Healthcare professionals' experiences and perceptions of providing support for mental health during the period from pregnancy to two years postpartum

Abstract

Objective Mental health issues in the perinatal period are common, and can have negative consequences for maternal and child health. Healthcare professionals (HCPs) who provide women with perinatal care are well-placed to detect mental health issues and provide support. This study therefore examines HCPs experiences and perceptions of providing mental health support during the perinatal period, including during the COVID-19 pandemic.

Design An exploratory realist qualitative study was conducted.

Setting Republic of Ireland

Participants A purposive sampling strategy was employed to recruit HCPs (e.g., general practitioners, midwives, public health nurses, practice nurses, doulas, and breastfeeding counsellors), via professional bodies in Ireland. An invitation to participate was also circulated via Twitter. A total of 18 HCPs participated in semi-structured interviews conducted between 18/8/2020 and 24/5/2021.

Measurements and Findings Semi-structured interviews were conducted according to a topic guide designed by a multidisciplinary team. Data were analysed using thematic analysis. Four themes were developed: 'Supporting women in healthcare settings,' 'Skills and capacity to provide adequate care,' 'Structural barriers to care provision,' and 'The impact of the COVID-19 pandemic on stress support.'

Key Conclusions HCPs reported providing emotional support and advocacy, but highlighted challenges, including limited capacity to address women's concerns, clinical culture and hierarchy, insufficient organisational investment, and social inequities in support access. Some HCPs felt these barriers could lead to additional psychological harm. HCPs also reported that the pandemic had introduced novel stressors and changed the nature of the mental health support they provided.

Implications for Practice Interventions incorporating education and physical resources for HCPs, increased investment in specialist perinatal mental health services, increased investment in holistic supports, and changes to address cultural challenges in care environments, may facilitate – or enhance – support for women.

Keywords. Stress; Perinatal; Pregnancy; Post-partum; Healthcare professionals; COVID-19

Introduction

Mental health issues during the perinatal period (from conception to two years postpartum), are a pervasive public health concern: approximately 30% to 36% of women will experience stress or anxiety, respectively, during the perinatal period (Leach et al., 2017; Loomans et al., 2013). Perinatal maternal stress and anxiety can arise from a range of sociodemographic, social, psychological, and physiological factors (Bayrampour, Vinturache et al., 2018; McCarthy et al., 2021), and from environmental stressors, such as the COVID-19 pandemic (Chmielewska et al., 2021). Perinatal stress and anxiety are associated with adverse maternal and child health outcomes. These include reduced maternal health-related quality of life (Slomian et al., 2019), increased risk of preterm birth and low birth weight (Lobel et al., 2008), and small for gestational age infants (Khashan et al., 2014). Perinatal maternal stress can also influence children's stress reactivity (Nazzari et al., 2019), and increases risk for developmental (Kinney et al., 2008), socioemotional, and psychiatric disruptions (Weinstock, 2008); or onmothers' health behaviours, such as smoking and breastfeeding (Dozier et al., 2012; Lobel et al., 2008), with further direct and indirect consequences for maternal and child health.

Early detection and intervention can mitigate the risks associated with poor perinatal mental health (NICE, 2022; Noonan et al., 2017). Previous research suggests, however, that many perinatal mental health issues, including stress and anxiety, go undetected or under-treated (Howard & Khalifeh, 2020). This may be partly due to the focus on maternal physical morbidity and mortality outcomes, rather than women's wellbeing (Byrne et al., 2017; Larkin et al., 2012). It may also reflect organisational challenges (Marks, 2017), such as uneven continuity of care, high caseloads, limited mental health training (Higgins et al., 2018; Huschke et al., 2020; Noonan et al., 2017), lack of privacy in care settings, unclear policy guidelines and referral pathways (Noonan et al., 2017, 2018), and limited health care professional (HCP) contact time with women (Higgins, 2017). Limited use of screening tools, engagement in care planning, or documentation of disclosed mental health problems have also been reported (McAuliffe et al., 2011), perhaps reflecting HCPs' documented discomfort and low self-efficacy in addressing women's mental health issues (Higgins, 2017; Huschke et al., 2020). Finally, clinical decision-making about perinatal mental health may also be informed (or impaired) by a variety of social and perceptual factors, such as HCPs' own personal experiences or attitudes about mental health, their understandings of mental health constructs (Coates & Foureur, 2019; Leddy et al., 2011), or their biases regarding women's histories of psychiatric illness, minority background status, or language proficiency (Carroll et al., 2018). HCPs may also sometimes provide

