP practice attachment), plus a matched sample of women (n=10) who received conventional care in neighbouring areas.

Findings. Women in both groups valued the same things. Key themes emerging in the analysis were 'midwives caring, being there for you'; caring and uncaring encounters; continuity and knowing the midwife; information, communication and preparation; language issues; preference for community-based care; natural birth and breastfeeding as a norm; and the importance of postnatal support. Those who received group practice care reported that they were more able to ask questions and felt listened to and so felt better prepared and less anxious. South Asian women had similar views and expectations to those from other ethnic groups, but they described a greater number of uncaring encounters, and had particular concerns about information and communication.

Conclusions and implications. In this small study, integrated, community-based and midwife-led models of care are preferred by an ethnically and socially diverse range of women, including women of South Asian origin.

Key words: Group practice midwifery, continuity, maternity, ethnicity, evidence-based care, grounded theory, evidence-based midwifery

Introduction

This paper examines the experience of group practice midwifery care from the user perspective in a socially and ethnically diverse area. The area included a large settled South Asian population and more recent immigrants from Somalia and the Balkans.

Maternity care is often fragmented and not always responsive to individual, family and cultural needs (Lewis, 2007; McCourt and Pearce, 2000). Government reports highlight the need for services to be organised more seamlessly to ensure that more socially disadvantaged women, including migrants and ethnic minorities receive appropriate access to care. The UK Department of Health's *National Service Framework for children, young people and maternity services* (Department of Health, 2004; 2007) recommended choice and community-based care and an emphasis on being inclusive of diverse needs, including those of socially disadvantaged women, recognising the potential long-term impact on the nation's health (Barker, 1995; Teixeira et al, 1999; Richards et al, 2001). Midwifery group practice offers a potential route to achieving current policy objectives, but although some research has been conducted, there still remains limited evidence as to its practical workings on a local level, particularly for areas with a high ethnic diversity (Sandall et al, 2001; McCourt et al, 2006).

Support from midwives may be particularly important for women who lack ordinary sources of support (Bennett et al, 2007; McCourt, 2009). A number of studies have found that women do prefer continuity of

care during their pregnancy where possible (McCourt et al, 1998; Proctor, 1998; Walsh, 1999; McCourt and Pearce, 2000; Homer et al, 2002; McCourt et al, 2006; Redshaw et al, 2006), but some studies have suggested that quality of maternity care is more important to women than continuity of relationships *per se* (Green et al, 1998). However, there is evidence that community-based models of care that offer more continuity tend to be associated with good quality relationships and support (McCourt and Stevens, 2006; McCourt et al, 2006). Additionally, reviews of maternal and infant deaths have identified that fragmentation of services and problems of access to care and communication across boundaries have been implicated in serious morbidity and mortality, particularly for more socially disadvantaged women (Lewis, 2004; 2007).

South Asian women are reported to have poor records of attendance at antenatal clinics (Katbamna, 2000) and, in general, women from minority ethnic groups are more likely to recognise their pregnancy later, and book later for maternity care. They are also less likely to feel that they are treated with respect and are talked to in a way they can understand (Redshaw et al, 2006). Women whose first language is not English may find it difficult to raise their concerns with health professionals and obtain the advice and information they need (Katbamna, 2000; McCourt and Pearce, 2000; Harper-Bulman and McCourt, 2002).

Greater emphasis is being given to women's emotional wellbeing during pregnancy, and its importance has been highlighted by recent reports (Lewis, 2004; 2007). Additionally, physiological research (Teixeira et al, 1999) indicates potential underlying mechanisms for the established relationship between social vulnerability, poor social support and low birthweight (Oakley, 1992). Research suggests that providing more supportive care may ameliorate longer-term health problems, particularly for socially disadvantaged women (McCourt, 2009). The limited research conducted to date suggests that caseload models of practice can facilitate greater access and more supportive care to such women (McCourt and Pearce, 2000; Harper-Bulman and McCourt, 2002).

Models of care such as group practice midwifery, which aim to improve both continuity of care and community-based care also introduce midwife-led care into settings where shared or obstetrician-led care is often the established norm. Hatem et al's (2008) Cochrane review of midwife-led models of care identified that such care does not increase risk of adverse outcomes, and may confer particular advantages.

The group practice studied for this project provided midwifery-led, community-based care by a small team of midwives to a shared caseload of women. The group practice was designed to provide care at all stages, both in hospital and the community. Their caseload was derived from three GP practices based in a community health centre, plus one single-handed GP practice nearby, giving a variable annual caseload of about 250 women. The group practice was planned to include six midwives, but at the time of this study, owing to local staff shortages, included only five whole-time equivalent midwives, who worked with a shared on-call rota for attending births and emergencies 'out-of-hours'. This model differs from other models of caseload midwifery, where midwives have an individual caseload. It also differs from team midwifery schemes, which generally work in large teams, and do not achieve any meaningful continuity of care or carer (McCourt et al, 2006). The standard maternity service was provided by a large consultant-led unit, which had recently experienced an increase in birth numbers following closure of a small local obstetric unit.

Study design and methods

As the study was focused on women's experiences and views of care, grounded theory methodology was used (Glaser and Strauss, 1999). Individual, semi-structured interviews were conducted with women using the local maternity service in the relevant year. Women were asked to recount the story of their pregnancy and birth, the care they received, and what they found helpful or would like to have changed. Prompts were used to explore in greater depth women's views and experiences of continuity of care, levels of support received, culturally and clinically appropriate care and any access difficulties.

The interviews took place in the women's homes and were conducted by a bilingual researcher, in order to include women who did not speak English. The interviews were tape recorded and then fully transcribed. Interviews with the women were conducted two to three years following the birth of their baby. The time chosen was when the group practice was said to be operating as planned. At the time the interviews were conducted, there was intense pressure on the local maternity service and the group practice had changed the way it worked as a consequence. Research has confirmed the validity of women's long-term memories of pregnancy and childbirth, but suggests that women's negative emotional evaluation of their experiences may increase over time (Simpkin, 1992; Waldenstrom, 2003).

Sample

The number of interviews conducted with women was informed by grounded theory principles of data saturation. Women sampled in this way were contacted by letter and then by telephone, consecutively in order of birth, and all those who agreed to participate were interviewed until there was confidence that no new themes were emerging in the analysis. In order to gain a baseline understanding of experiences of care in this maternity service, this sample was then matched as closely as possible on ethnicity, parity and obstetric risk, with women in the local community midwifery area receiving the usual care in the relevant year. Finally, eight women were interviewed from the group practice and ten from routine

Table 1. Profile of respondents

Characteristics	Group practice midwifery (n)	Standard maternity care (n)
Ethnicity		
Indian	3	4
Sri Lankan	1	0
Pakistani	1	1
White British/European	2	4
African/African British	0	1
Black Caribbean/Black	1	0
Total	8	10
Parity – median	1-2	1-2

care (as two women who had been matched subsequently did not complete the planned interview). Most of the women chose to be interviewed in English, while three were interviewed in Gujerati by a bilingual researcher. A profile of the respondents is given in Table 1. The main ethnic groups were South Asian, with five women in group practice (three of Indian origin, one of Sri Lankan and one of Pakistani), and five in standard care (four of Indian origin and one of Pakistani). Key challenges in arranging the interviews were in making initial contact with the women by telephone, and in arranging the interviews after they had agreed to participate. The women were generally keen to be interviewed, but their busy lives made the arrangements difficult to complete. Although access to interpreters had been pre-arranged for the study, if needed, the use of bilingual researchers was the preferred approach (Pitchforth and van Teijlingen, 2005).