information and support outside of what is indicated by guidelines or evidence bases (Hauck et al., 2015).

Perinatal mental health support can help minimise adverse maternal and child health outcomes. Examining HCPs' experiences and approaches to the provision of perinatal mental health supports (especially during times of heightened stress, such as the COVID-19 pandemic) (Lim et al., 2021; Townsend et al., 2021), is essential for understanding how these supports should be delivered. This study thus examined HCPs' experiences and attitudes regarding maternal psychological wellbeing, and the provision of perinatal mental health support, including during the COVID-19 pandemic.

Methods

Study design

An exploratory, qualitative realist design, involving semi-structured interviews.

Participants

Participants were recruited using a purposive sampling strategy in the Republic of Ireland (RoI). Eligible participants were clinically-practising HCPs in routine contact with women during

pregnancy and/or up to two years postpartum. Participants were recruited via email circulated to members of relevant professional organisations (e.g., the National Association of General Practitioners) and university departments (e.g., the University College Cork School of Nursing and Midwifery). An invitation to participate was also circulated publicly via Twitter.

Data Collection

Prior to interview, participants were asked to complete a sociodemographic questionnaire, indicating their gender, age, nationality, current professional role, length of time in current role, previous experience in another healthcare role, length of time in previous role, and setting of practice. See Supplementary File 1 for sociodemographic questionnaire.

Due to pandemic-related restrictions, interviews were conducted via phone (n=11), Zoom (n=1), or Microsoft Teams (n=6), according to participant preference, from 18/8/2020 to 24/5/2021. A semi-structured topic guide was developed by the multidisciplinary team, which included expertise in psychology, nursing, health visiting, family social services, and perinatal mental health and health services research. The topic guide focused on HCPs' attitudes and experiences regarding maternal psychological wellbeing and the provision of perinatal mental health support (see Supplementary File 2 for full topic guide). All interviews were conducted by a female Master of Public Health candidate with experience in family psychosocial intervention in healthcare environments [removed for peer-review]. In order to protect participant privacy, only the interviewer and participant were present during interview, although participants were free to be joined by a supportive other if they wished.

Iterative data collection continued until data adequacy, or sufficient richness of data, was achieved (Braun & Clarke, 2021; Lewin et al., 2015). Mean interview length was 47.1 minutes (SD=13.0). All interviews were audio-recorded, transcribed, and pseudo-anonymised.

Data Analysis

The analysis proceeded from the realist assumption that shared perceptions, while socially constructed, emerge from a knowable reality (Barnett-Page & Thomas, 2009). Transcripts of interview data were analysed in QSR NVivo 12 software, using Braun & Clarke (2006)'s inductive thematic analysis framework. This framework was selected because its six iterative "phases" provide a useful foundation for the systematic exploration and coding of data, and for identifying patterns across interviews (Braun & Clarke, 2006). Themes were reviewed and

discussed with all members of the multidisciplinary team throughout the analysis process.

Ethical Considerations

All participants provided written and ongoing verbal consent following provision of study information, which included details on the purpose of the research, as well as confidentiality and right to withdraw. Ethical approval for this study was granted by the [removed for peer-review].

Results

Participants were 18 HCPs in eight healthcare roles. Mean time in current role was 11.1 years; 12 participants (66.7%) reported prior experience in another healthcare role. See Table 1 for participant characteristics.

Table 1. Participant characteristics

	M(SD)	Range
Age (years)	47.1(8.1)	26.0
Length in current role (years)	11.1(7.5)	24.0
Length of time in previous role (years)	11.3(9.2)	29.0
	n	**%**
Gender		
Female	17	94.4
Male	1	5.6
Nationality		
Irish	13	72.1
Not specified	5	27.8

Current healthcare role		
Advanced midwife practitioner (AMP)*	1	5.6
Advanced nurse practitioner (ANP) - candidate	1	5.6
Breastfeeding counsellor	1	5.6
Doula	1	5.6
General practitioner (GP)	3	16.7
Lactation consultant	1	5.6
Midwife*	6	33.3
Public health nurse (PHN)	4	22.2
Previous healthcare role		
General nurse	5	27.8
Hospital doctor	1	5.6
Midwife	5	27.8
Paediatric nurse	1	5.6
Psychiatric nurse	1	5.6
No/not specified	6	33.3
Setting of practice		
Rural	1	5.6
Urban	11	61.1
Both	5	27.8
Not specified	1	5.6

*In Ireland, the Advanced Midwife Practitioner (AMP) qualification requires training to at least Master's level; and, reflecting this, AMPs often have a wider scope of practice than Registered Midwives (RMs). For this reason, midwives and advanced midwife practitioners are reported here as distinct professional groups.

Four themes were developed: 'Supporting women in healthcare settings,' 'Skills and capacity to provide adequate care,' 'Structural barriers to care provision,' and 'The impact of the COVID-19 pandemic on stress support.' A summary of these themes and related subthemes is presented in Table 2.

Table 2. Summary of themes and subthemes

Theme	Sub-themes
1. Supporting women in healthcare settings	1.1 Building relationships to provide support and advocacy 1.2 Women can get "lost in the system"
2. Skills and capacity to provide adequate care	2.1 Concerns about training, skills, and scope 2.2 Looking beyond medicalised approaches

3. Structural barriers to care provision	3.1 Clinical culture and hierarchy 3.2 Insufficient organisational investment and resources 3.3 Social barriers to support access
4. The impact of the COVID-19 pandemic on stress support	4.1 Impact of the pandemic on women's mental health 4.2 Impact of the pandemic on support delivery

1. Supporting women in healthcare settings

1.1. Building relationships to provide support and advocacy

Many HCPs identified as "an emotional support" (P12, Doula), a "support network" (P15, PHN), or "an advocate" (P12, Doula) for women. Some described themselves as being on the "frontline" of mental health support, and many reported that their familiarity and frequent contact with women put them in a strong position to facilitate mental health disclosures and provide support. PHNs and doulas felt especially well-placed in this regard because of the regularity of their contact with women, and because of the intimate nature of home-based care. Across disciplines, however, HCPs saw value in providing women with a safe place to "vent," or to seek reassurance. They also believed that strong relationships could be protective in terms of encouraging women's engagement in care.

> "The biggest skill that I feel I bring to a mother as . . . a healthcare professional, is my ability to listen, and to acknowledge her feelings" (P7, Lactation Consultant)

> "Absolutely [PHNs are on the frontline of mental health support] . . . we are in the home. We are with them for maybe the first few weeks of life, as opposed to any other profession" (P2, PHN).

HCPs from all disciplines felt they had a role to play in supporting women's mental health. Often, this role involved listening to and affirming women's feelings. HCPs also described engaging in, and advocating for, woman-centred care, to protect women's mental health. However, high service demands sometimes limited HCPs ability to build strong relationships with, and actively listen to, women, with potential consequences for the quality of mental health support they could provide.

> "If you give the woman the impression that you're busy and don't have time, she'll close up, and you'll hear nothing from her" (P16, Midwife).