Ethical permission for the study was sought and obtained from the local NHS ethics committee and care was taken to ensure the study met ethical principles.

Data analysis

Preliminary data analysis was concurrent with the interview process and employed constant comparison and re-reading of the data. Open coding was used, followed by axial coding to identify themes emerging from the data. Constant comparison was used to move between the emerging themes and the data, and potentially dissonant data were looked for. Transcripts were analysed by type of care received, but then all transcripts were combined to identify cross-cutting themes as this was not primarily intended to be a comparative study, but aimed to gain an understanding of the women's experiences of care. Additionally, the transcripts were re-examined to explore whether the views and experiences of the women from minority ethnic backgrounds differed from those who were from the ethnic majority – although this was treated very cautiously owing to the small numbers involved and the methodological approach taken, which is suited to in-depth analysis of emergent themes, rather than formal comparisons. For these reasons, the analysis is presented in terms of recurrent themes reflecting the women's overall experiences and views, with any notable differences highlighted, rather than as a formal comparison of the experiences of different groups of women. To ensure rigour and to guard against researcher bias, sets of transcripts were analysed independently by different members of the research team, who met several times to discuss, explore and agree the key themes.

Findings

In general, the women were very satisfied with maternity care, and particularly midwife and GP care, and some compared the system favourably with their home country where little or no formal ante- and postnatal care was available. However, they were relatively critical of hospital care, at all stages. The key themes emerging from the interviews are discussed below.

'Midwives caring, being there for you'

The women all saw the role of midwives as being important, and on the whole very caring and supportive, the main exception to this being during hospital visits and in postnatal hospital care, where midwives were mostly reported to be rushed and unable to offer much help. The women receiving care from group practice midwives emphasised feeling that the midwives cared, and were 'there for you'. As a result they felt more able to ask them questions, deal with fears and worries, and get information and reassurance, than the women receiving usual care. Those receiving shared care had more mixed experiences, with some describing similar care from a community midwife they saw regularly, or from their GP.

Caring and uncaring encounters

The care the women described was very varied, with uncaring as well as caring encounters. The women's views of care in labour varied the most strongly. Some women highlighted the positive care from an individual midwife in labour:

"The midwife who looked after me was so nice and helpful. If I knew who she was I would give her a big bunch of flowers for making it less traumatic for me. She told me basically that I could get into whatever position I wanted to make me feel more comfortable" (Marion, standard maternity care).

Other women felt the experience had been affected by uncaring, insensitive or harsh behaviour, for example:

"She didn't talk to me. We can't ask her any questions

because she is like... (pause) But that's not our regular midwife which we saw in (group practice), these are the hospital midwives. But one midwife, I'm afraid to speak to her" (Sangita, group practice care, speaks limited English).

Continuity and knowing the midwife

The women who received group practice care valued seeing midwives they knew, usually seeing two or three midwives throughout their antenatal and postnatal care. As a result, they felt the midwives got to know them well and were able to look out and advocate for them if needed. They felt prepared and less anxious about birth:

"It tended to be every time I went, the one that I had seen last was on duty so I sort of built up a good relationship with them. But they were all very nice anyway... very good at what they do, very caring... They were friendly... I used to ask... they used to quite reassure me because as I said, I had quite a fearful pregnancy" (Carol, group practice care).

Women receiving standard maternity care also expressed a wish for more continuity, ideally to see the same midwife, or few midwives throughout, even if they were happy with the care received. When asked if they could change anything about their care, two responded:

"Um, probably being able to see the same midwife all the way through. That would be my only thing if that was possible. Then she would get to know me and I would get to know her" (Marion, standard maternity care).

"It was like I was seeing somebody else every single time I go to the hospital. It's a bit, like, difficult because they don't know you and because they obviously haven't got time to read your notes or to talk to you or anything" (Naima, standard maternity care).

Only two of the eight women receiving group practice care actually had a group practice midwife available for birth, the on-call service having been largely withdrawn by this point as a result of staff shortages in the Trust. Those who did see a group practice midwife appreciated this:

"Like I said, I knew the midwife she knew me (sic) and I think she made a lot of difference. I have had midwives before you know, just from the hospitals and they have been good as well, but this one was err, I think she helped me a lot more. She was more encouraging, and I think she stepped in and she wanted to deliver the baby so you feel like it's a friend that helps" (Sushila, group practice care).

Although the women who did not have a group practice midwife available as they had expected expressed disappointment, several made clear that they had excellent midwife support in labour nonetheless:

"I should have had one of those four midwives but none were on duty... (laughs) I just had a midwife from the hospital and she was... she was fine, she was absolutely fine" (Carol, group practice care).

When asked if that made a difference:

"Yes, I think it would have made a difference to me initially, in the beginning of my labour because I started to go into panic mode... but it was okay, it turned out to be alright" (Carol, group practice care).

Most of the women said they would prefer a midwife they know to support them in labour, and several described feeling very afraid when there was not a known midwife there. However, this also depended on the manner and approach of the midwife or midwives who did attend them. While some had excellent support from a hospital-based midwife, others felt worried because the midwives were off-hand or uninformative.

Information and communication and preparation

The women emphasised the importance of good information and communication. They valued the antenatal classes, literature and leaflets available and midwives taking the time to inform them and explain things clearly. On the whole, the women appeared very proactive in wanting information, though they didn't always find asking questions easy in practice, especially during rushed hospital visits. They wanted to be actively involved in decision-making, but expected professionals to give them clear and detailed non-contradictory information:

"*They should listen to patients. They should check properly because if they checked properly at that time when I first went in, then I wouldn't have to suffer so much"* (Sangita, group practice care, referring to a hospital visit).

"*They should be more receptive to what patients are saying"* (Sandra, standard maternity care).

From the women's accounts it was clear that women receiving the usual care did not feel good information was readily available, at any stage. Several reported that they had relatively limited midwifery input, seeing mainly their GP or a practice nurse in pregnancy and having limited postnatal support at home, although some were able to rely on good family support to help them cope. These issues are particularly important given that a proportion of the women were not very familiar with the UK maternity services, and did not speak English as a first language.

Language issues

Women for whom English was not a first language were equally motivated to get good information, but found this more difficult. On the whole, they felt it was important for them to learn English, and they were actively pursuing this, but they found communication with health professionals and participating in classes a challenge.

Several women who did not speak fluent English described feeling very frightened, or panicky in labour, an issue perhaps related to greater difficulty in communicating with hospital staff, and getting information. For example:

"I was screaming and my husband was with me and he

gave me lots of support and everything. But that night, the experience of the midwives was so bad" (Nalini, group practice care, but practice midwife not available for the birth).