1.2. Women can get "lost in the system"

Modes of organisation in health services were considered complicated, and HCPs were concerned that women might fall through the cracks during referrals. Some HCPs, particularly GPs, therefore chose to handle mental health concerns "in-house," (P9, GP) rather than risking care fragmentation. Often, HCPs reported monitoring women for several weeks before making referrals, sometimes in breach of organisational protocols. They suggested that, in addition to causing confusion for women, referral could leave women feeling l like "cog[s] in a wheel" (P12, Doula), or as though HCPs had "pass[ed] the buck" (P14, Midwife). Thus, delaying referral was regarded as a way of protecting women from complicated care systems, and as a strategy for building trusting relationships

> "[Women say] 'I don't know how to get an appointment,' 'How can I get back to see the consultant? I'm now three months postnatally, they don't want to see me in the hospital.' 'My GP doesn't know what to do.' So it's a little bit lost in the system (P5, Midwife).

> "I'd see lots of women and I'm thinking, 'Hmm, this is mental health, what will I do here?' And I will, of course, say to them, 'Look I have a system and I can refer you . . . but you know what, why don't you come back to me in four weeks' time and I'll check on you' . . . I do not agree with all this [referral] . . . next thing you nearly have fifteen people involved in this woman, and the poor critter is going 'Jeepers, I don't know what I'm going to now'" (P5, Midwife).

2. Skills and capacity to provide adequate care

2.1. Concerns about training, skills, and scope

Many HCPs reported limited opportunity to engage in perinatal mental health training. Often, formal training was limited to self-paced modules or study days organised locally. Lack of time, and other professional demands, were identified as barriers to attending these optional trainings. HCPs therefore wanted more support to learn about perinatal mental healthcare provision.

Some HCPs highlighted concerns about their lack of training in the use of perinatal mental health screening tools. This sometimes impacted their engagement with recommended screening practices. In particular, HCPs expressed a lack of clarity about the role of screening tools in the overall assessment and intervention process. Specifically, HCPs were unsure about how to introduce screening tools into discussions with women, how to interpret the findings, and how screening results, which "have no context" (P10, GP), should be weighed against the other contextual information they had about women. In some cases, these concerns led HCPs to forgo the use of tools in favour of improvised questioning and observation.

> "We don't use any tools . . . [but] a lot of the recommendations that I looked at, they all say, you know, 'At every point of contact, you should ask the woman about her emotional wellbeing.' And we don't. It's something that we're not good at. But I do think that if midwives become more informed . . . " (P18, Midwife).

HCPs also reported limited confidence in selecting or facilitating appropriate mental health interventions. HCPs therefore placed high value on, and a desire for additional engagement with, specialised perinatal mental health serviceswhich were perceived to have broader authority and scope to identify appropriate interventions

> "Some of [women's] difficulties are outside of my skillset to help . . . I'm not a counsellor or a psychologist or a psychiatrist" (P7, Lactation Consultant)

> "We used to just refer anybody with problems to [a social worker] . . . now we have an excellent perinatal mental health midwife . . . it's made a huge impact" (P18, Midwife).

2.2. Looking beyond medicalised approaches

HCPs recognised that a small fraction of the women they worked with would experience clinical mental disorders requiring medical intervention. However, most drew distinctions between such disorders, considered to be uncommon, and more "normal" distress (P7, Lactation Consultant) related to the diverse psychosocial challenges of the perinatal period. Some HCPs perceived that the emphasis on clinical disorders in healthcare training came at the expense of educating providers about more common issues in mental health and well-being. In addition, many HCPs regarded perinatal-specific stress as common and "natural" (P18, Midwife). HCPs were

therefore wary about pathologising or taking a medicalised approach to understanding and treating women's mental health concerns.

> "[Y]ou'd be learning about . . . postpartum depression and puerperal psychosis and things that are as rare as hen's teeth . . . [but] when you come out into the real world, you realise: . . . that isn't the reality of most of the problems that people face . . . it's all the normal stuff" (P10, GP).

> "Sometimes it's normal to experience distress and upset. And being worried that what you're experiencing is somehow an illness, or abnormal, isn't helpful" (P10, GP).

Many HCPs described the high impact of informal social interventions (for example, providing "the cup of tea and the chat") (P15, PHN). They also suggested that women would benefit from additional holistic support from HCPs, including increased guidance around what to expect during prenatal visits and labour, more support around the transition to parenting and early chilldhood care,, and, especially, more social support. HCPs emphasised that social support could be protective even in the presence of serious stressors, and, conversely, that women without social support were more likely to struggle.

> "Oftentimes the young girl who is, like, 21 with an unplanned pregnancy, copes quite well . . . they might have maternal support . . . whereas the professional 38-year-old lawyer, it's assumed that she will be fine . . . [so she] is kind of left to her own devices, and she doesn't – she can't" (P9, GP).

3. Structural barriers to care provision

3.1. Clinical culture and hierarchy

HCPs across disciplines suggested that the culture of health services could be a barrier to providing perinatal mental health support. They described feeling constrained by high patient volume and care ratios, the lack of privacy on wards and in appointment spaces, and a culture which pressured them to be "running around physically working" rather than spending time with women (P4, Midwife).

Some HCPs also suggested that healthcare experiences could, themselves, be psychologically harmful to women. For example, midwives and doulas described the potential negative impacts of medicalised language on women's emotional wellbeing. They also described how medical

interventions experienced in maternity care could become a source of distress, due to the limited emphasis on woman-centred care and informed consent in maternity settings.

> "[T]here's a saying, you know, that women have, like, 'When you have a baby, leave your dignity at the door' . . . the level of trauma and the level of inappropriate care would knock the knees off you" (P3, Midwife)

> "I said . . . 'This woman doesn't want her waters broke,' and I wouldn't break them . . . and the senior midwife in control of the shift went into the woman and broke her waters while I didn't know about it. Sent me on a break, and went in, and did it. And afterwards this woman . . . said, 'I wanted to just see how long my wishes would be respected until someone would come in and break my waters,' and she said, 'I knew this would happen.' And she thanked me for being her advocate and stopping it happening for as long as possible" (P4, Midwife).

Additionally, some midwives reported that the quality of medical decision-making was influenced by dysfunctional power dynamics on care teams, with potentially harmful psychological consequences for women.

> "They'd say, 'Well I'm the obstetrician, I'm in charge, so the reason is: I'm telling you' . . . these people have so much power, they can just say, 'I'm picking up children at four, she needs to be delivered by that time so that I can leave.' So it was about them, not about the woman" (P4, Midwife).

However, many HCPs also reported taking steps to reduce healthcare-related psychological harm for women, often on their own initiative and with limited institutional support. For example, HCPs reported conducting tours of the labour ward with women during their pregnancies, in order to reduce fear of labour; creating space for women to ask questions about the interventions they experienced during their births; and providing women with opportunities to tell their birth stories.

3.2. Insufficient organisational investment and resources

HCPs reported a "systematic lack of investment" (P3, Midwife) in perinatal healthcare services. Lack of supportive physical infrastructure, high caseloads, and low staffing left many HCPs

feeling “thinn[ed] “across the board” (P2, PHN). It also limited the time and attention HCPs felt able to give to mental health support, particularly when women were not experiencing severe symptoms or issues.

> “I felt I spent so little time with this young woman, and at the end she said to me, ‘You’ve been so, so kind. And I said, ‘No, I really haven’t. I wish I could have spent more time.’ And I felt emotional, because she was talking about my kindness, and I really felt I hadn’t given her the time that she really deserved” (P4, Midwife).

HCPs also highlighted the inadequacy of existing referral pathways, particularly for women without private health insurance. Long waitlists for public mental healthcare, and the lack of public services tailored to the physical, scheduling, and childcare needs of new mothers, left many women without timely access to support. One HCP questioned the purpose of eliciting mental health disclosures from women at all, in the absence of adequate resources to meet their referral needs.