Women in this situation relied very strongly on family members being able to accompany them in labour, but also valued supportive midwife care and accessible information highly. They mentioned the advantage of having a midwife who gets to know you, making communication easier. One of the group practice midwives was able to speak several community languages, and so could offer good quality care more readily. This woman summed up some of the advantages of this more accessible care:

"I liked them (classes) even though I didn't understand and they weren't that hard that I couldn't understand – they explained them. One was Gujerati, one was English and one was, like, Pakistani, so they spoke Hindi, English and Gujerati, so they did explain well to us. And sometimes, just being at home all the time, you get a kind of depression because your weather here is like that, so if you go there you meet other women and talk and share your experiences, is useful (sic). At the time I was very scared of labour pains, but after I started to attend antenatal classes – it's good for me" (Nalini, group practice care).

Preference for community-based over hospital care

Women in both groups were generally critical of hospital-based clinics and care, with the exception of some positive aspects of care in labour, with supportive midwives and medical staff. Several women contrasted the increase in community antenatal visits positively with previous pregnancies:

"I found that the hospital was a bit cold, you know... you feel like you're sheep, being shepherded along. It's not very warm and friendly like the midwives are" (Sushila, group practice care).

"They keep you waiting for such a long time and the midwives are obviously always kind of like rushing, do you know for them it's like 'one out of the way, second [sic]' (Naima, standard maternity care).

Preference for natural birth and for breastfeeding

The women expressed general preference for a 'natural' birth if possible and for breastfeeding, seeing these as simply normal expectations. Although they were accepting that interventions such as caesarean section may be needed, several women would have liked better explanations and information about this, and some felt unconvinced that what they experienced had been necessary. When interventions were needed, they valued being given good information and supportive personal care, including information on why the intervention was needed.

Most also preferred to use the minimum pain relief they needed, but were open about this, and several women felt they had not been given information about epidural pain relief:

"They should advice (sic) the women more, even the epidural – what is the difference for the women?" (Luisa, group practice care).

Several women also commented on how encouragement from the midwives had helped them to keep going without need for an epidural.

Postnatal support

General lack of support on postnatal wards from busy, stressed midwives, was generally contrasted with positive views of postnatal home care, although women's experiences of hospital did vary, with some describing good support for breastfeeding, while others felt total lack of support:

"After the birth I did not have any help at all until I came home" (Meena, group practice care).

"One midwife (from the group practice) came to check the baby. She did remove the stitches and did everything. The hospital people, some really don't know what they are doing. There is no communication with each other. They are not doing a good service, they don't really care enough about people" (Sangita, group practice care).

The women were generally more positive about postnatal care at home, although this was particularly the case for women with group practice care, who had regular visits from a midwife they knew. Some women commented that in their home country, postnatal home care was not available, although they would look to family for support instead, and several commented that they did not need much care at home because family support was available. They also mostly saw breastfeeding as normal, and not a matter of 'choice' or difficulty, but they nonetheless felt that detailed information from midwives and offering support was important, in case difficulties should arise:

"The midwife tells us to do it in a certain way and she will say "if you do it that way you get back pain" so it's things like that which is helpful. Even our parents don't know all about this" (Meena, group practice care).

However, in hospital after birth they were cut off from this form of support, and several described feeling lonely or isolated from help.

In summary, the women were generally happy with and valued midwifery care highly, and preferred to have their care in the community with midwives who they knew and in some cases with a GP that they knew well. They were most critical of hospital care, because with the exception of some very caring midwives in labour, they found it often impersonal, uncaring, and at times frightening because of lack of information or communication. The women's views and what they valued were similar overall, but those of South Asian origin were more likely than the ethnic majority women to express dissatisfaction with information and preparation for birth, and to describe distressing and uncaring encounters with professionals in the hospital settings.

Discussion and conclusions

This was a small qualitative study, within a particular social and service context, so the findings cannot necessarily be generalised to other settings. Additionally, with small numbers in a grounded theory approach, formal comparison of experiences is not appropriate or possible, although we felt that interviewing women receiving usual care was valuable in providing an understanding of the general experience of care in this setting. Nonetheless, the overall themes that emerged from this research were similar to those described in earlier studies of caseload and small team care, including the few studies that have focused on minority ethnic women's views (McCourt et al, 2006). There are particular challenges in conducting research with women in areas of high cultural and language diversity, and it was important to be able to contact women by telephone, and to have appropriate language skills available within the research team. The women in this study were from diverse backgrounds, but a high proportion of them were of South Asian origin, reflecting the local community. The experience has demonstrated that although researching so-called 'hard-to-reach' populations may be challenging, women are keen to give their views and to participate in studies if appropriate methods and strategies are used. This includes appropriate means of initial contact, such as personal contact, and involvement of researchers or facilitators with relevant skills, including language skills (Harper-Bulman and McCourt, 2002). The main themes suggest that women in socially and culturally diverse areas also value continuity of care and carer from midwives highly and are keen to engage with the maternity services, to gain good information and supportive care in labour, but many do not receive this consistently (McCourt and Pearce, 2000; Harper-Bulman and McCourt, 2002; McLeish, 2005).

Women in this study, whether they received group practice or the standard care, were generally critical of all stages of hospital care, including antenatal clinics, labour ward and the postnatal wards. This may have reflected local shortage of staff and maternity beds at the time, but such problems have been reported widely in the UK (King's Fund, 2008). The accounts by women who did not speak fluent English were particularly worrying in this respect, as they described considerable fear relating to lack of communication and uncaring encounters, even though they found that individual midwives could provide caring support, even across language difficulties and in a situation of staff shortage.

The women emphasised the importance of good information and communication, including being listened to. Those with group practice midwives were generally more satisfied with this. This has been highlighted in previous research (Newburn, 2006), but our findings support the argument that fragmented hospital-based services continue to have difficulty in providing appropriate levels of support for women. These issues were particularly important for those women who did not speak English as a first language (Katbamna, 2000). They were keen to communicate and be well informed, but found encounters with some hospital staff and admissions to a very busy maternity unit difficult, and felt discouraged from asking questions. Some women described frightening or distressing experiences with midwives who they felt had acted in an uncaring way towards them. They valued their relationships with known midwives particularly highly.

Wider evidence suggests that the conditions and morale of midwives working in busy and fragmented maternity units in the UK NHS may have a negative impact on their ability to provide high-quality information, care and support (Ball et al, 2002; Hunter, 2004). Women who do not speak fluent English, those who are not familiar with the UK health services, and women who are socially disadvantaged or excluded may be particularly vulnerable in complex settings where NHS staff are busy and communication and support may be compromised (Lewis, 2004; 2007). Midwife-led models of care (Hatem et al, 2008), and particularly models that provide higher levels of organisational, informational and relational continuity (Haggerty et al, 2003; McCourt et al, 2006) can help to overcome such service provision problems, but the setting of this study showed that such models of care are often compromised by severe staff shortages.

The findings of this small-scale study echo earlier research on women's views of maternity care, particularly in relation to dissatisfaction with hospital-based care, preference for care by known carers and in a community setting, and the importance of care that is sensitive, caring as well as competent, and a high level of information and communication (Newburn, 2006). The women's accounts suggest this was more likely when they saw carers who they knew and who could get to know and understand them (McCourt and Stevens, 2005).