> “They didn’t have a pump on the [adult psychiatric] ward, so we needed to organise a breast pump. The babies weren’t allowed in. So like, I just don’t think it’s the appropriate service for a mum” (P15, PHN).

> “[W]e’re telling these patients all the time . . . ‘talk to your GP,’ or, ‘it’s important to tell people how you feel.’ But then they come to us, and we’ve no access to counsellors . . . If they have taken those steps, and that’s what we’re telling them to do, we have to have . . . people to refer them on to” (P13, GP).

3.3. Social barriers to support access

HCPs perceived social inequities in access to perinatal mental health supports. For example, HCPs described a “postcode lottery” for community-based mental health services (P13, GP). They also described disparities between the mental health services available in different regions and facilities.

> “In a lot of the hospitals down the country, like, they barely have a bereavement midwife, let alone, like, the mental health care teams. Various different units differ hugely” (P3, Midwife).

HCPs discussed how social factors, such as language or socioeconomic status, could impact relationships between women and medical staff, with consequences for the support women received. For example, many HCPs found it challenging to detect mental health issues for women with limited English language proficiency due to lack of interpreters. HCPs also discussed difficulties developing and maintaining relationships with women from lower socioeconomic backgrounds due to point-of-service fees in primary care, and challenges in facilitating mental health disclosures from women from lower socioeconomic backgrounds due to these women's concerns about differential targeting in child protective investigations.

> "They're terrified that somebody is gonna take the baby away . . . middle class parents are treated very differently to working class parents in the mental health forum . . . so that's another factor as well, you know, is the class" (P12, Doula).

4. The impact of the COVID-19 pandemic on stress support

4.1 Impact of the pandemic on women's mental health

HCPs reported that reduced contact, loss of practical support from family and friends, and loss of breastfeeding and/or mother and baby groups, had negative impacts on perinatal mental health during the pandemic. In particular, HCPs highlighted the negative impacts of social restrictions on women's ability to celebrate andmake sense of their transitions to motherhood.

> "Many of the mothers that I have encountered during COVID have not met another breastfeeding mother. So that has been a huge loss in their experience. Often they don't realise how well they're doing because they've got no one to share or celebrate their experience [with]" (P7, Lactation Consultant)

However, some HCPs identified positive impacts of pandemic-related restrictions on women's mental health. For example, some HCPs perceived that restrictions on hospital and home visiting had helped women to bond with their infants, or to establish independent parenting identities. HCPs also suggested that the universality of pandemic-related stress, and increased public focus on mental wellbeing, had made women "a little bit more willing to talk about" mental health, with positive impacts for perinatal stress detection (P17, PHN).

4.2 Impact of the pandemic on support delivery

HCPs described concerns for their own safetyas they worked on the pandemic frontline. Nonetheless, they also expressed a strong commitment to supporting women and adapting to new support needs. One new support need identified by many HCPs was guidance about the impacts of SARS-COV-2 on pregnancy and infants. “People were afraid,” recalled P3 (Midwife): “There was no information on what COVID would do.” Later, HCPs also reported speaking with women about the safety of receiving COVID-19 vaccines while pregnant or breastfeeding

HCPs further reported that the pandemic had greatly reduced the frequency and quality of their contacts with women, resulting in concern about potential undetected needs. However, HCPs also took steps to actively increase their contact with women during the pandemic, checking in with women by phone or email and facilitating remote prenatal classes and support groups. Most HCPs felt that these groups were under-resourced and provided a reduced quality of support, compared to in-person groups.However, a few HCPs also highlighted that digital services had levelled support access for women living in rural or historically under-resourced areas.

Many HCPs reported that in-person perinatal healthcare experiences were also negatively impacted by the pandemic. They reported that women displayed increased distress during scans, about labour, and about the possibility of postpartum hospitalisation, due to restrictions on visitors in healthcare settings.

> “COVID has had a massive, massive impact on all of us. But for . . . pregnant women – it has been huge . . . nobody coming to the hospital, so they’re on their own” (P16, Midwife)

> “[Women are] very anxious about labour, and how are they gonna manage? They want their partner to be there for them” (P12, Doula).

In response to this distress, HCPs took extra time and care to normalise in-person perinatal healthcare experiences For example, HCPs described helping women to include their partners in prenatal appointments or early labour via phone or video calls, and recordings.

> “One of the things that I came up with was . . . I used to say to them, ‘I’m listening to the baby’s heartbeat,’ and then I’d say to the woman, ‘Would you like to phone your partner?’ And then he heard the foetal heart on the phone. And it was absolutely – I mean, some of the occasions, you’d nearly be so emotional” (P16, Midwife)

Discussion

HCPs working in perinatal healthcare recognise the value of supporting perinatal mental health (Higgins et al., 2018; Noonan et al., 2018). Findings of the current study affirmed HCPs commitment to supporting women’s perinatal mental health and highlighted specific contributions HCPs make to protecting women’s mental health, including providing women with emotional support, advocacy, and a point-of-contact for perinatal mental health support. Study findings also identified important challenges to HCP provision of mental health support.

HCPs in this study emphasised the value of their relationships with women for facilitating mental health assessment and support. They perceived that strong relationships facilitated understanding of women's individual coping skills, support needs, and goals. This is in line with international guidance that perinatal mental health support should take into consideration a wide range of contextual factors, including a woman's environment, physical health, and psychological functioning (Blount et al., 2021; Reilly et al., 2013). , HCPs also perceived that their relationships with women could be safe, healing spaces where women could explore difficulties, seek reassurance, and receive positive regard. These spaces, sometimes called "holding environments," are increasingly recognised as a valuable component of woman-centred and trauma-informed maternity care (Sperlich et al., 2017). More broadly, this reflects a growing recognition that relational interventions and "therapeutic alliances" (characterised by mutual positive regard, trust, and shared goals) may, themselves, have a healing effect on women's perinatal mental health (Cox, 2021; Hartley et al., 2020). However, specific guidance about implementing these practices and interventions, especially in the presence of organisational barriers like high care ratios, remains limited (Curtin et al., 2020). Healthcare professionals in this study also reported struggling with the impacts of social factors, such as gender, language, nationality, and class, on their ability to build trust and relational continuity with perinatal women; and more explicit support in this area may be warranted.

HCPs in this study highlighted the need for further investment in physical infrastructure and maternity staffing. These needs have also been identified in prior studies (Glavin & Leahy-Warren, 2013; Higgins, 2017; Huschke et al., 2020). In addition, HCPs in this study emphasised a need for increased midwifery advocacy and leadership, a need to shift away from medicalised approaches to perinatal healthcare, and a desire for more cultural support to implement woman-centred care. In the absence of these, healthcare professionals perceived that contact with maternity services could compound stress or trauma, a phenomenon which likely bears further consideration as maternity services continue to develop their mental health supports. HCPs also reported that women's needs sometimes exceed the limitations of the medical model, or what can be provided as part of routine perinatal care and called for further expansion of the specialist perinatal mental health service, especially in currently underserved facilities. However, the role of specialist perinatal mental health services remains unclear, and has historically focused on the needs of women with psychiatric disorders (Howard & Khalifeh, 2020). merging evidence indicates that psychosocial interventions provided by trained non-specialists can

impact women's perinatal mental wellbeing (Howard & Khalifeh, 2020; Rahman et al., 2013), however; and the effectiveness and feasibility of providing non-specialist and holistic psychosocial intervention may therefore bear exploration.