A key difference, though, is that much of the research conducted on women's views of care has reflected the views of mainly 'white' and 'middle class' women. The context of this study was very diverse, with a high proportion of women of South Asian origin. As in earlier studies of minority women's views of maternity care (McCourt and Pearce, 2000; Harper-Bulman and McCourt, 2002), the women's wishes and expectations were at a fundamental level similar to those of the majority. They wanted care that was both skilled and kind, and they wanted to be well informed, reassured and involved in decisions about their pregnancy and birth – to have a good start to motherhood. The women also valued their independence and other sources of support, such as family and friends, and a key difference was that they did not always look to midwives for emotional or practical support (except during labour) and sought this from family and friends instead. The local context is, however, of a relatively stable community, where a number of South Asian women have family living close by and able to give such support. It cannot be assumed that all ethnic minority women receive high levels of support from family or community, or feel they have the type of support they need.

This study confirms the policy that routine care for

all women should be community based, using midwife-led models such as group practice midwifery, as this improves areas endorsed by government initiatives as well as what women want (Department of Health, 2004; 2007; Hatem et al, 2008). Having a relationship with a known midwife or small group of midwives has particular value for women who do not speak fluent English and for those who are less familiar with the way the health services function. The relevance of continuity of care within an otherwise complex and highly fragmented system has also been highlighted for wider areas of health care (Haggerty et al, 2003). Recent reports into maternal and child health have highlighted in a stark way that accessible and supportive care that follows women through the system, is not just a matter of nicety, but a matter of safety (Lewis, 2004; 2007). Cultural safety (Smye and Brown, 2002), supportive midwife care and clinical safety go hand in hand.

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Rowan C, McCourt C, Bick D. (2010) Provision of perinatal mental health services in two English strategic health authorities: views and perspectives of the multi-professional team. *Evidence Based Midwifery* 8(3): 98-106

Provision of perinatal mental health services in two English strategic health authorities: views and perspectives of the multi-professional team

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Abstract

Background. For women giving birth in the UK, psychiatric illness and suicide in particular have been a leading overall cause of maternal mortality. Although the most recent Confidential Enquiry into Maternal and Child Health indicated that this is no longer leading causes, mental health problems before and after childbirth have a significant impact on the health of women, family relationships and children's subsequent development. Reports and policy recommendations have highlighted the need for early detection, appropriate referral and management.

Aim. To follow-up the findings of a previous survey that explored the extent to which policy recommendations had been implemented in practice in two strategic health authorities (SHAs).

Method. Health professionals from two NHS Trusts selected from the two SHAs involved in the earlier survey were identified, along with professionals from their associated mental health and primary care services. Semi-structured interviews were undertaken with eight participants to examine the facilitators and limiting factors in developing services for women with perinatal mental health problems.

Results. Although women are now being screened for mental health problems at the booking interview, identification at subsequent points during pregnancy was less consistent and those interviewed felt that many women could be missed. There were pockets of good practice, such as a service in primary care for women with mental health concerns, a community psychiatric nurse who received referrals in relation to women during pregnancy and perinatal consultant psychiatrists to whom women may be referred. However, in some instances there were difficulties ensuring that women with mental health problems were followed up in the community, especially where there were complex catchment issues. The professionals interviewed felt that the services were often fragmented with poor liaison between professionals involved.

Conclusion. Despite evidence of local service development to enhance the care of women with mental health problems, it would appear from the survey and the follow-up interviews that identification, timely and appropriate referral of women with mental health problems and effective liaison between professionals need further development to meet policy and guidance recommendations. Barriers to progress include the complexity of service provision and funding across health sectors, and the fragmented nature of maternity services.

Key words: Perinatal mental health, perinatal mental health services, screening for mental health problems, evidence-based midwifery

Introduction

Depressive disorders constitute a large proportion of the global burden of disease both in developed and developing countries (Ustum et al, 2004). For women giving birth in the UK, psychiatric illness and suicide in particular were identified in previous reports of the triannual Confidential Enquiry into Maternal and Child Health (CEMACH) (Lewis, 2001; 2004) as the leading overall cause of maternal mortality. Although the most recent report (Lewis, 2007) identified that deaths

from suicide were no longer the leading overall cause of mortality, mental health problems among childbearing women remain a cause for concern. Mental health problems can range from transient depression and anxiety to severe depression and psychosis, and could have a significant impact on the woman and her relationships with her partner and other family members, and the emotional and cognitive development of her child (Beck, 1995; Murray and Cooper, 1997; O'Connor et al, 2002). Guidelines on antenatal and postnatal mental health to inform NHS care in England and Wales were published in 2007 (NICE, 2007), which recommended screening for maternal mental health problems at the first contact with a woman antenatally and postnatally. Screening for mental health problems is also a requirement for the Clinical Negligence Schemes for Trusts (NHS Litigation Authority, 2010), which handles all clinical negligence claims against NHS member bodies. There is, however, a dearth of evidence with regard to the impact of recent practice and policy recommendations for women, clinicians or the maternity services (Bick and Howard, 2010).

This paper presents findings from the second part of a two-stage study, which aimed to identify how far the recommendations identified in previous CEMACH reports (Lewis, 2001; 2004) had been implemented in two English strategic health authorities (SHAs). Data for the first part of the study were obtained from a survey of maternity units coinciding with publication of the NICE maternal mental health guideline (NICE, 2007) and the CEMACH report (Lewis, 2007), and are published elsewhere (Rowan and Bick, 2008). Key findings from this stage of the study highlighted that although units were working to develop services for women with mental health needs, gaps in service provision remained. The second part of the study, presented here, explored in more depth, factors influencing the provision of care in line with national policy and guidance for women with mental health needs in the two SHAs through interviews with a range of relevant clinicians.

Background

The key recommendations of the 2004 CEMACH report (Lewis, 2004), NICE antenatal care guidelines (NICE, 2003; 2008) and NICE guidance on perinatal mental health (NICE, 2007) included that women should be asked about family or personal psychiatric history when they first book for antenatal care. In addition, there should also be:

- Guidelines in place for women identified as at risk or having mental health problems
- Specialist health professionals available to the women.

The *National Service Framework for children, young people and maternity services* (Department of Health, 2004) also set standards for screening, referral and interprofessional working. Two UK-wide surveys of perinatal mental health service provision (Tully et al, 2002; Oluwato and Freidman, 2005) identified a lack of clear referral pathways for women with mental health needs, insufficient training to enable staff to identify and manage maternal mental health issues and a lack of specialist perinatal mental health services. These findings were supported in a report published by the mental health charity MIND (2006), which found that women with mental health needs often had difficulty accessing appropriate services, sometimes with a wait of weeks or even months to see a specialist in perinatal mental health. In view of these findings and the increased policy focus on the need to identify maternal mental health problems early in pregnancy and the postnatal period, the researchers wanted to explore what was happening in routine practice and barriers or facilitators to implementation of practice recommendations.

The first part of this study was a survey of service provision for women with mental health needs (Rowan and Bick, 2008). All 39 NHS Trusts with maternity units in two SHAs in the south of England were sent a questionnaire in April 2007. The aim of the survey was to assess if the services the Trusts provided reflected national policy and guidance recommendations. Information was collected on Trust policies for screening women for mental health problems, referral procedures for those identified with potential problems, use of guidelines and coordination of perinatal mental health services across the acute and secondary care sectors. The rationale for selection of two SHAs was to capture data from diverse populations across rural, urban and inner city areas. In total, 24 Trusts returned a questionnaire (62%). Key findings included that the majority of Trusts had guidelines for midwives and obstetricians to assist them in identifying women who had previously experienced mental health problems or who were experiencing problems, while the remainder were in the process of developing these. Midwives were expected to ask women at their antenatal booking appointment about their mental health in line with policy recommendations, but there was variation in practice with regard to whether women were asked about their mental health at subsequent visits. Only seven Trusts had access to a specialist psychiatrist. A range of debriefing type services were offered, despite the lack of evidence that these initiatives could make a difference to perinatal mental health outcomes (Rowan et al, 2007). It was clear that there was a wide variation in services. Many Trusts acknowledged that they did not meet all the recommendations for women with mental health needs, but most had plans to develop these. Barriers included lack of clear pathways to link with the local psychiatric team and a lack of resources 'ring-fenced' for specialist mental health care.

Methods

In order to gain more in-depth insights and individual perspectives on how far policy and practice recommendations had been implemented and views of barriers and facilitators to achieving change, a number of

relevant health professionals were interviewed for the second stage of the study. Two NHS Trusts were selected, one from each of the SHAs originally surveyed. Each of the Trusts were chosen because they reflected different populations – an inner city area and a more urban/rural area. The health professionals interviewed included managers of maternity services, community midwives, community psychiatric nurses and psychiatrists, as it was anticipated that information from each would provide a more complete picture of the reality of practice. Professionals were identified using snowball sampling (Rees, 1997). The key professional who completed the original survey was contacted and asked to identify professionals within their Trust with a specific mental health role or interest within the field. Semi-structured interviews included questions designed to obtain more detail on issues related to screening, guidelines, referral processes, interprofessional liaison, and facilitators and barriers to achieving policy and guidance recommendations (Lewis, 2004; NICE, 2007; 2008). The topics for discussion at interview were informed by responses to the original survey. Questions included:

- 'Would you like to comment on the guidelines and referral processes for women with mental health problems in your Trust?'
- 'How do professionals liaise with each other when concerns have been identified?'

The opportunity was also offered for interviewees to discuss other aspects of service provision not identified in the survey, which they felt were relevant, for example, areas of good practice, innovative approaches or gaps in perinatal mental health services in the geographical area served by their Trust. The interviews were taped and later transcribed or documented verbatim in detailed notes. Data were analysed using a framework approach (Ritchie et al, 2003), which employs both a prior coding framework and more open thematic analysis. As this small, interview-based study was designed to explore the context of our survey findings in greater depth, a coding framework based on the survey topics was utilised to organise the data. The survey topics themselves had been developed from a review of policy and research literature.

Interview data were read and re-read to consider the relevance or 'fit' of these categories, and enabled fresh themes to emerge if appropriate. There appeared to be a reasonable fit between the themes identified in the interviews and the framework.

Due to pragmatic considerations of time and resources available, the views of women were not included in either stage of the study and further studies to elicit their views and experiences are needed.

As this was a service evaluation study, ethics approval was not required, which was confirmed in writing by the National Research Ethics Service (NRES), following contact by the lead author. Although formal ethics approval was not required, it was nevertheless considered good research practice to provide written information about the aims and objectives of the study to potential participants. A letter was sent to each identified participant in the first instance, which explained the rationale for the study and offered them the opportunity to contact the researchers to discuss the study and ask any questions prior to deciding to take part. Once they agreed to take part, their written consent was obtained. All data were treated as confidential and no names were used that could identify any of the individuals or their place of work.

Findings

A total of eight in-depth interviews were conducted with healthcare professionals from the two NHS Trusts.

Study sites: service characteristics for women with mental health needs

Trust one

The maternity unit located in Trust one served a population based in an urban and rural area with around 5000 births per annum. The five health professionals interviewed included a community psychiatric nurse (CPN) based in primary care, a CPN employed by the local mental health Trust, a consultant perinatal psychiatrist, a midwifery manager and a community midwife.

A number of services were available for women with mental health needs. The maternity unit employed a perinatal consultant psychiatrist who could refer women to a local mother and baby psychiatric unit. A counselling and support service team was available at primary care level based in a general practice surgery, which comprised a CPN, an occupational therapist (OT) and a psychologist who were managed by the mental health team. Women could be referred to these services by their GP, health visitor or mental health team. An initial assessment of the woman's needs could take place at her home if this was appropriate. Women with babies under one year of age could be referred to, and assessed by a CPN colleague in the mental health team. The counselling service was reported to be easily accessible to women and, as there was no database, social services could not access information about women who might otherwise fear stigmatisation if they were known to have concerns related to their mental health. There was good liaison with other healthcare professionals, including a local trauma service for women experiencing post-traumatic stress disorder type symptoms.

Support groups were also available for new mothers and their babies to enable women to meet and establish informal social networks. Crèche facilities were provided and social events organised to involve the women. Specific educational workshops were also organised, which included topics such as stress and anger management and self-esteem issues.

A CPN in the mental health team had developed an expanded specialist role, which consisted of working with pregnant and postnatal mothers and liaising with local midwives and health visitors to support women

with mental health needs. Midwives, health visitors and GPs were able to refer women to this service, and women could also self-refer. The CPN was involved in providing support for the majority of women with mental health problems booked with the Trust maternity unit, as well as for women who had a family history of mental illness, a previous late termination, stillbirth, a previously traumatic birth or, in extremely rare cases, had committed infanticide. The CPN would also refer women to a specialist psychiatric registrar and advise other professionals, such as GPs and obstetricians, on the management of mental health issues surrounding childbirth including advice on medication.

The consultant psychiatrist linked to Trust one held two consulting sessions per week for women with severe depression, bipolar disorder or a family history of mental illness, but this service appeared to have been developed as a result of their individual interest and enthusiasm, with no identified Trust funding for these sessions. A four-bedded mother and baby unit was available for women who had an acute episode of mental illness, staffed by mental health nurses from the general psychiatric wards with facilities for partners to stay. However, if the woman became ill out of hours, she would usually be admitted to a general psychiatric ward without her baby for the first 24 hours.

Policies and guidelines for midwives were being reviewed and updated by midwifery managers at the Trust. At the time of the study, interviews were being held for a specialist midwife to coordinate the care of women with mental health needs as part of a team caring for vulnerable women that also focused on the needs of teenagers, those who misuse substances and those suffering from domestic violence.

Trust two

In comparison, the maternity unit in Trust two was based in an inner city location on the boundary of a very affluent area and a very deprived large council estate reported to have a high level of social problems. The unit was part of a teaching hospital, with around 3500 births a year, taking women from a wide catchment area. There was considerable socio-economic and ethnic diversity and mobility in the local population. In addition to the maternity unit, other Trust services included consultant psychiatric and specialist facilities, and some specialist mental health services, such as a psychotherapy centre. Three health professionals were interviewed from this Trust – a community matron who was also a midwife, an obstetrician and a GP.