HCPs in this study reported heavy reliance on experience and improvisation to provide support to women. For example, many HCPs relied on clinical judgement, rather than screening tools, to assess women's perinatal mental health. The uneven implementation of recommended screenings reflected uncertainty about the use of tools and their role in the assessment process. This suggests a need to clarify how screening tools can be introduced into care relationships, their purposes and limitations, and how they should be weighed to inform care planning and referral. Similarly, HCPs in this study often deferred referral for additional mental health services, due to concern that women might fall through the 'cracks' of care systems. Prior studies have also found evidence that providers hesitate to refer women for additional care when they feel that referral pathways are unclear (Higgins, 2017; Huschke et al., 2020; Noonan et al., 2018) or where they are concerned about care fragmentation (Bayrampour, Hapsari, et al., 2018; Noonan et al., 2017). This may lead to delays in care and compromised safety for women. As such, providing clear guidance to accessible referral resources is an important target for intervention with HCPs. Evidence also suggests a need for training and guidelines for HCPs around perinatal mental health, especially around the management of complex mental health needs, psychosocial stresses, and patient advocacy (Higgins et al., 2018; Noonan et al., 2018). This might take the form of Continuing Professional Development (CPD); however, to be most effective, such CPD should focus on implementation issues, such as ensuring shared team values and feasibility of knowledge translation (Manley et al., 2018). Given the complexity of barriers healthcare providers reported in this study, a systems change approach, which emphasises analysis of barriers and facilitators to implementation at multiple organisational levels (Fleuren et. al., 2014), might provide a useful framework for supporting professionals in providing appropriate mental healthcare.

Finally, while most prior research about the responses of the perinatal health services to the COVID-19 pandemic has focused on reductions in access to healthcare and healthcare professionals (Flaherty et al., 2022; Sheil & McAuliffe, 2021; Townsend et al., 2021), this study provides evidence that HCPs also provided improvised and adapted mental health supports during the COVID-19 pandemic. This underlines the need to further examine the provision of perinatal mental health supports during public health emergencies, such as pandemics and

climate-related disasters.

Strengths and Limitations

This study included professionals from a range of backgrounds and roles, allowing for a diversity of perspectives and experiences. In addition, the timing of recruitment (beginning early in the COVID-19 pandemic, and continuing through the first year of pandemic-related restrictions) facilitated exploration of experiences and perceptions both prior to, and in the context of, the COVID-19 pandemic.

Despite the strengths of the study and its contribution to understanding, this study also has a number of limitations. The study was limited by the absence of a midwifery expert on the research team, given the strong participation by midwives in this study. In addition, while recruitment targeted diverse professional organisations, the majority of participants who engaged in interviews came from primary care backgrounds, and so the results may privilege a primary care perspective, particularly regarding care barriers. Further research into the role of secondary care providers in supporting perinatal mental health would likely be beneficial. In addition, the majority of HCPs in this study were female, and Irish nationals. Therefore, the findings provide a limited perspective on the ways in which social factors, such as gender, nationality, and language, can impact care dynamics . Finally, recruitment for this study was limited to professionals working in the Republic of Ireland, and so findings may reflect challenges specific to the Irish national health service. Likewise, disproportionate participation by urban professionals may have resulted in data that privileges the experience of providing care in urban settings. However, the consistency of our findings with existing international evidence, and the new knowledge generated, provides confidence in the applicability of our findings across different contexts of perinatal mental healthcare support provision.

Conclusion

This study highlighted HCPs' perceived importance of their role in perinatal mental health support, but also highlighted educational and organisational barriers to implementing this type of support in practice. The study findings also highlighted the need for adaptive interventions and approaches to support perinatal mental health during the pandemic, and provided insight into the ways in which HCPs approached the care barriers they encountered. The findings demonstrate the need for interventions targeting educational and physical resources for HCPs. Implications for practice include the need to increase staffing and availability of specialist

perinatal mental health services, a need to to clarify and agree referral pathways to perinatal mental health support, and a need to increase provision of suitable perinatal mental health training for HCPs. Overcoming challenges to provision of appropriate perinatal mental health support by HCPs is essential to mitigate risks and improve outcomes associated with perinatal mental health in the perinatal period.

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