Specific perinatal mental health services at this Trust were only provided within the acute care sector. In the community setting, women were dependent on care from their GP and community midwives. If the woman was already under the care of the mental health team when she booked for her maternity care, the GP and obstetrician interviewed felt that there were generally good links across the acute and primary care sector, with clear referral and liaison pathways. Women not already receiving mental health care would be asked the standardised screening questions recommended by NICE at their booking visit (NICE, 2007) and referred appropriately if necessary, but following this visit, there were no other specific policies or procedures in place for identifying mental health problems. Women with major mental health problems were always referred for consultant-led obstetric care, but the unit was in the process of revising policies and guidelines so that women who required consultant care were also seen by a midwife. There were plans for a community-based antenatal clinic run by an obstetrician and a midwife in one of the most deprived areas served by the unit to support more vulnerable women and to appoint a specialist midwife.

There was a liaison psychiatrist for pregnant women, who held a weekly clinic at the same time as the consultant obstetrician's clinic to facilitate joint management of women with mental health problems. Women with severe mental health problems during their pregnancy who required hospital admission would be admitted to a general psychiatric ward or a maternity ward with liaison psychiatry visits, while postnatal mothers would be referred to a regional mother and baby unit out of the area. There was a crisis outreach team who could provide intensive, community-based support for a woman to try to avoid the need for hospital admission. Weekly psychosocial meetings, where cases could be discussed and general learning about perinatal mental health could be shared, helped to support good levels of communication around care.

A counselling service for obstetric and gynaecology patients was available at the hospital, run by three counsellors. Women with a range of mental health problems, including anxiety or mild to moderate depression, could be referred to the service, which maintained close communication with the liaison psychiatrist and maternity professionals.

Key themes identified from participants' interviews

Screening for mental health needs

CEMACH (Lewis, 2004; 2007) found that many women who developed mental illness in pregnancy had identifiable risk factors, including a previous history of mental illness or a first-degree relative affected, a finding supported in previous research reports (Jones and Craddock, 2001; Robertson et al, 2004; Leigh and Milgrom, 2008). It was evident from the findings of the original survey that midwives were asking women about current personal or family history of mental illness in line with NICE guidance, but there was no information on how questions were asked or documented. Two key questions (often referred to as the 'Whooley' questions, after the original authors who developed them, Whooley et al, 1997) to identify women with possible depression are recommended in the NICE antenatal and postnatal mental health guideline (2007). The two questions are:

'*During the past month, have you often been bothered by feeling down, depressed or hopeless?*' and '*During the past month, have you often been bothered by having little interest or pleasure in doing things?*' These should be followed by a third question, if the woman answers in the affirmative to either question: *'Is this something you feel you need or want help with?'* (NICE, 2007).

The community midwife interviewed in Trust one asked women at every visit antenatally and postnatally about their mental health, although the content of the questioning was unclear. In Trust two, the Whooley questions were asked at the antenatal booking visit, and appropriate referrals made if mental health problems were noted, but there was no clarity around how responses to the questions were documented or clear referral pathway as the following quote from the midwife highlights:

"*The arrangements are a bit ad hoc in terms of picking up either newly developing mental health problems or ones that perhaps were missed – in retrospect were already there, but we didn't pick up on. Now that's where we hope that clinical staff, both midwifery and obstetric, are sufficiently sensitive and alert and sympathetic or empathetic to be able to pick that up"* (midwife, Trust two).

Health professionals interviewed in Trust two felt that while women with significant mental health concerns were usually identified, those with more minor but still potentially significant problems could be missed. Additionally, there were complex catchment issues – such as women living outside of the area covered by the community midwives although they may have given birth in the Trust that employed the midwives – which meant that women with mental health needs in the postnatal period may not be identified following hospital discharge:

"... so we'll have women who've delivered at Trust x who don't fall in our community midwives' catchment area and vice versa, in fact women who've delivered at (x) hospital or (x) hospital... if their home is in our patch, then it'll be our (unit) community midwives. That's an area that (the community matron) and I and our counselling team and liaison psychiatrist, that's a phenomenon that we don't feel we've quite got to grips with. We try really hard and (community matron) puts in a lot of time liaising on a case-by-case basis with (neighbouring boroughs)... but we don't feel 100% confident that we've got a completely secure safety net there" (community matron, Trust two).

Referral pathways

The initial point of contact for women with mild to moderate mental health issues was, in most cases, their own GP. Midwives would usually refer women with signs and symptoms of mild depression to their GP in the first instance and to a psychiatrist via the woman's obstetrician if there were serious concerns about her mental health, including a history of severe depression, bipolar disorder, self harm or suicidal thoughts.

The community midwife from Trust one felt that the links with mental health services could be improved. She did not always receive timely information or support from the mental health team when concerns about a woman's mental health were identified and had experienced difficulty referring women, unless they had been ill enough to require hospital admission. In Trust two, links with hospital-based mental health services were in contrast reported to be excellent. The dedicated liaison psychiatrist, plus the availability of a counselling service for women under the care of the women's health team at the Trust, was considered to be highly effective and facilitated good links with the multi-professional teams. However, there were difficulties ensuring women with identified mental health problems were followed up in the community setting. The psychiatrist needed to conduct negotiations with the Trust to obtain dedicated resources for their service, and Trust boundary issues meant that this specifically developed service could only be provided in hospital:

'This is where we get into the difficult business of catchment services... the community midwifery is predicated on place of residence and not place of delivery" (community matron, Trust two).

She explained they had to work quite hard to set up arrangements whereby women outside the catchment could continue to come to the hospital for follow-up, and to maintain funding for this perinatal psychiatry service. The movement out of acute Trusts to primary care Trusts (PCTs) did not help in this respect, and it was only because this service remained part of the acute Trust that the provision for postnatal women to return for visits could be maintained.

Psychiatric services

Both the psychiatrists and the CPN in Trust one felt that an expanded CPN role to care for women with mental health needs during pregnancy worked well and could be adapted elsewhere. However, there was no identified funding and the CPN's current caseload of over 25 women was extremely time-consuming, leading to some women waiting longer than the recommended two to three weeks to be seen (NICE, 2007). The CPN felt that the profile of the service needed to be raised and information about the service more widely circulated, as many women were unaware that it was available, as the following quote illustrates:

"One of the things is the women themselves knowing the service exists... getting us out there, having a website... or mums actually knowing about our service when they attend the GPs' surgeries or attending perhaps mother and baby clinics" (CPN, Trust one).

The community midwifery managers in both Trusts acknowledged that while their services were being developed in line with national recommendations, developments lacked dedicated funding and support from their organisations, and relied on the good will and

enthusiasm of individuals with a particular interest in perinatal mental health. In Trust two, a lack of links with CPNs was identified as a problem, and catchment allocations meant that hospital-based services had to pay for the time of CPNs called in to provide care for women who were in-patients. With increased stress on finite NHS resources, there were concerns that services would be cut if dedicated resources were not available.

Liaison between the multi-professional teams

Effective management of pregnant and postnatal women with mental health problems depends on good coordination between the different services and specialists. One of the key issues raised in the CEMACH report (Lewis, 2007) and identified in the survey (Rowan and Bick, 2008) were the difficulties professionals experienced liasing with colleagues in other professional groups. This issue was further emphasised during the interviews with the health professionals. In both Trusts, respondents felt that there was a lack of continuity of care for women who had mental health problems. In one instance, a woman had remained in contact with her community midwife six months following the birth because of the relationship that had been established between them. This was somewhat problematic as the midwife had to combine the support she continued to offer the woman with her existing workload, as she had no other dedicated time to offer the woman. Women with pre-existing mental illness may have a key worker, but the professional base and level of knowledge could vary and relevant information was not always passed on. She felt that multi-professional meetings to plan the care of such women would improve the services and the communication between healthcare professionals:

"Links with mental health are not the best, it is difficult to refer women unless they need to be admitted. If they are stable the mental health team are not so interested. Sometimes there is a lack of information from the key worker and information being shared" (midwife, Trust one).

The health professionals interviewed in both Trusts were not always aware of the services available in other areas of the health service and recommended the provision and circulation of named links to support more joined up working. Professionals also identified a lack of communication between community-based professionals and between community–and hospital-based services. It was indicative, for example, that maternity professionals contacted from Trust two were not able to identify a named CPN for contact. The GP interviewed from this Trust felt that improvements could be made with greater awareness of referral systems and processes, named individuals, more continuity of midwifery care and knowing who to talk to when there were concerns identified.

There were continuing challenges raised by catchment issues particularly where funding was defined by geographical boundaries. One of the key challenges identified in Trust two was the complex organisation of services. For example, the liaison psychiatrist had a specific agreement with the PCT to provide care during pregnancy, but following birth, this agreement only extended to postnatal care at the hospital site and did not cover community care. Complex catchment issues also created difficulties for communication. Women are now supposed to be offered a choice regarding place of birth (Department of Health, 2007), but this does not yet extend to choice of place of community care. For example, there was a community midwife clinic close to the hospital, but midwives would only see women who had booked to give birth in that Trust and would not see other women who may have lived in the same catchment area. Follow-up postnatally would be dependent on the initiative of community midwives, or where relevant, hospital social workers, to provide information to their counterparts in neighbouring Trust areas. In addition, as there were several community midwives running the clinic, there was the potential for difficulties with continuity of care and contact. Following up women in an urban area was also made more difficult by the high turnover of patients registered with GP practices, including pregnant women, making it difficult for GPs to get to know the women and their families and provide continuity of care. The GPs' perception was that as the maternity service was very fragmented, women with mental health problems may not be identified or receive appropriate care.

Those interviewed also highlighted differences in professional philosophies creating some challenges for communication. For example, some professionals such as social workers were viewed as concerned mainly with the needs of the child rather than the mental health of the mother.

It is likely that women with mental health problems will continue to be seen by a number of health professionals. Overall, multi-professional liaison was challenging with respect to both Trusts, particularly with services that were not hospital based. In Trust two, for example, although a plan of care was organised for antenatal women with a serious mental health problem, there were issues for her management if she became ill after the birth. One of the key predictors of postnatal psychosis is bipolar disorder, and antenatal depression may predispose women to depression postnatally. Therefore, women with an identified history should have a management plan for follow up after the birth.

Access to mother and baby units

Only Trust one had a local mother and baby unit, although midwives could not refer women directly. The service appeared to work well for women with an acute episode of mental illness. The psychiatrist interviewed from Trust one commented that the incidence of psychosis appeared to be reducing, but that a number of women with schizophrenia were becoming pregnant and may need their mothering skills assessed on the unit. While he felt that mother and baby units

should be provided on a more regional basis, he also recognised the advantages of a smaller unit for families: *"I would recommend mother and baby units are on a more regional basis so that there are more beds and greater expertise available. The advantages of a smaller unit are that dads can stay"* (psychiatrist, Trust one).

In Trust two, postnatal mothers would be referred to a regional mother and baby unit outside of the area, with delays reported in transfer. The obstetrician interviewed felt that distance was a challenge in terms of maintaining family links and support.

Training of health professionals

The need for ongoing training of health professionals in mental health issues has been identified (Stewart and Henshaw, 2002; Sullivan et al, 2003; Ross-Davies et al, 2006) and was also raised as an issue in the first-stage survey (Rowan and Bick, 2008). Those interviewed from the two Trusts reported that while some training for staff was available, attendance was not mandatory and competed with other demands on study time. The community midwife in Trust one felt that there was a lack of knowledge among her midwifery colleagues and the need for more support to care for women who often feared disclosing their difficulties. The CPN also identified a need for further training:

"Everyone thinks they know what depression means but it means something different for everybody, but also in terms of picking up psychosis afterwards. I think midwives and health visitors are often quite scared of mental health and asking the question" (CPN, Trust one).

However, the weekly psychosocial liaison meetings in Trust two, potentially involving midwives, obstetricians, counsellors and social workers provided opportunities for more informal and interprofessional learning.

Discussion

The interviews with health professionals from the two Trusts substantiated the findings of the earlier survey (Rowan and Bick, 2008) that although there were examples of good practice within and between maternity units, services were often fragmented with variation in the provision of care for pregnant and postnatal women with mental health needs. Of the two Trusts, one had developed practice in line with current policy and guidance in more informal and community-based services, and the other in acute care and more specialised care for women with serious problems, but identifying gaps in community-based care. From the healthcare professionals interviewed, it is evident that in their view, women are being routinely asked about their personal or family history of mental illness at the initial antenatal visit. However, this form of screening may be less consistent at subsequent antenatal and postnatal contacts. In some cases, staff highlighted that women with less severe problems may have a risk of not being identified following postnatal hospital discharge.

Although the NICE *Antenatal and postnatal mental health* guidelines (2007) recommend the use of the two screening questions, it is not known whether all midwives ask these specific questions of antenatal or postnatal women, or whether the questions have sufficient sensitivity and specificity to accurately identify mental health needs (Bick and Howard, 2010). As the antenatal booking interview is already very comprehensive, with the requirement to ask women about a number of health issues, including current and previous medical history, midwives may perceive difficulties in being able to give sufficient time to sensitive discussion of women's needs. An observation study of the antenatal booking visit (McCourt, 2006) found that a primarily checklist approach was used by time-pressured midwives in busy clinics, very limited discussion took place, and women asked few questions and raised few topics of their own concern. Additionally, women may be reluctant to disclose concerns about their mental health because of fear of the potential consequences.

Based on these findings, NICE guidance to inform effective perinatal mental health care (NICE, 2007) appeared to be in the process of adaptation and implementation for local use for the acute service. However, it was clear that concerns existed as to what priority this implementation was being given within primary care services. This is perhaps even more important given the rapid transfer home of women following birth, who may not have had their mental health needs assessed as an integral part of their hospital discharge planning. Women whose mental health needs had been identified appeared to be in contact with a range of different health professionals, but the level of effective communication between the maternity and psychiatric services was sometimes lacking. A review of current contracts and service arrangements to promote liaison between professional groups across the acute and primary care sector in health and social care in the UK is required, to ensure local healthcare needs are addressed. It is encouraging that specialist roles with identified funding streams were being developed, which may support better coordination of services and improve continuity of care for women. Nevertheless, service provision was dependent on the initiative of individual professionals with a specific interest in perinatal mental health. As these roles were frequently undertaken alongside other clinical commitments and did not have identified funding, services are vulnerable when individuals are not available (for example, because of annual leave) or leave the employment of the NHS Trust. Unless structures and resources are developed as part of core service provision, it is unclear if the NHS can support these initiatives in the longer term.

Counselling services were provided within primary care in Trust one and were hospital based in Trust two. This finding was in contrast to other NHS Trusts included in the original survey (Rowan and Bick, 2008), where such services appeared to be less well

developed and few were based in primary care. In the initial survey, it was found that waiting lists of between four and six weeks existed in some areas delaying women's mental health needs assessment (Rowan and Bick, 2008). Psychological and psychosocial therapies have been found to help women with mild postnatal depression or anxiety. A recent Cochrane library review, which included ten trials and data on 956 women, found that any psychosocial or psychological intervention compared to usual postnatal care was associated with a reduction in the likelihood of continued depression, however measured, at a final assessment within the first year of the birth (Dennis and Hodnett, 2007). Although the methodological quality of trials was not strong, meta-analysis results suggest that psychosocial and psychological interventions are an effective treatment option, although longer-term effectiveness remains unclear. Cochrane library reviews of psychological and psychosical interventions to treat antenatal depression found that the evidence was inconclusive (Dennis et al, 2007; Dennis and Allen, 2008).

Treatment options for women with postnatal depression have been neglected despite the large public health impact. Given the potential risks and side-effects involved in taking medication, further research into the effectiveness of psychological therapies particularly during the antenatal period needs to be prioritised, with postnatal interventions more widely available for women who may benefit from their use. Additionally, the obstetrician interviewed for Trust two identified that a number of women were seen who had stopped taking their medication in an unplanned way because of fears about effects on their babies. Such women clearly need prompt care and advice, with further research required to compare different antidepressants in the treatment of postnatal depression and provide more evidence of the adverse effects of antidepressants including long-term effects (Hoffbrand et al, 2001).

Effective management will also be compromised if a woman referred to the mental health services does not take up the referral. A recent qualitative study from the US of 51 perinatal women – identified by screening as at risk of depression or via calling a perinatal mental health hotline – were followed up by survey and interview to understand patient behaviour, and barriers and facilitators to acceptance of mental health referrals at four steps in the treatment engagement process (Kim et al, 2010). Although 30 (59%) of the women accepted mental health referrals, only 14 (27%) actively engaged in treatment. A number of barriers and facilitators to successful mental health treatment linkage were identified at patient, service provider, patient/service provider interaction and system levels. Lack of time was a commonly cited barrier at patient level, with availability a key factor having an impact on treatment linkage at service provider level. Other commonly described barriers included poor match of referral to need, geographic boundaries and lack of response from the service provider. Conversely, women's recognition of their need for treatment was a facilitator. The authors highlight the concern that women and families may remain at significant risk, even if clinical follow-up to positive screening is uniformly applied. Despite differences in healthcare funding and context of care between the US and the UK, it is notable that many of the issues raised are similar to this study and findings of the survey of women undertaken by the mental health charity MIND (2006).

The findings further show the concerns raised in the current study about the follow-up and care of women identified with mental health needs and need for management plans to be in place for those at risk as well as good liaison between professionals involved (Lewis, 2004). Although the recommendations of the most recent CEMACH report (Lewis, 2007) are that women with more severe mental health illness following birth should be admitted to a mother and baby unit, there is clear variation in availability. Processes for referral and provision of care are needed for those women who develop an acute episode of mental illness following the birth (MIND, 2006), with a recent Cochrane library review also recommending that research is needed into the effectiveness of units (Irving and Saylan, 2007).

If the care of women with mental health problems is to improve, health professionals clearly need realistic access to appropriate in-service training to develop the confidence and knowledge to identify women with signs and symptoms of mental health problems, to support these women, to understand cultural differences and approaches to mental health, and ensure familiarity with local referral pathways. The NHS Scotland *Perinatal mental health curricular framework* (NHS Scotland for Education, 2006) provides broad educational goals for educationalists to use when planning the development of perinatal mental health aspects of pre-registration, undergraduate, post-registration and postgraduate programmes. It provides a useful starting point for those developing local training initiatives and is included as part of the implementation guidance for the antenatal and postnatal mental health guideline (NICE, 2007). It is nevertheless important that whichever approach is developed and used locally, that outcomes for the multi-professional team and the women they care for are regularly evaluated and updated.

Conclusion

This study has reported the in-depth views of relevant healthcare professionals on the extent to which perinatal mental health services are meeting policy and practice guidance. Their views highlight that although there have been developments in service provision, gaps persist particularly with respect to appropriate ongoing identification of needs and appropriate follow-up of women. Real challenges for the maternity services persist in relation to complex boundary issues that impacts on opportunities to support effective continuity of care

and funding issues. Additionally, examples of good practice may still depend on the initiative and commitment of individual professionals, rather than the support of the organisation, including dedicated resources. Further research is required to ascertain the extent to which resource issues and the drive to cut NHS healthcare budgets are limiting appropriate service provision for women with perinatal mental health needs. There is also an urgent need to elicit the views of the women who use the service.

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Information for authors

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News and resources

Science minister delays REF for a year

The Research Exellence Framework (REF) will be delayed by a year so the Higher Education Funding Council for England (HEFCE) and its UK-wide counterparts can review whether there is a methodologically sound way of assessing impact.

This means that the assessment phase of REF will take place in 2014 to inform funding from 2015 to 2016, according to the Minister for Universities and Science David Willetts in a speech to the Royal Institution.

HEFCE is now inviting applications for sub-panel chairs – the deadline for which is 17 September 2010 – and nominations for panel members. This deadline is 8 October 2010. For more information, please visit: www.hefce.ac.uk

Responses sought for NI abortion consultation

Northern Ireland's Department for Health, Social Services and Public Safety has issued revised guidance on legal and clinical practice around the termination of pregnancy. The guidance, which covers issues such as counselling and conscientious objection, will be open for consultation until 22 October 2010. For further information, please visit: www.dhsspsni.gov.uk/showconsultations?txtid=43372

Australian university seeks new professor of midwifery

Griffith University on Queensland's Gold Coast is inviting applications for the post of professor of midwifery.

The successful candidate for the five-year fixed-term post will have a doctoral qualification in midwifery or a related discipline and will be eligible to be registered as a midwife in Australia. She or he will provide leadership in the critical examination of current trends and evidence-based practice and the related implications for research, education and practice. The closing date is 15 September.

For more information, please visit: www.unijobs.com.au/show.php?id=34818

Last chance to contribute to EBM's ethics issue

Evidence Based Midwifery has extended the deadline for contributions to its themed ethics issue until 1 November. Please send papers of no more than 3500 words to the editor at: emma.godfrey@redactive.co.uk

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